Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Unannounced)

PCP Cardiff

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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 unannounced inspection of PCP Cardiff on 10 July 2025. The service provides alcohol and drug rehabilitation treatment.

Our team for the inspection comprised of three HIW healthcare inspectors and a clinical peer reviewer.

During the inspection we invited patients to complete a questionnaire to tell us about their experience of using the service. A total of three questionnaires were completed by patients. We also spoke to staff working at the service during our inspection. 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:
Patients gave positive feedback about their stay, feeling safe and satisfied with the environment, activities, and access to facilities. We observed staff being respectful and kind during their interactions with patients.

Appropriate healthcare checks were completed on admission, and information on substance misuse support was available to patients. The setting had nine individual bedrooms and two shared bedrooms; we suggested that the service may wish to review the continued use of shared bedrooms and consider their impact on patient privacy and dignity.

Consent forms were signed on admission, and patients received relevant information. Patients were encouraged to be independent and involved in their care planning, with support from external professionals. Discharge information was also provided. However, community meetings between staff and patients were inconsistent, with limited detail recorded in the minutes.

This is what we recommend the service can improve:

- Develop a policy on issuing bedroom keys to patients based on individual risk assessments and promoting privacy and security
- Keep the 'Patient Status at a Glance' board consistently up to date
- Ensure community meetings occur as scheduled, with more detailed minutes and action points
- Create and share an equality and diversity policy with staff
- Keep the wheelchair ramp clean and clear at all times.

This is what the service did well:

- Adjustments were made for patients with mobility needs
- Patients told us they had not faced discrimination when accessing or using the service and felt that they could access the right healthcare at the right time regardless of any protected characteristic.

Delivery of Safe and Effective Care

Overall summary:
The building and facilities appeared appropriate for a rehabilitation service. Health and safety measures were in place, including regular audits and system

checks. Ligature cutters were available, and a ligature risk assessment had been completed, although mitigating actions lacked sufficient detail.

Infection prevention and control measures were generally appropriate; however, cleaning schedules were not evidenced during the inspection.

Patients had access to food and drink throughout the day, and all patients reported satisfaction with meals. The clinic room was small but organised, and daily temperature checks of the medication fridge and clinic room were being undertaken.

The electronic medication administration records were being maintained to a good standard. Safeguarding policies were in place, and staff had completed appropriate training. Staff felt supported and able to deliver care safely.

Patient records were generally well maintained, but one historic record was initially unavailable. Care plans were not clearly documented, though relevant information was recorded elsewhere. A consistent care planning framework would help improve coordination and tracking of patient progress.

Immediate assurances:

- A review of the controlled drugs register identified several instances where required entries had not been completed, including missing ‘Quantity given’ records and incomplete ‘Administered by (signature)’ sections
- Only one staff member was employed during night shifts, resulting in the second signature in the controlled drugs register being completed retrospectively by day staff. This second signature appeared to validate stock levels rather than witness administration, which was not in line with the service’s medication policy
- Medication was being administered to patients at night by staff that had completed internal medication training on induction to the service rather than by a registered nurse
- Appropriate arrangements were not in place to ensure a safe and effective response to a medical emergency. One registered nurse had not completed Basic Life Support training since September 2022, and a non-clinical staff member’s resuscitation training dated back to May 2021. Emergency equipment consisted only of two defibrillators, both stored in locked cabinets secured with combination codes
- Staff were unable to locate the health record of a patient that had previously been treated at the service.

Details of the concerns for patient’s safety and the immediate improvements and remedial actions required are provided in Appendix B.

This is what we recommend the service can improve:

- Remove the large, stained chair stored outside
- Repair cracked metal drain cover and secure loose radiator cabinets throughout the building
- Update the ligature risk assessment with clearer mitigation details to strengthen its effectiveness
- Remind staff to always wear their personal identification badge
- Produce a risk assessment on the need for personal alarms for staff
- Ensure cleaning schedules are completed and maintained
- Keep the medication fridge locked when not in use
- Develop care and treatment plans for all patients and ensure they are regularly reviewed with the patient and relevant professionals.

