Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
St David's Clinic, 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.

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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 St David's Clinic, Aneurin Bevan University Health Board on 18 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. We also invited staff to complete a questionnaire to tell us their views on working for the service. Unfortunately, we received no completed questionnaires from patients or their carers, however we did receive five that 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 practices' appointment system operates a triage model. Patients can complete an online request for an appointment via their website, or by telephone. Appointment requests are triaged daily by a duty doctor, with both urgent and routine appointments being allocated as appropriate. Appointments with the Nurse and Healthcare Assistant can be booked six weeks ahead. Patients under 16-years-old would be triaged for a face-to-face appointment as appropriate.

The practice had a range of health promotion information available for patients on a variety of topics, including healthy eating, smoking cessation and immunisation information.

The practice offered chaperones in all appropriate circumstances, and this was supported by a chaperone policy. A chaperone information notice was displayed in the waiting area and within all clinical treatment rooms.

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.

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

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- ensure that the active offer of Welsh is promoted to patients.

This is what the service did well:

- good appointment system
- good evidence of health promotion being available for patients
- information is available to patients regarding the option of a chaperone in all clinical treatment rooms

Delivery of Safe and Effective Care

Overall summary:
Overall, the IPC arrangements in place were not robust, with some arrangements needing strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

The process in place for managing patient safety alerts and significant incidents was robust.

Processes were in place to ensure the safe prescribing of medication, and the process to request repeat medication was clear.

The practice had a named safeguarding lead for adults and children and staff had access to the practice safeguarding policies and procedures.

We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear and written to a good standard.

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:

- Full clinical waste bags situated in an unlocked bin outside of the practice which were accessible to patients and the public.
- A record was not in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity status recorded.
- Emergency equipment checks were completed monthly, however, this must be checked and recorded weekly.

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- Some aspects of IPC arrangements need strengthening to maintain the safety of staff and patients

This is what the service did well:

- Robust process in place for managing patient safety alerts and significant incidents
- Good process in place to ensure the safe prescribing of medication.
- Patient records were clear and written to a good standard.

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.

Staff meetings were routine and were formally recorded and included a record of actions. Clinical meetings took place fortnightly and were recorded; however, a record of actions was not recorded to enable action owners to understand what was required of them.

We reviewed a comprehensive suite of policies and procedures. 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 sought patient feedback via their website. However, there was no information displayed in the waiting area detailing how people could feedback on their experiences.

An effective complaints process 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.

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:

- Disclosure and Barring Service (DBS) checks had not been completed at the required level for all practice staff
- The training matrix identified poor compliance with mandatory training across all staff groups.

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- Actions should be recorded following meetings to enable action owners to understand what is required of them
- Implement a robust document control system for policies and procedures

- Patient and staff feedback should be completed and considered to learn and inform service improvement

This is what the service did well:

- Patient feedback is displayed in the staff room highlighting positive quotes from patients, patient letters and thank you cards
- Effective complaints process in place to monitor, review and resolve complaints and feedback
- Staff felt comfortable to speak up regarding any concerns they may have, and to share any suggestions they might have

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

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. Unfortunately, we received no completed questionnaires from patients or their carers. All respondents to the staff questionnaire said patient feedback was collected within the practice.

Person-centred

Health promotion

The practice had a range of health promotion information available for patients. We saw health promotion information on a variety of topics, including healthy eating, smoking cessation and immunisation information. All respondents to the staff questionnaire agreed the practice offered health promotion advice and information about chronic conditions to patients.

We were told the practice engages with several agencies to improve access to various healthcare professionals via their cluster group. This included access to a Psychology Health Practitioner and pharmacist, which enables patients to access help and support 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.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their GP journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available. All respondents to the staff questionnaire agreed that measures are taken to protect patient privacy and dignity.

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. To protect confidentiality, telephone calls could also be taken in the administration room, away from the reception desk if needed.

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. A chaperone information notice was displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available.

Timely

Timely care

There were processes in place to ensure patients could access care and with the most appropriate person in a timely manner. All respondents to the staff questionnaire agreed that patients can access services the practice provides in a timely manner.

