Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Oakdale Medical Centre, Aneurin Bevan University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Oakdale Medical Centre, Aneurin Bevan University Health Board on 6 May 2025.

Our team for the inspection comprised of one HIW healthcare inspector, two clinical peer reviewers, and a practice manager peer reviewer

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of eight questionnaires were completed by patients or their carers and four were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The findings in our patient questionnaire were mostly positive across all areas. All respondents rated the service as ‘very good’ or ‘good’. We witnessed staff speaking to patients in a polite and respectful manner.

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.

Appointments can be made by telephone, online and in-person. Appointments comprised of urgent on the day appointments or routine bookable appointments. We were told that the practice offered bookable appointments six weeks in advance. Practice nurse appointments were bookable 12 weeks in advance and Phlebotomy appointments eight weeks in advance. All appointments are face to face.

A number of same-day appointments are provided by the practice for those with urgent clinical needs. These patients are triaged by a general practitioner to help ensure that the patient receives the most appropriate appointment format.

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.

Clinical rooms provided patients with privacy with doors kept closed during consultations and all but one of the treatment rooms had privacy curtains. However, we found an interconnecting door between clinical rooms which were not locked. We also found a hatch door that could be opened in one of the treatment rooms. This hatch opened directly into the accessible toilet and there was no mechanism to lock it.
We were told that there was one member of staff who spoke Welsh at the practice. However, as part of the “Active Offer” for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was available in English only.

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
- Inconsistent and timely management and oversight of incoming hospital correspondence.

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- Privacy and dignity are maintained throughout the practice
- Ensure that the active offer of Welsh is promoted to patients.

This is what the service did well:

- Good appointment system
- Good availability of health promotion information

Delivery of Safe and Effective Care

Overall summary:
The process in place for managing patient safety alerts and significant incidents was robust. Patient safety alerts are received and disseminated to staff electronically and communicated in meetings.

During our inspection, we didn't see any evidence of a systematic approach to audits.

Overall, the IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

A separate area was available in the waiting area where patients were able to use the blood pressure machine. Patients were able to hand in their results which would be recorded in their patient record. This is an area of noteworthy practice, since patients can access this anytime the surgery is open.

During our inspection we were not assured about the practice's oversight for 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.

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

During the inspection, we found one fridge within the practice nurses' room to be overstocked. As a result, we found ice had built up at the back of the fridge, which could compromise the fridge functioning correctly and maintaining the proper temperature for the storing of vaccines and medications. We also found that daily temperature checks of the fridge were not being carried out.

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:

- Poor records to evidence that clinical staff had received their Hepatitis B vaccinations and immunity status recorded
- Storage of emergency equipment
- Storage of vaccines and medications in clinical fridges, was not robust, which could pose an immediate patient safety risk.

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
- Introducing an annual audit programme

This is what the service did well:

- Robust process in place for managing patient safety alerts and significant incidents
- A separate area was available in the waiting area where patients were able to use the blood pressure machine
- 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.

We were told staff meetings were routine and these were formally recorded with a record of actions recorded to enable action owners to understand what was required of them. We were told clinical meetings, such as their multidisciplinary team meetings were formally recorded.

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.

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 we were told that the practice was in the process of ensuring that DBS checks/ outcomes are on file for the clinicians; however, none of the administrative staff had been subject to a DBS check.

We are also not assured that the management and oversight of mandatory training compliance was robust to ensure all staff remained competent to perform their roles safely and appropriately. We were provided with an overarching training matrix which identified poor compliance with mandatory training across all staff groups.

We saw no evidence displayed in the waiting area indicating the ways a patient can submit feedback. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

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 to improve services.

Immediate assurances:
We identified several areas which needed to be addressed 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 administrative 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:

- Implement a robust document control system for policies and procedures
- Patient feedback should be completed and considered to learn and inform service improvement

This is what the service did well:

- 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

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

Person-centred

Health promotion

The practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting areas and promoted through the practice website. We saw health promotion information on a variety of topics including mental health services, vaccinations and carers information.

We were told the practice engaged with several agencies to improve access to various healthcare professionals. These included access to a psychological practitioner, physiotherapists, specialist diabetic nurses and Marie Curie nurses attend the practice twice a year.

