Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Criccieth Health Centre, Betsi Cadwaladr 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 Criccieth Health Centre, Betsi Cadwaladr University Health Board on 15 July 2025.

Our team for the inspection comprised of a 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 12 questionnaires were completed by patients or their carers and none 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:
Patients were provided with a good range of information on the practice website about the services provided and how to access them. Posters and leaflets at the practice provided advice and support on a range of health-related issues.

There were good processes is in place to ensure patients could access the right services and in a timely manner. Nine out of twelve patients who responded to the HIW questionnaire said they could get routine appointments when they needed them, and same-day appointments for urgent matters.

We observed staff talking to patients in a friendly and professional manner. However, physical restrictions at reception made communication more difficult and had an impact on patient privacy.

This is what we recommend the service can improve:

- Ensure that a patient information leaflet is made readily available to patients
- Address communication barriers at the reception desk.

This is what the service did well:

- Good provision of Welsh language service and materials.

Delivery of Safe and Effective Care

Overall summary:
We found Criccieth Health Centre to have staff who were committed to providing a high standard of care for their patients. Patients benefitted from a range of services at the practice. Clinical staff worked well together to share learning and support trainees.

There were clear measures in place to ensure infection prevention and control, and effective processes to manage medical emergencies.

There were good processes in place to support the safeguarding of children and adults. Patient records were kept securely, detailed and provided a clear narrative about the condition and treatment of patients.

This is what we recommend the service can improve:

- Formal audit and supervision of locum GPs and non-medical prescribers.

This is what the service did well:

- Efficient review of blood tests
- Patient records completed to a high standard
- High level of medication reviews completed.

Quality of Management and Leadership

Overall summary:
The practice was part of Hwb Iechyd Eifionydd and was managed by Betsi Cadwaladr University Health Board (BCUHB).

Recruitment and retention of staff was a significant issue for the practice, leading to increased pressure on remaining staff. This had contributed to low morale and senior staff were making efforts to improve the situation.

The practice made good use of health board support, including use of policies and procedures. We advised that site-specific documents should be put in place where relevant.

There was a positive approach to staff development, however compliance with mandatory training requirements needed to be addressed.

Immediate assurances:
A review of staff training records indicated poor compliance with mandatory training requirements, including six members of staff that did not have up-to-date Fire Safety training. This presented an increased risk to patient and staff safety.

This is what we recommend the service can improve:

- Clear direction to staff about roles and responsibilities
- Continue efforts to improve staffing levels.

This is what the service did well:

- Instigating new initiatives such as ‘win and whinge’ sessions.

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

Patients who expressed an opinion in the HIW questionnaire were generally satisfied with the premises and facilities provided, with all agreeing it was clean and infection control measures were used.

All respondents who expressed an opinion felt their GP explained things well, that they were listened to and were treated with dignity and respect. However, half of the respondents felt they were not able to talk to reception staff without being overheard.

All but one of those who responded to the HIW questionnaire rated the overall service as very good or good.

Patient comments included:

> *" Great staff! All so very friendly while staying professional"*
>
> *"I made an appointment to see a GP. Only to be told on the day after sitting in the waiting room for nearly an hour that there was no appointment for me! It is hard to get through as the phones don't get answered"*

Person-centred

Health promotion

A wide range of health information leaflets and posters were available for patients in the reception area, in both English and Welsh. These included information on smoking cessation, alcohol reduction and healthy eating. The practice website included a self-help and wellbeing section, with links to advice and support on a range of topics.

A self-service monitoring device was available in the waiting area for patients to measure their height, weight and blood pressure. This was operated using tokens provided by the reception staff and provided a printout of results.

Information about the practice was available on the practice website, including contact details, services provided and how to provide feedback. However, there was no printed version of a patient information leaflet available at the practice.

The practice must ensure that a patient information leaflet is made readily available at the practice.

We advised that some information on the practice website required updating, such as MyHealth Online having been replaced by the NHS Wales application.

The practice should review and update the content of the practice website.

All those who responded to our patient questionnaire agreed there was health promotion and patient information material on display and most agreed that they were offered healthy lifestyle advice.