The practices' appointment system operates a triage model. Patients can complete an online request for an appointment via their website, or if preferred they can telephone the practice and have a member of staff assist them over the phone. All requests are triaged daily by a duty doctor, with both urgent on the day appointments or routine bookable appointments being allocated. All afternoon appointments are allocated to urgent on the day issues. Appointments with the Nurse and Healthcare Assistant can be booked six weeks ahead. 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.**

The practice has implemented a telephone 'call back' system, which allows patients to request the practice to call them back when they are at the front of the queue, instead of waiting on hold.

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. The practice also has access to a psychology healthcare practitioner, who holds a clinic once a week.

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.

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.

We were told there were some Welsh speaking staff at the practice. As part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were available in Welsh, however, most were available in English only.

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

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 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.**

We saw evidence of an equality and diversity policy in place; however, it was unclear whether all staff had completed equality and diversity training. **This was addressed under our immediate assurance process at Appendix B.**

All respondents to our staff questionnaire told us that the practice was supportive of equality, diversity and inclusion, and they felt they had fair and equal access to workplace opportunities. Staff also stated that they had not faced any discrimination in the last 12 months.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy and mostly free of clutter. However, we found old unused equipment being stored in the clinical rooms, which poses an infection prevention and control risk and/or a health and safety hazard.

The practice should consider the removal of any unused equipment within the treatment rooms

We found some areas that needed repair. We were told that the practice had suffered a water leak which had affected several rooms within the practice, as well as the flooring along the corridor. Patients did not have access to these rooms, however, the flooring along the corridors were also affected, resulting in a potential trip hazard. There were, however, measures in place to protect the health, safety and wellbeing of all who used the practice relating to this issue.

We reviewed the practice business continuity plan which covered the business partnership risk and pandemic risk, however, it did not detail contingencies for long-term GP sickness absence.

The practice should update the business continuity plan to include 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 process in place for managing patient safety alerts and significant incidents was robust. The practice manager was responsible for receiving patient safety alerts, and we saw how these were received, disseminated to staff and communicated in meetings. The practice had a Significant Event Analysis (SEA) register which would be discussed at SEA meetings with appropriate actions taken. Staff are fully engaged in this process. The deputy practice manager would cover this process in the absence of the practice manager.

During our inspection, we found sharps boxes that were out of date. Sharps boxes should be disposed of either when they are ¾ full or after three months to minimise the risk of injury or cross contamination. Using a sharps container beyond its expiry date can also compromise its structural integrity and safety. Over time, the materials may degrade, increasing the likelihood of leaks, cracks or failure of the

lid-locking mechanism. This deterioration poses a heightened risk of injury or contamination. The sharp boxes were immediately removed.

The practice must ensure that full or out of date sharps boxes are removed and disposed of appropriately to minimise the risk of injury or cross contamination

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. As mentioned above, we found that the building needed repair work in several areas.

A needlestick injury policy was in place and we found that needlestick injury advice posters were on display in all but one (room 10) clinical treatment rooms, to support staff in the event of such injury.

The practice must ensure that needlestick injury posters are displayed in all 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 nor were there any daily schedules in the treatment rooms. However, we found that the public areas, treatment rooms and reception were all clean and tidy.

The practice must ensure weekly cleaning schedules are implemented, as well as daily schedules in each treatment room.

We found expired equipment in the stock room, and there was no mechanism in place to record what medicines including vaccines were in the practice and their expiry dates.