This is what the service did well:

- Patients had access to TVs, game consoles, and a well-maintained garden.
- Gas and electrical systems were routinely checked and maintained
- Staff had access to personal protection equipment and handwashing stations.

Quality of Management and Leadership

Overall summary:
At the time of our inspection, the service was experiencing a period of organisational change, with several leadership and staff roles recently replaced. During the inspection we found the service had breached its HIW conditions of registration which constituted an offence under the Care Standards Act 2000. Given the serious nature of this, and the other issues we identified throughout the inspection, it was evident that the service requires time to embed new leadership, stabilise staffing, and implement consistent systems and processes to support effective governance and safe service delivery.

Patient safety incidents were recorded using an electronic patient management system. However, the incident reports we reviewed lacked sufficient description of lessons learned and actions taken, which limited opportunities for improvement and risk mitigation.

Recruitment, induction, and training policies were in place, but gaps were found in staff personnel files, including missing references.

Immediate assurances:

- We found evidence that the service had admitted patients aged 65 years or above which was in breach of their conditions of registration with HIW

Details of the concerns for patient's safety and the immediate improvements and remedial actions required are provided in Appendix B.

This is what we recommend the service can improve:

- Ensure incident reports include detailed investigation to identify lessons learned and actions taken
- Submit registered manager application to HIW for approval
- Update and submit the Statement of Purpose to reflect managerial and recent staffing changes
- Ensure staff recruitment complies with Schedule 2 of the Independent Health Care (Wales) Regulations 2011.

This is what the service did well:

- The service had a written complaints procedure, shared with patients on admission
- Staff reported having enough time to deliver care safely and felt the team worked professionally and collaboratively.

3. What we found

Quality of Patient Experience

Patient feedback
Overall, the responses to the HIW questionnaire were positive. Respondents were satisfied with aspects of their stay such as the activities, bedrooms and the hospital environment. Respondents said they were able to access the facilities important to them at a convenient time and told us that they felt safe while at the setting.

Health protection and improvement
We found suitable information available for patients relating to alcohol and drug rehabilitation services and advice.

We saw evidence within patient records that patients received a series of healthcare checks and tests on admission to ensure patients were not at risk of immediate harm through withdrawal symptoms.

Dignity and respect
The patients we spoke with during the inspection told us that they had been treated with dignity and respect by staff. We observed kind and positive interactions taking place between staff and patients throughout the inspection.

Single sex bathrooms and showers were available to help safeguard patients and promote dignity.

The setting had nine individual bedrooms and two shared bedrooms. We observed that sharing a bedroom made it more difficult to maintain patients' privacy and dignity. The service may wish to review the continued use of shared bedrooms and consider their impact on patient privacy and dignity.

Patients could personalise their rooms to make it more homely during their stay. We noted that most bedrooms had been left unlocked; staff told us that patients could have a key to their room on request.

The service must develop a policy to review the provision of bedroom keys to patients as standard, considering individual risk assessments and the potential benefits for privacy, dignity, and security of possessions.

Patient information and consent
All three patients who completed a HIW questionnaire said that they were provided with information about their stay. We saw that patients are required to sign a consent form prior to their admission.

We saw that a 'Patient status at a glance' board containing confidential information was kept out of sight of patients in the nursing office. However, we noted that some details on the board were inaccurate, such as the number of beds occupied, and the board did not list all patients that were at the setting on the day of the inspection.

The registered manager must ensure the 'Patient status at a glance' board is always kept up to date.

Communicating effectively
The information we saw displayed and provided to patients at the service was in English only. Given that the service operates in Wales, further efforts should be made to routinely provide information in both Welsh and English.

We observed staff communicating with patients in an appropriate way throughout the inspection. We were told the service uses digital technology to support effective communication, for example video calls with clinical professionals or advocacy and probation services.