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

Dignified and respectful care

We found patients were treated with dignity and respect throughout their GP journey. All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Clinical rooms provided patients with privacy with doors kept closed during consultations and all but one of the treatment rooms had privacy curtains. However, we found an interconnecting door between the Examination room and room five, which was not locked. We also found a hatch door that could be opened in one of the treatment rooms. This hatch opened directly into the accessible

toilet and there was no mechanism to lock it. Therefore, this could pose a privacy and dignity issue to patients using the accessible toilet.

The practice must ensure that:

- **privacy curtains are installed**
- **Interconnecting doors are locked during patient consultations**
- **Hatch door has a lock.**

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area. For those responding to our patient questionnaire, three respondents felt they couldn't talk to reception staff without being overheard.

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. We saw evidence of this being recorded in the medical records. A chaperone information notice was displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available. However, two respondents to our patient questionnaire said they were not offered a chaperone for intimate examinations or procedures.

The practice must ensure patients are offered a chaperone where appropriate and it is documented in the clinical records

Timely

Timely care

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

Appointments can be made by telephone, online and in-person. Appointments comprised of urgent on the day appointments or routine bookable appointments. We were told that the practice offered bookable appointments six weeks in advance. Practice nurse appointments were bookable 12 weeks in advance and Phlebotomy appointments eight weeks in advance. All appointments are face to face.

A number of same-day appointments are provided by the practice for those with urgent clinical needs. These patients are triaged by a general practitioner to help ensure that the patient receives the most appropriate appointment format.

All but two of the respondents to our patient survey said they were able to get a same-day appointment when they needed to see a GP urgently and all but one said they could get routine appointments when they needed them. Half of the respondents also said they were offered the option to choose the type of appointment they preferred.

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.

We are not assured that the management and oversight of incoming hospital correspondence was robust, to ensure GP's can review such documents and implement any actions in a timely manner. During our inspection, we found 373 outstanding hospital correspondence that had been assigned to GP's but had not been actioned. These dated back to the 11 March 2025. **This was addressed under our immediate assurance process at Appendix B.**

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 at appointments. Where patients are known not to have digital access, letters would be sent to individuals, and communication through telephone calls.

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

We were told that there was one member of staff who spoke Welsh at the practice. However, as part of the "Active Offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was available in English only.

The practice should ensure that the Active Offer of Welsh is promoted to patients.

Rights and equality

The practice offered good access for patients. We noted that patient areas including treatment rooms, and an accessible toilet were all located on the ground floor. However, during our inspection we found that the accessible toilet 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. **Mandatory training was addressed under our immediate assurance process at Appendix B.**

All but one respondent to our staff questionnaire told us that the practice was supportive of equality, diversity and inclusion, and all respondents 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.

All patients responding to our questionnaire thought the building was easily accessible and said they had not faced discrimination when accessing or using this health service.

Delivery of Safe and Effective Care

Safe

Risk management
The practice was clean and tidy, free of clutter and in a good state of repair. There were processes in place to protect the health, safety and wellbeing of all who used the practice services.

We reviewed the business continuity plan (BCP), which adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence. The practice also demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

The process in place for managing patient safety alerts and significant incidents was robust. Patient safety alerts are received and disseminated to staff electronically and communicated in meetings.

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

We found expired single use equipment (urine sample bottles and blood bottles) in room one. These were removed and discarded appropriately on the day of inspection.

The practice must complete a thorough stock check of all rooms to ensure expired single use equipment is removed.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

There was an IPC policy in place which was specific to the practice as well as specific local policies for the management of blood borne viruses, cold chain management and sharps management.

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

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

The practice must ensure weekly cleaning schedules are implemented

We saw no evidence that an annual IPC or any associated audits had been completed. We recommend that an annual IPC audit is completed, with consideration given to completion of associated audits, including hand hygiene and aseptic touch techniques.

The practice must ensure that IPC audits are completed, at the minimum this should include an annual audit.