The practice provided a range of clinics and additional services. These included phlebotomy, spirometry, physiotherapy assessments, audiology (ear syringing) and occupational therapy for mental health. The practice also had shared access to three Urgent Care Practitioners (UCPs) that were used primarily for home visits. A prescribing pharmacy team provided in-person assessments for patients with diabetes and chronic diseases.

The offer of respiratory syncytial virus (RSV) vaccinations to patients was managed by the health board vaccination team. Vaccination programmes for winter flu and Covid-19 were run as combined schemes with the practice sharing information and promoting the campaigns and the health board issuing invitations. Typically, patients would receive three invites comprising of two SMS text messages and a letter.

Staff at the practice worked with the patient participation group to ensure they received the right care from the right services. Home visits were carried out daily, with the majority of these being to five care homes. Staff told us that the number and geographical spread of home visits presented a challenge and discussions were ongoing about how to manage them more effectively.

Dignified and respectful care
Clinical rooms provided patients with an appropriate level of privacy with external windows being obscured and doors kept closed during consultations. Privacy curtains and screens were also available.

A touch screen computer was in place for patients to sign in upon arrival. This included Welsh language option and a high contrast setting for visually impaired patients.

A screen was in place at the reception desk due to health and safety issues. However, the screen and layout of the staff area impeded communication, resulting in both staff and patients having to use raised voices. This compromised patient privacy as discussions could be heard by patients in the waiting area. Music was not played and a television in the patient waiting area was out of use during the inspection, making conversations at reception more easily heard. Staff told us that this was a known issue and a microphone system and hearing loop had been ordered.

The practice must ensure measures are put in place to enable effective and private communication with patients at the reception desk.

Staff told us that patients wanting a private conversation would be taken through to an available room in the clinical area.

The practice had a chaperone policy in place and provided both male and female chaperones as required. However, this required revision to include updated staff and practice details and document control information. Information about the availability of chaperones was provided on the practice website but was not clearly displayed at the premises. We reviewed a sample of patient records however none of the examinations reviewed would have required a chaperone to be offered. We noted one patient that declined to be examined and that this was respected and recorded.

The practice must review and update the chaperone policy and clearly display information about the service to patients in consulting and treatment rooms.

Four respondents to the HIW questionnaire who provided an opinion agreed they were offered a chaperone for intimate examinations or procedures, whilst one respondent disagreed.

Timely

Timely care

Appointments were mostly made via telephone and could also be made in person or by email request. Appointments with nurses could be booked in advance and online booking was possible for some services, such as blood tests.

Reception staff would discuss appointment requests with the patients using an established protocol and signpost to the most appropriate clinician. Children would always be seen on the day of request. When GP appointments were fully booked, there was a process in place to triage any further appointment requests and efforts would be made to see patients according to clinical need. Patients received safety

netting advice if their condition was likely to deteriorate and reviewed acutely if needed.

Due to the catchment being a popular tourist destination, patient numbers increased significantly during the summer months which presented a challenge. Staff told us that in rare circumstances where all appointments had been used patients were advised to contact NHS 111 or attend an accident and emergency department, as appropriate.

Patients who responded to the HIW questionnaire were satisfied with the opening hours of the practice. Nine out of twelve respondents agreed that they could get routine appointments when they needed them and a same-day appointment if it was urgent, and three respondents disagreed.

Equitable

Communication and language
Staff told us they could access a translation service to help communicate with patients whose first language was not English. The details were not readily available however this was resolved during the inspection with contact details found and put on display in the reception office.

Bilingual signage and patient information were available. There were several Welsh speakers at the practice and the Welsh language active offer was displayed to promote the use of Welsh language while at the practice. We saw 'Iaith Gwaith' lanyards and badges worn by staff so that patients could identify them as a Welsh speaker. We observed staff talking to each other and to patients in Welsh.

No patient information was offered or seen to be available in alternative formats, such as large print.

The practice should review whether any patient information could be provided in an alternative format.

Patient comments made in response to the HIW questionnaire and observations made during the inspection suggested patients were sometimes unclear whether their appointment was at Criccieth Health Centre or the sister practice at Porthmadog. The practice manager may wish to consider this when seeking patient feedback, to establish whether it is an issue that needs addressing.