We were told that a weekly community meeting was held for staff and patients to discuss any relevant issues. However, we noted from a review of previous minutes that the community meetings were not always being held every week. The minutes we reviewed were also brief and did not contain a record of what was discussed; for example, some meeting minutes stated 'Ironing board' and 'Bin liners', without further explanation.

The registered manager must ensure that community meetings are held as scheduled and that minutes contain more detail and description about any issues discussed and actions identified.

Care planning and provision
Patients were encouraged to make decisions for themselves to promote self-care. Patients had their own clothes and possessions, had access to a laundry room and were responsible for keeping their own bedroom clean.

We saw evidence that other professionals had been involved in the care planning and provision for patients. This included social workers and housing association staff visiting the service to engage with patients both during and after their stay.

Patients are provided with information on relevant services and groups available in their local area on discharge.

Equality, diversity and human rights
The patients who completed a HIW questionnaire told us they had not faced discrimination when accessing or using the service and felt that they could access the right healthcare at the right time regardless of any protected characteristic.

Staff were required to complete mandatory equality and diversity training. However, we did not see evidence of an equality and diversity policy in place to set out how the service would ensure all patients, staff and visitors are treated fairly and without discrimination.

The registered manager must ensure an equality and diversity policy is created and share this with staff once ratified.

Staff described adjustments that had been made to accommodate patients with mobility needs. These included providing crutches and a stool for the shower room and ensuring patients have access to a ground floor bedroom.

We saw that a ramp was available to help wheelchairs users access the building. However, we noted that the access route was covered in litter.

The registered manager must ensure that the wheelchair ramp access route is clean and kept clear at all times.

We were told that information on advocacy services is provided to patients on request. The service may wish to consider proactively displaying or providing this information directly to support patients in having their voices heard and their rights upheld.

Citizen engagement and feedback
There were opportunities for patients to comment on their experiences of using the service. Patients were given a feedback form on admission and a follow-up questionnaire was sent to patients following their discharge. Patients could also provide informal feedback through the weekly community meetings.

Delivery of Safe and Effective Care

Environment
The building and facilities appeared appropriate for use as a rehabilitation service. Patients had access to TVs and game consoles and a large garden area which was well maintained.

The environment was generally clean and tidy, but we identified the following issues:

- A large, stained chair was being stored outside which needed to be removed
- A metal drain cover in the outside area was cracked and needed to be repaired or replaced
- Several radiator cabinets throughout the building were loose and required fixing to the walls

The registered manager must take action to resolve the issues identified above.

Managing risk and health and safety
The setting had taken appropriate measures to manage the risk to health and safety. We saw evidence of health and safety and legionnaires audits being regularly undertaken. Checks were taking place to ensure that the gas and electrical systems at the setting were in working order.

We saw two sets of ligature cutters located throughout the building for use in the event of a self-harm emergency and an up-to-date ligature point risk assessment was in place. However, we noted that the mitigating measures described in the ligature point risk assessment lacked sufficient detail.

The registered manager must update the ligature risk assessment to include more detailed descriptions of the mitigating actions taken to reduce the identified risks to strengthen its effectiveness.

We noted that some staff members were not wearing a personal identification badge during the inspection which made it difficult to differentiate between staff and patients. We also did not see any staff members wearing a personal alarm.

The registered manager must:

- **Remind staff to wear their personal identification badge at all times**
- **Produce a risk assessment to determine whether personal alarms are necessary to protect staff and patients at the service.**

Infection prevention and control (IPC) and decontamination
Written policies and procedures were available to help guide staff on IPC. Staff had access to personal protective equipment (PPE) to help prevent cross infection and hand washing stations were available. Sharps bins were available and stored appropriately. All patients who completed a HIW questionnaire felt that the service was clean.

We saw evidence of a weekly IPC audit being undertaken. However, we did not see evidence of completed cleaning schedules. The documentation we were provided with during the inspection were blank templates.

The registered manager must ensure that cleaning schedules are fully completed and maintained as evidence of compliance with IPC standards.