The training matrix included IPC training as mandatory for staff. We found that not all staff had completed IPC training relevant to their roles. **This was addressed under our immediate assurance process at Appendix B.**

A separate area was available in the waiting area where patients were able to use the blood pressure machine. Patients were able to hand in their results which would be recorded in their patient record. This is an area of noteworthy practice, since patients can access this anytime the surgery is open. However, the current portable screen poses as an IPC risk as the curtain was dirty, stained and not disposable. We also suggested placing antibacterial wipes and hand gel in the area.

The practice should ensure that all equipment, including the privacy screen, in the blood pressure area are included in the practice cleaning schedules.

During our inspection we were not assured about the practice's oversight for 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. **This was addressed under our immediate assurance process at Appendix B.**

There was a process in place for the management and disposal of all waste, and a policy was in place to support this. The waste was observed to be secure.

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

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

Prescriptions are collected by the local pharmacies. Prescriptions can also be collected at the reception desk and are managed by maintaining a log to ensure a clear audit trail.

We were told that prescription pads were kept securely by the GP's. We were told there was a process in place to securely dispose of prescription pads when a GP leaves the practice, and we saw evidence of prescription pad audits conducted by the deputy practice manager.

The practice had a prescribing policy and medicine management policy in place; however, the staff training records we reviewed showed that they had not undertaken any medicine management training**. This was addressed under our immediate assurance process at Appendix B.**

We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements were in place for reporting any incidents. We referred staff to a recent safety alert regarding staff training requirements for the use of oxygen and ensuring cylinders are correctly opened. Not all staff had completed the appropriate portable oxygen cylinder online training. **This was addressed under our immediate assurance process at Appendix B.**

All necessary emergency equipment was in place. An automated external defibrillator (AED) was in place and was fully charged. A poster was displayed in reception and in every clinical room stating where the emergency equipment was located. However, the recognised AED sign or Safety Oxygen sign were not placed on the door where these were kept.

The practice must ensure the recognised signs for AED and Oxygen are placed on the door in which these are 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 appropriately and this was completed weekly. However, we found that the emergency drugs were not stored in tamper-evident containers, **a**nd we were not assured that appropriate measures were in place for the correct storage of the emergency bag.

The emergency bag was located within the practice nurses' room; however, we were told that the room was used to undertake examinations, such as cervical screening. During these consultations the room would be locked. This could pose a risk in accessing the emergency equipment in a timely manner as well jeopardising a patient's privacy and dignity. **This was addressed under our immediate assurance process at Appendix B.**

The practice must ensure that the emergency drugs are stored in tamper-evident containers.

Not all staff had undertaken appropriate basic life support training. **This was addressed under our immediate assurance process at Appendix B.**

We were not assured that appropriate measures were in place for the safe storage of vaccines and medications in the fridges, which could pose an immediate patient safety risk. During the inspection, we found one fridge within the practice nurses' room to be overstocked. As a result, we found ice had built up at the back of the fridge, which could compromise the fridge functioning correctly and maintaining the proper temperature for the storing of vaccines and medications. We also found that daily temperature checks of the fridge were not being carried out. **This was addressed under our immediate assurance process at Appendix B.**

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

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

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level. **This was addressed under our immediate assurance process at 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 notable examples of safe monitoring of medication and chronic illness management, and clear narrative with evidence of patient centred decision making.

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

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

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested. However, during review of one patient, we found a referral for suspected cancer that had not yet actioned because it was marked as routine instead of urgent. The practice actioned this on the day of our inspection as well as recording it as a Significant Event.

The practice must ensure accurate recording of referrals at all times

The practice must ensure that any learning from the Significant Event meeting is robustly implemented.

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.

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

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

From the notes reviewed we found that the patient's language choice was not always recorded, however we found that in new patient registrations, language choice was recorded.

The practice must ensure that patient language preference is recorded and easily identified in their clinical records.

Efficient

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

Quality of Management and Leadership

Staff feedback

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

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

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

All respondents felt:

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

Leadership

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.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes via team meetings for example.

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

We were told staff meetings were routine and these were formally recorded with a record of actions recorded to enable action owners to understand what was required of them. We were told clinical meetings, such as their multidisciplinary team meetings were formally recorded.