Rights and equality
The practice had a free car park with designated disabled bays outside the main doors and an access ramp, to assist patients with impaired mobility. There were

automatic doors to the front entrance of the premises, with an additional-width conventional door immediately beyond.

All patient areas were on the ground floor, with level flooring throughout. There was a lower reception desk area that allowed for ease of access for patients in wheelchairs. A wheelchair was available for patient use whilst at the practice. There were two mixed gender toilets for patients. One was wheelchair accessible and fitted with grab handles and an emergency alarm.

All patients responding to a questionnaire thought the building was easily accessible and had suitable seating and toilet facilities.

As the practice was managed by the health board, they had adopted the BCUHB equality, diversity and human rights policy.

To respect the rights of transgender patients, staff said they made sure to use appropriate names and pronouns. A Gender Identity Service operated out of the premises giving staff access to additional information and advice if needed.

Staff told us the practice had a Patient Participation Group (PPG), with members being active in the local community and helpful in sharing information.

Delivery of Safe and Effective Care

Safe

Risk management
The premises were generally clean, tidy and free of clutter. Some areas would benefit from updating and there was evidence of previous water damage to the ceiling at reception. Staff told us that maintenance requests were managed through the health board and generally resolved promptly.

A Business Continuity Plan was in place, however this required review to ensure it was up-to-date, relevant to the practice and to include document control information.

The practice must review the Business Continuity Plan to ensure it is up-to-date, relevant to the practice and includes document control information.

The practice manager had responsibility for ensuring patient safety alerts were disseminated to the practice and communicated in meetings.

The practice served five local care homes that required regular home visits. Staff were able to describe appropriate processes for assessing and managing severe cases where attendance by ambulance staff was required during home visits.

Infection, prevention and control (IPC) and decontamination
Policies about IPC and waste management were in place with all staff having access to them. We noted that the documents were general health board policies rather than site-specific versions.

The practice had a named nurse identified as the IPC lead and staff demonstrated an understanding of their IPC roles and responsibilities. Staff told us they accessed up-to-date guidance through liaison with the health board IPC team and intranet.

Clinical rooms were seen to be appropriately equipped to maintain hand hygiene and surface cleaning. The practice was tidy and well organised which assisted effective IPC management. We saw evidence of a cleaning contract and an audit of scheduled cleaning activities.

Appropriate policies and procedures were in place about the vaccination of staff and the process to follow should staff sustain a needlestick or sharps injury. Occupational health support was provided by the local hospital. Flowcharts

showing the process to follow in the event of a needlestick injury were not on display in clinical rooms.

The practice should ensure that flowcharts showing the process to follow in the event of a needlestick injury are displayed in clinical rooms.

Staff vaccinations against Hepatitis B were managed by the health board occupational health service. The service would contact individual staff as required and inform the practice manager to ensure they had oversight.

All respondents to the HIW questionnaire agreed that the practice was 'very clean' or 'clean'

Medicines management
The practice used several non-medical prescribers, including pharmacists, a physiotherapist, advanced nurse practitioner and paramedics. In addition, a significant number of locum GPs were employed. We were assured that all had professional supervision. However, we advised that formal processes should be in place to assess and audit the consultations and prescribing carried out.

The practice should ensure that the consultations and prescribing carried out by locum GPs and non-medical prescribers are formally audited.

Staff described how the practice had responded effectively to a coroner 'prevention of future deaths' report (Regulation 28 notice) regarding medication reviews. In January 2025 only 45% of patients at the practice on repeat medication had undergone medication reviews and this had increased to 95% in approximately six months.

Vaccines were stored appropriately within dedicated vaccine fridges, which had appropriate annual maintenance and calibration. An up-to-date cold chain process document was in place to ensure safe storage of refrigerated medicines. However, this document did not include references to national policy or include document control information such as a review date.

The practice should review the cold chain policy document to ensure it refers to relevant national policy and includes document control information.