Nutrition
There were suitable facilities available for patients to have hot and cold drinks, and we saw patients accessing these throughout the inspection. Staffed kitchens were located on site to provide patients with a variety of meals throughout the day. Patients were able to store their own snacks and food throughout their stay. Staff told us that they regularly monitor patient food and discard any items that are out of date. All patients who completed a HIW questionnaire said that they were satisfied with the food at the service.

Medicines management
The clinic room at the service was small but well organised. We saw that medicines were being stored at the clinic in cupboards and a fridge. While the cupboards were locked during our visit, we noted that the fridge was unlocked.

The registered manager must ensure that the medication fridge is kept locked when not in use.

We saw that daily temperature checks of the medication fridge and clinic room were being completed accurately to ensure that medication was stored at the manufacturer's advised temperature.

The electronic medication administration records were being maintained to a good standard. They were consistently signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. However, improvements were required in relation to the administration of controlled drugs to patients at the service. This is because:

- We reviewed the controlled drug register and saw several occasions where the ‘Quantity given’ entries had not been completed and the ‘Administered

by (signature)' entries had not been signed by the required two members of staff. We also saw one occasion where the 'Administered by (signature)' entry had not been signed by any member of staff at all
- The service employed one staff member at night, which meant the second signature (the witness) in the controlled drug register would not have been recorded at the time of administering the medication to the patient but rather signed by a member of staff working at the service the following morning. It appeared that the second member of staff was signing to validate the stock check of the medication, rather than signing to witness the administering of the medication to the patient. This was in breach of the service medication policy.

Furthermore, we identified that the medication was being administered to patients at night by staff that had completed internal medication training on induction to the service rather than by a registered nurse. We discussed this with staff during the inspection, and it was positive that action was taken to bring forward the medication round planned for the evening of the inspection to ensure the controlled drugs could be administered by a registered nurse and witnessed by a second member of staff.

Our concerns on these issues were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection issuing a non-compliance notice requiring that urgent remedial actions were taken. Details of the actions taken by the service are provided in Appendix B.

Safeguarding children and safeguarding vulnerable adults
Written policies and procedures were available which set out the procedures for staff to follow in the event of a safeguarding concern. We saw that staff working at the service had completed safeguarding training to a level appropriate to their roles.

The patients we spoke with during the inspection told us that they felt safe at the setting.

Medical devices, equipment and diagnostic systems
During the inspection we reviewed the arrangements in place to respond to a medical emergency at the service. We identified the following issues:

- One registered nurse had last completed Basic Life Skills training in September 2022, and one non-clinical member of staff had last completed Resuscitation Adults Levels 1, 2 and 3 in May 2021
- The emergency equipment on site solely consisted of two defibrillators

- Both defibrillators were kept in cabinets that were secured by combination locks.

Furthermore, we reviewed the 'Responding to Deterioration in Patient Health Procedure' policy which did not contain guidance or set out expectations for staff in relation to required type and level of CPR training, required list of emergency equipment or requirements for storage and accessibility of emergency equipment (including defibrillators) in an emergency.

Our concerns on these issues were dealt with under our immediate assurance process. Details of the actions taken by the service are provided in Appendix B.

Safe and clinically effective care
There was a range of policies and procedures available to support the operation and development of the service and these were being reviewed and updated on a regular basis.

The staff we spoke with during the inspection felt that they had enough time to deliver care to patients safely and that their team work together in a professional and collaborative way.

Participating in quality improvement activities
We saw evidence that the responsible individual had regularly visited PCP Cardiff to assess and monitor the quality of the services provided against the requirements set out in the relevant regulations.

Information management and communications technology
The service used an electronic patient management system called KIPU, which was password protected to prevent unauthorised access and breaches in confidentiality.