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

We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

Despite there being an appropriate skill mix across the teams to deliver the services required, no practice nurses were available at the practice on the day of our inspection due to unforeseen circumstances. At the time of our inspection, there was also no nurse available to work on a Wednesday, however, we were told that they had successfully recruited another nurse who was due to start imminently.

We were told appraisals had been completed for administrative staff and that clinical supervision or annual appraisals were taking place for clinical staff. We also saw a thorough induction programme for new starters, however for established non- medical prescribers we suggest considering a formal process to ensure their competencies such as auditing, consultations and prescribing is captured. The practice uses locum GP's and conducts orientations for new starters. However, we suggest producing a GP locum pack which could include useful information about the practice e.g. where the emergency equipment is kept.

The practice should consider a formal process for established non-medical prescribers to ensure their competencies such as auditing, consultations and prescribing is recorded

The practice should consider producing a GP locum pack specific for the practice

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 we were told that the practice was in the process of ensuring that DBS checks/ outcomes are on file for the clinicians; however, none of the administrative staff had been subject to a DBS check. **This was addressed under our immediate assurance process at Appendix B.**

We are also not assured that the management and oversight of mandatory training compliance was robust to ensure all staff remained 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.

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

Culture

People engagement, feedback and learning
The practice had a patient complaints policy; however, this was not aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy.

The practice must ensure that the complaints policy is aligned with the NHS Wales Putting Things Right process

Of those who responded to our survey, five patients confirmed they had not been asked by the practice about their experience of the service provided and four patients did not know how to make a complaint about the service. However, all respondents agreed that the service they had received was 'very good' or 'good'.

We saw no evidence displayed in the waiting area indicating the ways a patient can submit feedback. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

The practice must ensure that:

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

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 to improve services.

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

Information

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

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

Learning, improvement and research

Quality improvement activities
The practice engaged in learning from internal and external reviews, including incidents and complaints. We were told learning was shared across the practice via regular staff meetings to make improvements

Whole-systems approach

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

We were told that the practice is involved with a new charity for men's mental health called Jolly Brew Crew. The practice also has quarterly cluster meetings where good practice can be shared.

We were told that the practice has been involved in a pilot to measure the early signs of kidney damage in patients with diabetes. This had resulted in 260 identified patients who had been sent a testing kit through post, with an uptake of

63%. This work has been shared with the cluster, and they are now looking at ways they can roll out the project further.

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 review of one patient record, we found a referral for suspected cancer that had not yet actioned because it was marked as routine instead of urgent.	A referral marked as routine instead of urgent can lead to a delay in treatment	Escalated to the GP on the day of the inspection	The practice actioned this on the day of our inspection as well as recording it as a Significant Event.
We found expired equipment (urine sample bottles and blood bottles) in room one.	Expired single-use equipment should be removed due to potential risks to patient safety and effectiveness	Escalated to the practice manager on the day of the inspection	These were removed and discarded appropriately on the day of inspection.

Appendix B - Immediate improvement plan

Service: Oakdale Medical Centre

Date of inspection: 6 May 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	I have contacted our electrician today 9/5/25 with a view to the emergency pull cord. He will sort this out w/c 19 May 2025.	Tania Jones	W/C 19 May 2025

Findings

During our inspection we were not assured about the practice's oversight for 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 immunity status of all relevant staff.	Health & Care Quality Standards (2023) – Safe	All staff have been contacted with a view to Hep B status, some staff have had this at previous employment and we will update	Rebeca Taylor	ASAP

Findings

We are not assured that the management and oversight of incoming hospital correspondence is robust, to ensure GP's can review such documents and implement any actions in a timely manner.

During our inspection, we found 373 outstanding hospital correspondence that had been assigned to GP's but had not been actioned. These dated back to the 11 March 2025.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must ensure there is an efficient process in place to manage incoming hospital correspondence; ensuring backlogs do not occur, and action are implemented where applicable.	Health & Care Quality Standards (2023) – Safe; Timely; Information	All outstanding hospital correspondence have now been completed. We have added to our practice meeting agenda and will discuss with all clinicians to ensure that correspondence is dealt in a timely manner	Tania Jones / Rebeca Taylor	Practice Meeting 13 May 2025

Findings

We are not assured that the management and oversight of mandatory training compliance is 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	Since taking over as Practice Manager and Deputy Practice Manager we have tried to ensure that all new staff have completed the necessary training. We are in the process of amalgamating all certificates and will ensure that the staff are up to date with all courses.	Tania Jones / Rebeca Taylor	Within the next 2-3 weeks all current certificates to be passed to Tania from Gerald. All outstanding training to be completed within 4 to 6 weeks due to annual leave etc.