The practice must:

- **Complete a thorough stock check of all treatment rooms, as well as the stock room to ensure expired single use equipment is removed.**
- **Implement a system where medicines and vaccines are recorded which includes the expiry date**

There was a process in place for the management and disposal of all waste, and a policy was in place to support this. However, we found full clinical waste bags situated in an unlocked bin outside of the practice. These clinical waste bags were accessible to patients and the public. We were not assured that appropriate measures were in place for the safe storage of clinical waste material which could

pose an immediate patient safety risk. **This was addressed under our immediate assurance process at Appendix B.**

The training matrix included IPC training as a mandatory for staff. However, not all staff had completed IPC training relevant to their roles. **Compliance with mandatory training was addressed under our immediate assurance process at Appendix B.**

The process for monitoring the Hepatitis B immunity status of clinical staff was not robust. A record was not in place to evidence that clinical staff had received their Hepatitis B vaccinations and their immunity response. **This was addressed under our immediate assurance process at Appendix B.**

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection.

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 via a repeat order slip or via email. Prescriptions were processed by the prescription team and a system was in place for annual medication reviews and ongoing monitoring.

Prescriptions which are collected by staff from the local 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 however, the staff training records we reviewed showed that there was poor compliance with medicine management training. **Mandatory training was addressed under our immediate assurance process within Appendix B.**

We saw that prescription pads were securely stored in a locked cupboard. Staff described to us the process in place to securely dispose of prescription pads when a GP leaves the practice.

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, new stock is put at the back of the fridges and older stock at the front.

During our inspection we were told that the fridge located in reception was used for samples. It was suggested that the practice seek clarification from the pathology laboratory on whether this is still needed, and if not, they should look to decommission the fridge.
We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements 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. We were not assured that staff at the practice had completed the appropriate online training for Portable Oxygen Cylinder. **Compliance with mandatory training was addressed under our immediate assurance process within Appendix B.**

All necessary emergency equipment was in place. An automated external defibrillator (AED) was in place and was fully charged. A notice was visible in reception stating where the emergency equipment was located.

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, however this was only being completed monthly. The primary care equipment standards outlined by the Resuscitation Council UK guidance currently states that these checks should be done weekly. **This was addressed under our immediate assurance process within Appendix B.**

We were not assured whether staff at the practice had undertaken appropriate basic life support training. **Compliance with mandatory training was addressed under our immediate assurance process within Appendix B.**

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 children at risk and looked after children were appropriately flagged and followed a suitable safeguarding pathway. However, we found one record where the household members of the child at risk had not been appropriately flagged on the system.

The practice must ensure a process is implemented to ensure all relevant staff can easily identify children who are subject to the child protection register

(and their household members) and are aware once a child is removed from the register, and that this is appropriately coded in child records.

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level. **Compliance with mandatory training was addressed under our immediate assurance process within Appendix B.**

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. Minutes and actions were taken and shared with 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 records
We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

Read codes were used appropriately and we found good examples where the reasons for discontinuing medication were present in a patient's medication record. **We viewed this as good practice.** However, we found examples where medication was not always linked to the patient's problem/ presentation within their record.

The practice should ensure medication is appropriately linked to a patient's problem/ presentation within the records

We also found that 'safety netting' needed to be strengthened in one of the records we reviewed, to ensure patients are provided with clear instructions and guidance on what to do if their condition deteriorates or if they had any further concerns, requiring timely follow up and re-assessment.

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

Quality of Management and Leadership

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. One of the comments received from our staff questionnaire stated:

> *'I feel very supported in my role by management and staff'*

As mentioned previously, we were told staff meetings were routine and were formally recorded, including any actions. We were told clinical meetings took place fortnightly and were also formally recorded; however, a record of actions was not recorded to enable action owners to understand what was required of them.

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

We reviewed a comprehensive suite of policies and procedures. 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
During our inspection we requested details of mandatory staff training. We were provided with an overarching training matrix which identified poor compliance with mandatory training across all staff groups. Therefore, we were not assured that the management and oversight of mandatory training compliance was robust to ensure all staff remain competent to perform their roles safely and

appropriately. **This was addressed under our immediate assurance process at Appendix B.**

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. However, during our inspection there was evidence to confirm that DBS checks had not been completed at the required level for all practice staff. This posed a potential risk to the safety and wellbeing of patients. **The DBS completion and monitoring requirement for staff was addressed under our immediate assurance process at Appendix B.**

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. During our inspection, we saw a notice board in the staff room which displayed lots of positive quotes from patients, patient letters and thank you cards that the practice had received. It also displayed pictures of all members of staff. We suggested that something similar could be displayed in the patient waiting areas.