During the inspection we spoke with staff about the care provided to a patient that had previously been treated at PCP Cardiff. We requested to see the patient record for this patient; however, staff were unable to locate the record on KIPU. On the evening of the inspection, we were provided via email with a copy of the patient record that had been recovered by staff from KIPU. While this was positive, we were concerned that other patient records may have been deleted or unavailable and not kept in line with the minimum period of retention of eight years in line with the regulations.

Our concerns on these issues were dealt with under our immediate assurance process. Details of the actions taken by the service are provided in Appendix B.

Records management
During the inspection we reviewed the records of patients currently at the service. The records were being maintained to a good standard. Appropriate risk assessments for patients were being undertaken and documented. Each patient had their own programme of care that reflected their individual needs and risks.

All three patients who completed a HIW questionnaire said that they were aware of a care and treatment plan to make them feel better. However, during our review of patient records, we did not see any evidence that care and treatment plans had been created. After discussing this with staff, it appeared that information typically captured in care and treatment plans was being recorded elsewhere in various forms. We felt it would benefit the service to develop care and treatment plans to provide a consistent framework for staff to co-ordinate care, track progress and adjust treatment as required for each patient.

The registered manager must ensure patients have a personalised care and treatment plan to ensure their individual treatment needs are clearly identified, addressed, and regularly reviewed with the patient and relevant professionals.

Quality of Management and Leadership

Governance and accountability framework
During the inspection we determined that PCP Cardiff had breached their conditions of registration with HIW, which constitutes an offence under the Care Standards Act 2000. While undertaking our review of patient records, we found four instances of patients being treated by the service that were aged 65 years or older at the time of their admission. On the evening of the inspection, we received confirmation from the service that a fifth patient had been treated by the service that was aged 69 years on admission. Condition 2 of the HIW Conditions of Registration for PCP Cardiff states:

- 'Only patients aged between 18 (eighteen) and 64 (sixty four) years may be accommodated at the independent hospital.'

Our concerns on these issues were dealt with under our immediate assurance process. Details of the actions taken by the service are provided in Appendix B.

Given the serious nature of this, and the other issues we identified throughout the inspection, it is evident that the service requires time to embed the new leadership arrangements, stabilise staffing, and establish consistent systems and processes to support effective governance and service delivery.

Dealing with concerns and managing incidents
The service had an up-to-date written complaints procedure, which was provided to patients on admission to the service. This set out who patients could contact for advice in addition to the timescales for responding to complaints.

The patient management system was being used to record incidents. However, we reviewed a sample of previous incident reports from the previous 12 months and noted that the 'Lessons learned or actions required to mitigate risk in future' section had not been completed. This meant we were not assured that the service was fully analysing or responding to incidents in a way that promotes learning and improvement and help prevent repeated incidents.

The registered manager must ensure that all incident reports include documented lessons learned and actions taken to mitigate future risks to support effective governance and continuous improvement.

Workforce recruitment and employment practices
At the time of inspection, the service was experiencing a period of organisational change, with several members of the leadership and wider staff team having

recently left and been replaced by new starters. This included the registered manager previously approved by HIW to be in day-to-day charge of the service. We were told shortly following the inspection that a new registered manager had been appointed by the service.

The registered manager must submit their application to be evaluated and approved by HIW.

The service had a 'statement of purpose' and 'patient guide' and both contained all the information required by the regulations.

The registered manager must update the statement of purpose to reflect the new managerial arrangements and submit a copy to HIW.

A recruitment and induction and training policies were in place. However, during our review of staff personnel files we could not find any references for one member of staff that had recently been employed at the service.

The registered manager must ensure that staff recruitment processes comply with Schedule 2 of the Independent Health Care (Wales) Regulations 2011 to confirm their suitability and support safe recruitment practices.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified and resolved on this inspection.			