We saw logs confirming that temperature checks were carried out twice daily and the fridges had a built-in data logger that could be accessed as needed. Staff were aware of the actions to take should there be a breach in the cold chain and described a recent example of power failure at the site and the measures taken. A

suitable container was available to ensure medicines maintained appropriate temperatures during home visits.

Appropriate processes were in place for reporting adverse reactions to drugs, using the yellow card system, and for the disposal of expired medicines. The drugs we checked during the inspection were all in date. The practice had a nominated person and deputies responsible for checking the drugs on a weekly basis.

There was appropriate resuscitation equipment and drugs in place for use during a patient emergency such as cardiac arrest. We saw records showing that equipment was checked daily and emergency drugs checked weekly. The equipment included an automated external defibrillator (AED), with both adult and child pads. There was no signage to indicate the presence of the AED.

The practice should display signage to indicate the location of the AED.

Emergency drugs for use in cardio-pulmonary resuscitation were stored with the emergency equipment. Further emergency drugs were stored in a locked cabinet in a treatment room, in line with the health board guidance. The cabinet used to store emergency drugs did not have signage to indicate this. This was addressed during the inspection by the lead nurse emailing all staff to advise them of the location of the drugs and the key to the cabinet.
We advised that any drugs used for all medical emergencies should be stored in a single, readily accessible location for ease of access in an emergency. These medicines should be clearly marked as 'For emergency use' and be tamper evident. Staff told us that the health board intended to issue sites with tamper-evident emergency trolleys, where all emergency drugs and equipment would be stored together in due course.

Safeguarding of children and adults
Processes were in place to identify individuals with safeguarding concerns and ensure a suitable safeguarding pathway was followed.

One GP was the safeguarding lead for adults and another was the safeguarding lead for children. All GPs had safeguarding training to level three and a recent protected education time session was used as a safeguarding update.

The practice held regular child safeguarding meetings which included both safeguarding leads, a health visitor and a social worker. The practice kept a list of children of concern and these were discussed at the meetings. Patient records were linked to family records where appropriate and alerts removed by GPs only when appropriate. All patients on the child protection register had an alert on their records.

Adult safeguarding concerns were discussed at online weekly case review meetings which included a nurse, the practice care co-ordinator, district nurses, and staff from social services. Any findings were shared with GPs as appropriate.

Management of medical devices and equipment
We found medical devices and equipment were in good condition, safe to use and had been appropriately checked. The practice manager had overall responsibility for checking devices and arranging repair or replacement.

Single use items were used where appropriate and disposed of correctly.

Effective

Effective care
The practice telephone system signposted callers with emergency conditions to dial 999. Care navigation trained staff showed good awareness of how to identify life threatening emergencies and signpost help. An example was provided where staff described a patient attending the practice with chest pain and appropriate actions taken. Patients contacting the practice in mental health crisis would be directed to a GP.

Staff described a suitable organised process for ordering tests and urgent requests would normally be fulfilled on the same day. A GP was contracted to work remotely and review all results received that day and assign tasks as necessary. Patients requiring a follow-up would be contacted by the practice, otherwise after two weeks patients could ask for an update but would not be routinely contacted.

Patient records
We reviewed a sample of 10 electronic patient medical records. These were stored securely and protected from unauthorised access in compliance with relevant legislation. Paper records were not kept on site and could be requested from storage if required.

Consultation narratives were thorough with evidence of appropriate decision making, suitable management plans and appropriate referrals when necessary. Patient records were completed contemporaneously, and the information were presented in a manner that was easy for other clinicians to review. We found that clinical Read codes were used effectively and consistently, supporting analysis and audit processes.

We found one instance of an anti-sickness medicine (domperidone) being prescribed by a locum GP to a teenage child, where the requirement to do so was uncertain and not in line with current guidance.

The practice should circulate current guidance on the prescription of domperidone to all prescribers, including locum GPs.

Efficient

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

Patients could self-refer to several services through the practice such as smoking cessation, weight management, sexual health and family planning.

The practice worked with other services to co-ordinate care, such as referring patients to radiology at the local minor injury unit with the result being sent to a radiologist at the main hospital, to interpret and advise if the patient should be admitted.

Nursing staff told us they felt the workload could be distributed more efficiently across the nursing team. Discussions were taking place about restructuring the appointments template, to address this issue.