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.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place, however the records we reviewed showed not all staff had completed training on this topic**. Compliance**

with mandatory training was addressed under our immediate assurance process within Appendix B.

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; however, we did not see evidence that all staff had completed training on this topic. **Compliance with mandatory training was addressed under our immediate assurance process within Appendix B.**

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.

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. During the inspection, the practice informed us that they were proud to have a focus on staff wellbeing, for example they celebrated staff birthdays, produce a newsletter that celebrates life events, Secret Santa, Docstars - awards at Christmas and arrange staff lunches.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During our inspection, we found sharps boxes that were out of date.	Sharps boxes should be disposed of either when they are ¾ full or after three months to minimise the risk of injury or cross contamination. Using a sharps container beyond its expiry date can also compromise its structural integrity and safety. Over time, the materials may degrade, increasing the likelihood of leaks, cracks or failure of the lid-locking mechanism. This deterioration poses a	Raised with nurse during the inspection	The out of date sharp boxes were immediately removed.

	heightened risk of injury or contamination		

Appendix B - Immediate improvement plan

Service: St Davids Clinic

Date of inspection: 18 March 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	Contractor contacted for quotation and scheduled to visit the practice on 25.03.2025 to assess and install an emergency pull cord in the accessible toilet, ensuring compliance with safety standards.	C Podmore	Installation to be completed no later than 04.04.2025.

Findings

During our inspection we were not assured regarding the Hepatitis B immunity status of clinical staff. A record was not in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity response.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The practice must ensure the hepatitis B register is kept up to date to reflect the status of all relevant staff	Health & Care Quality Standards (2023) – Safe	Comprehensive review and update of the Hepatitis B register for all clinical staff. Staff vaccination and immunity evidence to be obtained, documented, and maintained centrally.	C Podmore	Register fully updated and accurate by 30.04.2025

Findings

We are not assured that appropriate checks are undertaken on the emergency drugs and equipment. The records we reviewed showed checks were only being recorded monthly. Checks should be carried out weekly, in line with the Resuscitation Council UK; Quality Standards: Primary care equipment and drug list. This should include checks of the oxygen cylinder, the defibrillator and resuscitation equipment and drugs.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must ensure all emergency drugs and equipment are checked and recorded on a weekly basis	Health & Care Quality Standards (2023) – Safe; Timely; Information	Protocol revised to clearly outline weekly checks required for oxygen cylinders, defibrillator, and resuscitation equipment/drugs. Staff responsible briefed on updated procedure, and weekly compliance monitoring implemented immediately.	C Podmore to inform staff responsible	Completed and effective immediately from 20.03.2025 onwards

Findings

We are not assured that the management and oversight of mandatory training compliance is sufficiently robust to ensure all staff remain competent to perform their roles safely and appropriately.

During our inspection we requested details of mandatory staff training. We were provided with an overarching training matrix which identified poor compliance with mandatory training across all staff groups.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
4.	The practice must: • Ensure all staff complete all aspects of mandatory training, and provide evidence of completion • Implement a robust system to monitoring staff compliance with mandatory training and any update training.	Health and Care Quality Standards (2023)– Safe; workforce; information	Immediate communication to all staff to complete outstanding mandatory training modules. Protected time allocated to ensure completion. Certificates of completion to be provided to management and securely filed. Evaluation of Practice Index learning package scheduled (demo booked) to enhance recording, monitoring, and	C Podmore/C Etheridge	Training fully completed and system robustly implemented by 31.05.202

			facilitation of mandatory training compliance.		

Findings

We were not assured that the systems and procedures in place were sufficiently robust to ensure adequate governance of the practice relating to the Disclosure Barring Service (DBS) checks.