Appendix B – Immediate improvement plan

Service: PCP Cardiff

Date of inspection: 10 July 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The service 'Admission, Treatment Planning and Discharge' policy did not accurately state its Conditions of Registration with HIW.	The service must update its 'Admission, Treatment Planning and Discharge' policy to ensure it accurately reflects and adheres to its Conditions of Registration with HIW.	Regulation 24 of the Care Standards Act 2000	The policy has been reviewed and updated to accurately reflect the 4 conditions contained in the details of registration specifically mentioned in the eligibility criteria. Further instructions have been added to the policy to explain steps that need to be taken at pre-screening stage to verify the age of the patient and how to do this and where to document evidence.	Perry Clayman	Completed 05/08/2025
2.	We found evidence that the service had admitted patients aged 65 years or	The service must investigate and provide a clear explanation to HIW regarding the	Regulation 24 of the Care Standards Act 2000	One patient was transferred by another PCP centre without proper screening from PCP Cardiff or an understanding of the different	Perry Clayman Robert Owen	Completed 19/07/2025

	above which was in breach of their conditions of registration with HIW.	circumstances under which patients were treated in breach of their Conditions of Registration, including how and why this occurred.		conditions between England & Wales, two of the other patients lied about their age and the other patient was not identified at the pre-screening process, i.e. error of service. All staff to undertake further training and understanding of the admissions/discharge policy and to abide by strict adherence to the registration conditions for eligibility, where possible ID/passport/driving licence to be asked for at pre-admission. This has now been clearly outlined in the admissions policy and the policy will be discussed and rolled out at the next team meeting and future meetings to reiterate.		
3.	Staff were unable to locate the health record for a patient that had previously been treated at PCP Cardiff.	The service must investigate and provide a clear explanation to HIW regarding the circumstances under which the health record of one patient was not able to be found on KIPU, including how and why this occurred.	Regulation 23 of the Independent Health Care (Wales) Regulations 2011	Client was moved to a safe area within the IT system. After attempts to download pdf versions of the file the system security system moved the file to another part of the system which was recoverable by myself as a super admin user.	Perry Clayman	Completed 15/07/25

4.	Staff were unable to locate the health record for a patient that had previously been treated at PCP Cardiff.	The service must investigate and inform HIW of the extent to which any other patient health records may be missing from KIPU.	Regulation 23 of the Independent Health Care (Wales) Regulations 2011	After investigation and with comparing backups it has been determined that no records have been lost or missing from the system. We managed to restore the one file missing. Conversations are now taking place with Kipu support to identify the safe keeping of files long term and it was established that daily backups are performed by Kipu to manage this risk.	Perry Clayman	Completed 25/07/25
5.	We saw that on several occasions the 'Quantity given' entries in the controlled drugs register had not been completed and 'Administered by (signature)' entries had not been completed by the required two members of staff. On one occasion the 'Administered by (signature)' entry had not been signed	The service must provide assurance on how it will embed best practice by ensuring that controlled drugs are administered by a registered nurse, witnessed by another member of staff, and that both persons sign the controlled drug register simultaneously.	Regulation 15(5)(a) of the Independent Health Care (Wales) Regulations 2011	Controlled drugs (Schedules 2 and 3) required improvement. To address this, we have implemented a new protocol where controlled drugs will now be administered at 8 a.m. and 8 p.m. This schedule ensures that both day and night staff, Nurse and staff member are present during administration, allowing for dual verification of the drug count and proper witnessing of the process resulting in a double signature at point of administration.	Robert Owen	Completed 05/08/25

	by any member of staff at all.					
6.	We were not assured that appropriate arrangements were in place for the safe administration of controlled drugs to patients.	The service must update its medicines management policy to reflect the procedures staff must follow to safely administer controlled drugs to patients.	Regulation 15(5)(a) of the Independent Health Care (Wales) Regulations 2011	Medicines management policy to be amended and reflect legal requirement for administering controlled drugs schedule 2 and 3 relating to signature and witness signature in the CDR. To ensure we are able to do this we have moved medication times for CD's 2/3 to 8am and 8pm added to policy. Must be administered by registered nurse and trained member of staff (witness) no longer can be done using face time or any online tool. This has been removed from policy.	Perry Clayman	Completed 05/08/25
7.	We were not assured that appropriate arrangements were in place to ensure a safe and effective response to a medical emergency.	The service must review its current arrangements for responding to medical emergencies. This review must include an assessment of training requirements, the contents, availability and location of emergency equipment,	Regulation 38 of the Independent Health Care (Wales) Regulations 2011	As part of induction training to the service in addition to mandatory training each employee are trained in "basic life support" City & Guilds assured, included course content, calling for help, defibrillation, medical emergency etc. Both defibrillators have now had locks removed and are easily accessible. Two go bags have been purchased, one upstairs and one downstairs to	Robert Owen Perry Clayman	Completed 1/8/2025