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 DBS checks/ outcomes are on file for the clinicians; however, none of the administrative staff had been subject to a DBS check.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The practice must ensure that: • relevant DBS checks (relevant to staff roles) 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	DBS checks have been applied for, for all staff. Staff having their annual appraisals going forward will be asked to complete a declaration form to confirm that no changes to their DBS has taken place.	Rebeca Taylor	Completed

Findings

We were not assured that appropriate measures were in place for the safe storage of vaccines and medications in the fridges, which could pose an immediate patient safety risk.

During the inspection, we found one fridge within the practice nurses' room to be overstocked. As a result, we found ice had built up at the back of the fridge, which could compromise the fridge functioning correctly and maintaining the proper temperature for the storing of vaccines and medications. We also found that daily temperature checks of the fridge were not being carried out.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
6.	The practice is required to:	Health and Care Quality Standards	An urgent discussion has taken place with Kelly Llewelyn (senior nurse) and Julie Williams (senior nurse). A nurses meeting	Kelly Llewelyn / Julie Williams	Completed

	• Ensure the fridges used for medication and vaccinations are not overstocked • Daily temperature checks of the two fridges are taken and recorded	(2023) – Safe; information	is being arranged with regards to this. We have a new nurse starting with the practice and we will ensure that the fridge temperature is checked regularly as required, also nursing staff to ensure that the fridges are not overstocked		

Findings

We were not assured that appropriate measures were in place for the correct storage of the emergency bag, which could pose an immediate patient safety risk.

The emergency bag was located within the practice nurses' room; however, we were told that the room was used to undertake examinations, such as cervical screenings. During these consultations the room would be locked. This could pose a risk in accessing the emergency equipment in a timely manner as well jeopardising a patient's privacy and dignity.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
7.	The practice must review current storage arrangement of emergency equipment, and ensure a suitable area is identified to maintain timely access to emergency equipment whilst maintaining patient privacy and dignity.	Health and Care Quality Standards (2023) – Safe; Timely	The emergency equipment has been moved to a more suitable location, ie the examination room. All posters in reception / clinical rooms have been updated with this. We have also added poster to the outside of the emergency room to advise that AED and Oxygen are stored within	Tania Jones	Completed

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): **Tania Jones**

Job role: **Practice Manager**

Date: **9 May 2025**

Appendix C - Improvement plan

Service: Oakdale Medical Centre

Date of inspection: 6 May 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 found an interconnecting door between the Examination room and room five, which was not locked. We also found a hatch door that could be opened in one of the treatment rooms. This hatch opened directly into the accessible toilet and there was no mechanism to lock it.	**The practice must ensure that:** • **privacy curtains are installed** • **Interconnecting doors are locked during patient consultations** • **Hatch door has a lock.**		• Room is not used for by clinicians who are examining patients, bed is being removed from that room and taken to our main site in Avicenna. This room was previously a Health Visitor room.	Rebeca Taylor DPM	Completed

				• Doors are locked at all times. • Hatch door will now have a lock on both sides.		
2.	Respondents to HIW's patient questionnaire said they were not offered a chaperone for intimate examinations or procedures.	**The practice must ensure patients are offered a chaperone where appropriate and it is documented in the clinical records**		All clinician staff are aware of this and will incorporate in all appointments where appropriate. It will also be recorded in patent's notes that a chaperone has been offered.	Rebeca Taylor DPM	Completed
3.	As part of the "Active Offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was	**The practice should ensure that the Active Offer of Welsh is promoted to patients.**		Practice information is available on our website in all languages.	Tania Jones PM	Completed