During our inspection we were told that the practice was in the process of ensuring that there were DBS checks on file for the clinicians and administrative staff.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The practice must ensure that: • relevant DBS checks are completed for all staff and evidence maintained on file • Staff annually confirm that the information on the DBS check remains accurate and that there have not been any changes since this check	Health and Care Quality Standards (2023) – Safe; workforce; information	HORUS system utilised to perform outstanding DBS checks. All staff files audited and updated with current DBS evidence. Annual confirmation protocol implemented, requiring staff to verify accuracy and any changes in DBS status annually.	C Podmore	All DBS checks completed and files fully updated by 30.04.2025

Findings

During the inspection we found full clinical waste bags situated in an unlocked bin outside of the practice. These clinical waste bags were accessible to patients.

We were not assured that appropriate measures were in place for the safe storage of clinical waste material which could pose an immediate patient safety risk

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale

6.	The practice is required to: • Remove the clinical waste bags from the unlocked bin • Ensure clinical waste is stored safely and securely in a locked bin	Health and Care Quality Standards (2023) – Safe	Immediate removal of clinical waste from the unsecured bin. Unsecured bin removed from the premises to prevent further use. Stericycle contacted urgently to expedite replacement with secure, lockable clinical waste bins. Staff and cleaning team retrained on correct clinical waste handling and secure storage requirements.	C Podmore	Clinical waste and unsecured bin removed immediately (completed). Replacement lockable bins confirmed by Stericycle to be delivered and installed by 28.03.2025

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **CAROLINE PODMORE**

Job role: **PRACTICE MANAGER**

Date: **24.03.2025**

Appendix C - Improvement plan

Service: St David's Clinic

Date of inspection: 18 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.	We were told there were some Welsh speaking staff at the practice. As part of the "active offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some signs and posters were	**The practice should ensure that the active offer of Welsh language is promoted to patients.**	Health & Care Quality Standards - Information	▫ Conduct a full audit of all signage, posters, and patient-facing materials across all sites. ▫ Replace or supplement English-only materials with bilingual (Welsh/English) versions where appropriate. ▫ Ensure all new materials (posters, signs, forms, website content) are created or ordered in	Dr James Naughton, NCN Lead. Caroline Podmore - Practice Manager Helen Dearden - Office Manager	▫ Audit completed by: **31.07.2025** ▫ Updated materials in place by: **15.08.2025** ▫ Website and leaflet update by: **15.08.2025** ▫ Staff training completed by: **15.08.2025**

	available in Welsh, however, most were available in English only.			bilingual format moving forward. ▫ Create a protocol to ensure any future materials displayed are checked for bilingual compliance. ▫ Add a statement on the website and in the practice leaflet explaining that the practice supports the Welsh Government's "active offer." ▫ Include Welsh language awareness in induction training and update existing staff training.		
2.	The practice was clean and tidy and mostly free of clutter. However, we found old unused equipment being	**The practice should consider the removal of any unused equipment within the treatment rooms**	Health & Care Quality Standards –Safe	▫ Conduct a full audit of all clinical rooms to identify old or unused equipment. ▫ Liaise with clinical staff to determine what	Dr Peter Speirs The nursing Team	▫ Audit completed by: **30.06.2025** ▫ Removal of equipment by: **15.08.2025** ▫ Protocol update and communication

	stored in the clinical rooms, which poses an infection prevention and control risk and/or a health and safety hazard.			items are no longer in use or required. ▫ Remove and appropriately dispose of all unused equipment, ensuring compliance with waste and recycling procedures. ▫ Ensure regular environmental checks include a review of stored equipment. ▫ Communicate the change with staff to promote ongoing vigilance in maintaining clutter-free, safe environments.		to staff by: **30.06.2025**
3.	We reviewed the practice business continuity plan which covered the business partnership risk and pandemic risk, however, it did not detail	**The practice should update the business continuity plan to include contingencies for long term sickness absence**	Health & Care Quality Standards – Information; Safe	▫ Review and revise the current Business Continuity Plan (BCP) to incorporate scenarios involving long-term GP sickness absence. ▫ Include measures such as:	Caroline Podmore-Practice Manager	▫ CP update completed by: **30.06.2025** ▫ Circulation to key staff by 30.06.2025 ▫ Next review scheduled: **01.04.2026**