		and the safe storage of such equipment.		include various other emergency equipment such as guedal airway set, CPR pocket mask and many more emergency items and we have added Naloxone and ligature cutters. Apart from basic life support training as part of mandatory training we shall offer once a year face to face training on basic life support and resuscitation to all staff to freshen knowledge.		
8.	We were not assured that appropriate arrangements were in place to ensure a safe and effective response to a medical emergency.	The service must update its 'Responding to Deterioration in Patient Health Procedure' policy to clearly reflect the revised requirements and outline the procedures staff must follow to respond to medical emergencies safely and effectively.	Regulation 38 of the Independent Health Care (Wales) Regulations 2011	Policy to be updated with clear instructions and procedures to follow in the case of a medical emergency and provide location details of where exactly medical equipment is stored in accordance with recent changes that have been made with the purchase of go bags and location.	Robert Owen Perry Clayman	Completed 1/8/2025
9.	The issues we identified throughout the inspection meant we could not be assured that effective	The service must provide assurance to HIW on the actions it will take to improve the governance and oversight arrangements in place to	Regulation 19 of the Independent Health Care (Wales)	Although all of these are already in place we shall continue as a team to better improve auditing and monitoring systems, action planning and accountability, staff involvement and communication, adopt a	Robert Owen Perry Clayman	Ongoing

governance and oversight arrangements were in place at the service.	more effectively monitor compliance with relevant regulations and standards.	Regulations 2011	proactive learning culture through incident reporting, client feedback and complaints.		

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): **Perry Clayman**

Job role: **Responsible Individual**

Date: **21 July 2025**

Appendix C - Improvement plan

Service: PCP Cardiff

Date of inspection: 10 July 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 noted that most bedrooms had been left unlocked; staff told us that patients could have a key to their room on request.	The service must develop a policy to review the provision of bedroom keys to patients as standard, considering individual risk assessments and the potential benefits for privacy, dignity, and security of possessions.	Dignity and respect	Policy drafted to allow patients access to bedroom keys following individual risk assessments, balancing privacy, dignity, and security. Staff informed via team meeting. Policy uploaded to governance folder.	Robert Owen	Completed
2.	We noted that some details on the 'Patient safety at a glance' board were inaccurate, such as the number of beds	The registered manager must ensure the 'Patient status at a glance' board is always kept up to date.	Patient information and consent	Weekly audits in place to ensure 'Patient Status at a Glance' board is updated daily. Compliance monitored by Registered	Robert Owen and all Staff	Ongoing

	occupied, and the board did not list all patients that were at the setting on the day of the inspection.			Manager and evidenced on KIPU.		
3.	We noted that community meetings were not always being held every week. The minutes we reviewed were also brief and did not contain a record of what was discussed.	The registered manager must ensure that community meetings are held as scheduled and that minutes contain more detail and description about any issues discussed and actions identified.	Communicating effectively	A new Community meeting template created with a lot more detail and capturing of client's needs. Also, a section that reflects the status of such requests and who is the person responsible for actioning. These meetings are run every Monday at 10am and will be thorough.	Robert Owen Justin Crilly Philip Pawsey	Ongoing
4.	We did not see evidence of an equality and diversity policy in place to set out how the service would ensure all patients, staff and visitors are treated fairly and without discrimination.	The registered manager must ensure an equality and diversity policy is created and share this with staff once ratified.	Equality, diversity and human rights	Policy Created and shared with staff on email. Also uploaded to our document's repository. Also as part of the mandatory training all staff complete a course on this entitled - CSTF Equality, Diversity and Human Rights Training.	All Staff and Management	Ongoing