	available in English only.					
4.	We found expired single use equipment (urine sample bottles and blood bottles) in room one.	**The practice must complete a thorough stock check of all rooms to ensure expired single use equipment is removed.**		Regular checks are completed in each clinical room weekly.	Kelly Llewelyn Senior Nurse	Completed
5.	There were no weekly cleaning schedules available.	**The practice must ensure weekly cleaning schedules are implemented**		Cleaning schedules are in place and followed by the contracted cleaning company.	Rebeca Taylor DPM	Completed
6.	We saw no evidence that an annual IPC or any associated audits had been completed.	**The practice must ensure that IPC audits are completed, at the minimum this should include an annual audit.**		An infection control inspection by named staff (contained within the Infection Control Policy), using the checklist will take place on at least a bi-monthly basis and the findings reported to the partners' meeting for (any) remedial action.	Tania Jones PM	Completed

7.	The current portable screen in the blood pressure area poses as an IPC risk as the curtain was dirty, stained and not disposable.	**The practice should ensure that all equipment, including the privacy screen, in the blood pressure area are included in the practice cleaning schedules.**		Privacy screen removed from the reception area and disposed of. Hand sanitiser and antibacterial wipes now available for patient use.	Rebeca Taylor DPM	Completed
8.	The recognised AED sign or Safety Oxygen sign were not placed on the door where these were kept.	**The practice must ensure the recognised signs for AED and Oxygen are placed on the door in which these are located**		Signs now in place on the doors where the equipment is kept.	Rebeca Taylor DPM	Completed
9.	We found that the emergency drugs were not stored in tamper-evident containers	**The practice must ensure that the emergency drugs are stored in tamper-evident containers.**		No controlled drugs are kept with the emergency equipment. Medication such as aspirin, are sealed and therefore we would be aware of any tampering	Tania Jones PM	Completed
10.	We found a referral for suspected cancer that had not yet actioned because it	**The practice must ensure accurate recording of referrals at all times**		Significant event was raised following this finding and dealt with appropriately, all staff	Rebeca Taylor DPM	Completed

	was marked as routine instead of urgent.	**The practice must ensure that any learning from the Significant Event meeting is robustly implemented.**		are aware of the importance in marking urgent referrals.		
11.	Patient's language choice was not always recorded in the clinical records	**The practice must ensure that patient language preference is recorded and easily identified in their clinical records**		If a patient advises staff of a language preference, this would be recorded and added to patient 'pop up' on their medical record		
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.**		All policies will now be reviewed on an annual basis, amending each policy as required and updating the policy with the date reviewed and by whom.	Tania Jones PM	Completed

13.	We also saw a thorough induction programme for new starters, however for established non-medical prescribers we suggest considering a formal process to ensure their competencies such as auditing, consultations and prescribing is captured. The practice uses locum GP's and conducts orientations for new starters. However, we suggest producing a GP locum pack which could include useful information about the practice e.g. where the emergency equipment is kept.	**The practice should consider a formal process for established non-medical prescribers to ensure their competencies such as auditing, consultations and prescribing is recorded** **The practice should consider producing a GP locum pack specific for the practice**		We do not have any non medical staff who prescribe medication. This has been reviewed, a GP locum pack is in place and we follow the All Wales Locum Policy. We have always shown staff where the emergency equipment is located, whether new starters, locum GPs or work experience.	Tania Jones PM	Completed

14.	The practice had a patient complaints policy; however, this was not aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy.	**The practice must ensure that the complaints policy is aligned with the NHS Wales Putting Things Right process**		NHS Wales putting things right policy is followed by the practice.	Rebeca Taylor DPM	Completed
15.	We saw no evidence displayed in the waiting area indicating the ways a patient can submit feedback. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.	**The practice must ensure that:** • **Information is displayed in the waiting area detailing how people can feedback on their experiences; and** • **Patients experience feedback is used to help inform service improvement and**		Posters are now displayed in reception detailing how patients can feedback their experiences & suggestions. Patients are also asked to complete an annual patient feedback questionnaire, all comments are taken into account and when needed discussed in	Rebeca Taylor & Tania Jones DPM & PM	Completed

		enhance the patient experience.		the relevant practice meetings. Staff are made aware of the positive and negative comments, and improvements made where possible.		

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): **Tania Jones**

Job role: **Practice Manager**

Date: **17 July 2025**