	contingencies for long-term GP sickness absence.			• Use of locum GPs (bank or agency). • Redistribution of clinical workload among remaining GPs, ANPs, or other allied professionals. • Use of digital consultation tools to increase capacity where possible. • Cross-site clinical support (if applicable). • Engagement with the Local Health Board for additional support if needed. ▫ Ensure the updated BCP is shared with all partners and key management staff. ▫ Schedule an annual review of the BCP to keep it up to date with		

				staffing and operational changes.		
4.	During our inspection, we found sharps boxes that were out of date. Sharps boxes should be disposed of either when they are ¾ full or after three months to minimise the risk of injury or cross contamination. Using a sharps container beyond its expiry date can also compromise its structural integrity and safety. Over time, the materials may degrade, increasing the likelihood of	**The practice must ensure that full or out of date sharps boxes are removed and disposed of appropriately to minimise the risk of injury or cross contamination**	Health & Care Quality Standards – Information; Safe	▫ Reinforce existing policy that sharps bins must be changed when ¾ full or after three months, whichever comes first. ▫ Conduct immediate re-education with all clinical staff on safe sharps disposal protocols. ▫ Add a monthly sharps bin check to the infection control checklist at each site. ▫ Label each sharps bin clearly with the **date of opening** and **expiry date** (3 months from first use). ▫ Designate responsibility for monitoring sharps bins to a named staff member per site.	IPC Lead- Sian Chapman Nursing Team Practice Manager	▫ Immediate re-education completed by: **30.06.2025** ▫ Monthly check system implemented by: **30.06.2025** ▫ Inclusion in next IPC training by: **To be included in next update.**

	leaks, cracks or failure of the lid-locking mechanism. This deterioration poses a heightened risk of injury or contamination. The sharp boxes were immediately removed.			▫ Include this topic in annual infection prevention and control (IPC) training.		
5.	A needlestick injury policy was in place and we found that needlestick injury advice posters were on display in all but one (room 10) clinical treatment rooms, to support staff in the event of such injury.	**The practice must ensure that needlestick injury posters are displayed in all the clinical treatment rooms**	Health & Care Quality Standards – Information; Safe	▫ Immediately display the needlestick injury advice poster in Room 10. ▫ Conduct a check across all clinical rooms to ensure posters are correctly displayed and clearly visible. ▫ Ensure all new clinical rooms or changes in layout include poster	IPC lead Sian Chapman and Operations Manager	▫ Poster displayed in Room 10 by: **07.06.2025** ▫ Full clinical room check completed by: **07.06.2025** ▫ Ongoing monitoring included in room audits by: **ongoing**

				placement as standard protocol. ▫ Keep laminated spare copies of the poster accessible in a central location (e.g., stationery cupboard).		
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 nor where there any daily schedules in the treatment rooms. However, we found that the public areas, treatment rooms	**The practice must ensure weekly cleaning schedules are implemented, as well as daily schedules in each treatment room.**	Health & Care Quality Standards – Information	▫ Liaise with the external cleaning contractor to ensure that detailed weekly cleaning schedules are created and provided for each site. ▫ Display daily cleaning checklists in all treatment rooms for staff or cleaners to sign and date once cleaning is completed. ▫ Ensure weekly cleaning schedules are visible in a central location (e.g., cleaning cupboard, staff room or	Deputy Practice Manager and Operations Manager	▫ Daily and weekly schedules created and displayed by: **30.06.2025** ▫ Monitoring system implemented by: **30.07.2025** ▫ Monthly audits to include cleaning schedule checks from: **30.07.2025**