Quality of Management and Leadership

Leadership

Governance and leadership
The practice was managed by the health board with key management roles at the practice being a Health Services Manager and Practice Manager, with a Head of Service for Managed Practices overseeing several managed practices in the area. At the time of inspection, the Health Services Manager role was vacant and recruitment was in progress.

Staff told us that recruitment and retention of staff in recent months was a considerable and ongoing issue. This included a reduction in staff numbers, staff working reduced hours and difficulties accessing funding to recruit into existing posts. One outcome of this was administration and clinical staff being asked to cover reception duties.

We noted that as a health board managed practice, many of the recruitment issues described to us were outside the control of the practice. However, we recommended that the practice continue working with the health board to identify and address the issues.

The practice must make every effort to ensure staffing numbers are appropriate for the services provided.

We were told that issues arising from staffing numbers had contributed to low morale and affected working relationships.

However, some staff felt that recent initiatives were having a positive impact. We were told that weekly 'win and whinge' sessions had been introduced and were well received. The sessions had an educational element and were an opportunity for staff to raise concerns or discuss any issues and potential solutions.

The Service Manager described a recent review where they held one-to-one discussions with all staff at the practice, to discuss morale and how to achieve more effective working relationships. The review was to be discussed with human resources staff at the health board to identify possible courses of action.

There were designated leads in place, including for nursing, IPC, reception and administration. We found that some staff were not sufficiently clear about their roles and the importance of working within their delegated responsibilities. The Service Manager outlined work that was underway to:

- link job descriptions to operational tasks at the practice
- clarify the distinct roles and responsibilities of the Health Service Manager and Practice Manager

The practice must ensure that roles and responsibilities are clearly set out and understood by staff.

A wide range of policies and procedures were in place to support the effective running of the practice. However, we found a reliance on general health board policies that were not specific to the practice. Where local policies and procedures were used, there was a lack of document control information, such as publication and review dates, version history and document owner.

The practice must review their policies and procedures to ensure they:

- **are specific to the practice where appropriate**
- **are up to date and contain document control information**

During the inspection, staff were engaged in the process and welcomed advice on areas for improvement.

Workforce

Skilled and enabled workforce

We saw good evidence of staff development. This included use of monthly protected education time, training as part of the 'win and whinge' sessions and sharing of information and knowledge between clinical staff. The lead nurse had recently completed a master's degree qualification to develop their practice scope and qualified as an Advanced Nurse Practitioner and prescriber.

We were told that there was good support from the clinical matron in the health board, including an annual review with staff training needs analysis.

A review of staff training records indicated poor compliance with mandatory training requirements. We found examples where training had expired and others where there was no evidence the training had been undertaken.

The practice used an electronic system (ESR) to monitor compliance with mandatory training requirements. This showed members of staff without up-to-date training in:

- Fire safety
- Health, Safety and Welfare
- Moving and handling
- Infection prevention and control

This presented an increased risk to patient and staff safety and was dealt with under HIW's immediate assurance process. Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

The practice held regular clinical team meetings, including for GPs, prescribers and for palliative care and safeguarding teams. Staff told us that regular meetings for management and reception staff would normally be held, however these had not been taking place in recent months due to staffing issues.

Working with the BCUHB primary care academy, the practice hosted a Skills, Education and Training Hub to support the development of trainee clinicians. Trainees included doctors, nurses and paramedics and these were supported and supervised by the practice and the academy.

The practice used the health board recruitment and induction policies. Pre-employment checks for new members of staff were managed centrally by the health board using an electronic system (TRAC). We saw that the checks carried out were appropriate and included checks using the Disclosure and Barring Service (DBS). The practice had access to the TRAC system to monitor compliance with the required tasks and all actions had to be completed prior to employment.

The practice must implement a local induction process for all new substantive and temporary staff.

Culture

People engagement, feedback and learning
The practice used the health board's integrated concerns policy for the handling of complaints. Copies of the NHS Putting Things Right leaflets and posters were readily available in the patient waiting area, in both English and Welsh.