5.	The wheelchair ramp access route was covered in litter.	The registered manager must ensure that the wheelchair ramp access route is clean and kept clear at all times.	Equality, diversity and human rights	This has been added to the newly designed “Cardiff Cleaning Records” sheet. This will be uploaded to KIPU at the end of each week.	Robert Owen and all Staff	Ongoing
6.	We identified some environmental issues during the inspection.	The registered manager must take action to resolve these issues.	Environment	These are being addressed, and quotes are being collated, and the work will commence shortly.	Robert Owen Perry Clayman Contractors	Ongoing
7.	The mitigating measures described in the ligature point risk assessment lacked sufficient detail.	The registered manager must update the ligature risk assessment to include more detailed descriptions of the mitigating actions taken to reduce the identified risks to strengthen its effectiveness.	Managing risk and health and safety	The policy has been updated to reflect the requirement.	Robert Owen	Completed
8.	We noted that some staff members were not wearing a personal identification badge or personal alarm during the inspection.	The registered manager must: • Remind staff to wear their personal identification badge at all times	Managing risk and health and safety	All staff have been briefed that it is mandatory for them to always wear and display their staff badges.	All Cardiff Staff	Completed

		• Produce a risk assessment to determine whether personal alarms are necessary to protect staff and patients at the service.				
9.	We did not see evidence of completed cleaning schedules.	The registered manager must ensure that cleaning schedules are fully completed and maintained as evidence of compliance with IPC standards.	Infection prevention and control (IPC) and decontamination	This has been rectified. They will now be uploaded to the management Audits section of KIPU.	Robert Owen Linda Darlington	Ongoing
10.	We noted that the medication fridge was unlocked during our visit.	The registered manager must ensure that the medication fridge is kept locked when not in use.	Medicines management	The fridge has an integrated lock, and it has been communicated to the relevant team members that it must remain locked at all times.	All Staff who can use the meds room	Completed
11.	We did not see any evidence that care and treatment plans had been created for each patient.	The registered manager must ensure patients have a personalised care and treatment plan to ensure their individual treatment needs are clearly identified, addressed, and regularly reviewed with the	Care planning and provision	Treatment plans are now in place for each client and are Meticulously reviewed and maintained.	Eve Mbabazi and Aisha Abdulrahaman	Ongoing

		patient and relevant professionals.				
12.	We noted that the 'Lessons learned or actions required to mitigate risk in future' section of incident forms had not been completed.	The registered manager must ensure that all incident reports include documented lessons learned and actions taken to mitigate future risks to support effective governance and continuous improvement.	Dealing with concerns and managing incidents	We acknowledge this oversight by previous management and will ensure all future incidents are properly documented and reviewed.	Robert Owen	In progress
13.	The registered manager previously approved by HIW had recently left the service.	The registered manager must submit their application to be evaluated and approved by HIW.	Workforce recruitment and employment practices	A new application was submitted on July 30th.	Robert Owen	In progress
14.	The service had a statement of purpose as required by the regulations.	The registered manager must update the statement of purpose to reflect the new managerial arrangements and submit a copy to HIW.	Workforce recruitment and employment practices	This has been updated and is a true reflection.	Robert Owen	Completed
15.	During our review of staff personnel files, we could not find any references for one member of staff	The registered manager must ensure that staff recruitment processes comply with Schedule 2 of the Independent Health	Workforce recruitment and employment practices	There were files we just didn't have the key to open the locked drawer so you could review them. These	Robert Owen	Completed

	that had recently been employed at the service.	Care (Wales) Regulations 2011 to confirm their suitability and support safe recruitment practices.		are now available and maintained.		

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): Robert Owen

Job role: Acting Registered Manager

Date: 15 September 2025