	and reception were all clean and tidy.			utility room) and reviewed regularly. ▫ Document any issues or missed cleans and follow up with the cleaning contractor as part of performance monitoring.		
7.	We found expired equipment in the stock room, and there was no mechanism in place to record what medicines including vaccines were in the practice and their expiry dates.	**The practice must:** • **Complete a thorough stock check of all treatment rooms, as well as the stock room to ensure expired single use equipment is removed.** • **Implement a system where medicines and vaccines are recorded which includes the expiry date**	Health & Care Quality Standards – Information; Safe	▫ Conduct a full stock check of all clinical rooms and stock areas to identify and remove expired equipment and medical stock. ▫ **We are currently undergoing a process where we have brought in external specialists to review our stock monitoring, ordering, and storage systems. This includes assessing our current processes and advising on the implementation of a**	Lead Nurse Sian Chapman	▫ Stock check and removal of expired items by: **30.06.2025** ▫ External specialist recommendations implemented by: **01.09.2025** ▫ Stock recording system in place by: **01.09.2025** ▫ Weekly checks and monitoring to commence from: **immediately**

				more robust and efficient system. ▫ As part of this review, a new stock control system (e.g., spreadsheet or digital inventory tool) will be developed to record all medicines and vaccines, including expiry dates. ▫ Assign responsibility for weekly stock checks to designated clinical staff to ensure early identification of items nearing expiry. ▫ Ensure all vaccines continue to be stored in line with cold chain requirements, with fridge log checks integrated into expiry monitoring. ▫ Review and audit the new stock control system quarterly to ensure effectiveness and compliance.		▫ First quarterly review: **01.11.2025**

				compliance and effectiveness.		
8.	On review of patient records, we saw examples where children at risk and looked after children were appropriately flagged and followed a suitable safeguarding pathway. However, we found one record where the household members of the child at risk had not been appropriately flagged on the system.	**The practice must ensure a process is implemented to ensure all relevant staff can easily identify children who are subject to the child protection register (and their household members) and are aware once a child is removed from the register, and that this is appropriately coded in child records.**	Health & Care Quality Standards – Information; Safe	▫ Review current safeguarding protocols and clinical coding procedures for children on the child protection register. ▫ Implement a clear process to ensure **all household members** of children on the register are appropriately flagged and coded on the clinical system. ▫ Ensure timely updates are made when children are **removed** from the register, including appropriate removal of codes/flags. ▫ Provide safeguarding refresher training for clinical and admin staff, including how to manage coding and the	Safeguarding Lead- Dr R Ganesan, Caroline Podmore- Practice Manager	• Review of coding process and flagging system by: **30.07.2025** • Updated process implemented by: **30.07.2025** • Staff training completed by: **ASAP** • First safeguarding search and audit: **01.09.2025**

				importance of household linkage. ▫ Work with the safeguarding team to ensure information received from social services is up to date and actioned promptly.		
9.	We found examples where medication was not always linked to the patient's problem/ presentation within their record.	**The practice should ensure medication is appropriately linked to a patient's problem/ presentation within the records**	Health & Care Quality Standards – Information	▫ Reinforce the importance of linking prescribed medication to the relevant clinical problem or diagnosis in patient records. ▫ Provide refresher training to all prescribing clinicians (GPs, ANPs, pharmacists) on correct coding and linking of medications in the clinical system (e.g., EMIS). ▫ Update prescribing protocol outlining best practice for recording	Dr Brenda Ferrao-Prescribing Lead	▫ Refresher training completed by: **30.07.2025** ▫ Prescribing protocol finalised by: **15.08.2025** ▫ Audit of record linkage completed by: **30.09.2025** ▫ Follow-up actions and ongoing monitoring in place from: **01.10.2025**

				medications and problem-linking. ▫ Conduct a clinical audit of a random sample of records to assess current compliance and identify gaps. ▫ Address gaps through targeted feedback or additional support where needed. ▫ Add this as a standing item in clinical meetings for ongoing reinforcement and peer discussion.		
10.	We found that 'safety netting' needed to be strengthened in one of the records we reviewed, to ensure patients are provided with clear instructions and guidance on what to do if	**The practice must ensure that patients are provided with clear instructions and guidance on what to do if their condition deteriorates or if they have any further concerns, to ensure a timely follow up and**	Health & Care Quality Standards – Information	▫ Reaffirm the importance of clear and documented **safety netting advice** in all relevant patient consultations. ▫ Provide **refresher training** for all clinicians on effective safety netting communication	Dr Rhos Davies	▫ Refresher training delivered by: **31st July 2025** ▫ EMIS templates reviewed/updated by: **15th August 2025** ▫ First audit of safety netting documentation by:

	their condition deteriorates or if they had any further concerns, requiring timely follow up and re-assessment.	**re-assessment if necessary.**		and how to record it clearly in the notes using EMIS templates or codes. ▫ Introduce or refine **clinical templates** in EMIS to include prompts for safety netting advice and documentation. ▫ Include safety netting practice as a **topic in upcoming clinical meetings**, with anonymised case reviews to demonstrate good and poor examples. ▫ Audit a sample of consultation records to evaluate safety netting consistency across clinicians. ▫ Provide **written safety netting resources** (e.g., printed handouts or text templates) for common conditions to support verbal advice.		**30th September 2025** ▫ Feedback and learning session held by: **15th October 2025**

11.	We were told staff meetings were routine and were formally recorded, including any actions. We were told clinical meetings took place fortnightly and were also formally recorded; however, a record of actions was not recorded to enable action owners to understand what was required of them.	**All staff meeting minutes should be recorded and actions documented, and shared with all staff**	Health & Care Quality Standards – Information; Workforce	▫ Standardise the format of all meeting minutes to include a clearly labelled **Action Log**, listing: • The action required • The responsible person or team • A target completion date ▫ Ensure this format is applied to clinical meetings, team meetings, and managerial meetings. ▫ Allocate responsibility for taking and distributing minutes, including follow-up of outstanding actions. ▫ Store minutes in a central shared location (e.g., internal drive or staff noticeboard) accessible to all relevant staff. ▫ Review open actions at the start of each	Practice Manager- Caroline Podmore	▫ New minute template introduced by: **15.06.2025** ▫ Process implemented for all meetings from: **01.07.2025** ▫ First review of action tracking process: **01.09.2025**

				subsequent meeting to ensure accountability and completion. ▫ Provide a brief training or guidance note to minute-takers and leads to support consistent documentation of actions.		
12.	We reviewed a comprehensive suite of policies and procedures. 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	Implement a **centralised policy management system**, either digital or spreadsheet-based, to log: • Policy title • Owner/responsible officer • Date last reviewed • Next review due date • Version number ▫ Assign a **Policy Review Lead** to oversee the document control process and ensure all	Dr Ganesan-Governance Lead & Caroline Podmore-Practice Manager	▫ Document control system implemented by: **15.07.2025** ▫ Full policy review and update completed by: **30.09.2025** ▫ Shared policy access system live by: **31.07.2025** ▫ First quarterly policy audit: **31.10.2025**

				policies have a set review cycle (e.g., annually or bi-annually). ▫ Review and update all existing policies to ensure they are aligned with the **specific procedures and needs** of the practice. ▫ Ensure version-controlled, up-to-date policies are stored in a shared location accessible to all staff (e.g., intranet folder, shared drive). ▫ Include policy awareness in staff induction and ensure updates are communicated via meetings or internal bulletins. ▫ Conduct a spot-check audit quarterly to confirm availability and awareness of key policies among staff.		

13.	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.	**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	▫ Design and display posters, leaflets, or digital displays in all waiting areas explaining how patients can provide feedback (e.g., website links). ▫ Establish a system to **review and log feedback monthly**, categorising themes and suggestions. ▫ display "You said, we did" boards or notices to patients. ▫ Use themes from feedback to inform quality improvement projects and service development plans. ▫ Continue to review annual patient survey.	Dr V Anand-GP Partner Caroline Podmore-Practice Manager	• Patient feedback posters displayed by: **15.07.2025** • Monthly feedback log and review process implemented by: **15.07.2025** • First staff feedback discussion and "You said, we did" display by **31.08.2025**

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Caroline Podmore**

Job role: **Practice Manager**

Date: **04.06.2025**