Staff told us that complaints were directed to the practice manager and passed to the BCUHB complaints team to be logged as feedback on the central Datix system and responded to as appropriate.

The practice manager told us that outcomes and learning points from complaints were shared with staff during team meetings and discussed with specific staff if relevant.

Verbal complaints or feedback were typically addressed informally by the reception team or practice manager as appropriate. We recommend that verbal

feedback be routinely discussed at team meetings as learning points and for staff awareness.

We recommend that verbal feedback and complaints be routinely discussed at team meetings.

The practice carried out patient experience surveys annually and posters with QR codes were displayed encouraging patients to leave feedback. Staff told us that a suggestion box was periodically put in the waiting area. This was promoted as a 'positivity box' for patients to include suggestions for improvement.

The practice did not have a mechanism to share with patients if and how feedback had been acted upon.

The practice should consider sharing with patients how their feedback has been acted upon, such as using a 'you said, we did' board.

The practice used the health board's Duty of Candour policy and we were told that staff had attended workshops and completed online training on the subject.

Information

Information governance and digital technology

We considered the arrangements in place for patient confidentiality and compliance with Information Governance and the General Data Protection Regulations (GDPR) 2018. We saw evidence of patient information being stored securely.

The practice used the health board policy for information governance. Staff were required to complete mandatory training, however records indicated that six members of staff did not have up-to-date training on information governance.

The practice must ensure that staff complete mandatory training on information governance.

Learning, improvement and research

Quality improvement activities

There was evidence of audits being carried out to monitor quality. We were told learning was shared across the practice to make improvements.

We found the practice had good processes in place to carry out and record significant event reviews. We reviewed an incident and found management of the

event to be appropriate and an identified area for improvement was shared with staff and implemented.

Whole-systems approach

Partnership working and development
The practice was a key part of the local community, providing a range of services and signposting patients to other services, advice and support.

Being a health board managed practice, there were strong links in place between the practice and wider health board services. The practice worked with others in the cluster and other health board managed practices.

There was evidence of working with the cluster and other practices managed by the health board. This included online meetings and the use of a shared intranet site to host information for staff. Some staff were shared across the cluster, such as three Urgent Care Practitioners, with Criccieth Health Centre having an allocated number of days. Staff told us that to access funding from the cluster, this was done using a pilot project and associated business plan.

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
Emergency drugs for anaphylaxis were stored with the emergency equipment. Further emergency drugs were stored in a locked cabinet in a treatment room. The cabinet used to store emergency drugs did not have signage to indicate this.	The location of emergency drugs must be clear to all staff in the event of a medical emergency.	This was raised with the lead nurse.	This was addressed during the inspection by the lead nurse emailing all staff to advise them of the location of the drugs and the key to the cabinet.

Appendix B – Immediate improvement plan

Service: Criccieth Health Centre

Date of inspection: 15 July 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.		The practice must ensure that staff are up to date with mandatory training requirements set by the practice and / or Health Board, and that there is sufficient oversight in ensuring its timely completion	Health and Care Quality Standards 2023: Safe / Workforce	1. Practice Manager will identify suitable time within the staff members shift to undertake the appropriate outstanding mandatory training identified. 2. Weekly reviews will be undertaken by the Practice Manager and the Head of Service for Managed Practices to ensure that compliance levels are achieved 3. In the case of the GPs or Nurses, the Matron/Lead Nurse for Managed Practices and the Clinical	1 & 2: Practice Manager Head of Service 3: Matron/Lead Nurse Clinical Lead GP	Completion by 31st August 2025

				Lead GP will performance manage where necessary.		

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): **Carys Greer**

Job role: **Practice Manager**

Date: **18 July 2025**

Appendix C - Improvement plan

Service: Criccieth Health Centre

Date of inspection: 15 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.	There was no printed version of a patient information leaflet available at the practice.	The practice must ensure that a patient information leaflet is made readily available at the practice.	Health and Care Quality Standards - Information	Printed bilingual/larger print patient information leaflets will be available at the practice.	Lead Administrator	30/10/2025
2.	We advised that some information on the practice website required updating.	The practice should review and update the content of the practice website.	Health and Care Quality Standards - Information	Information will be updated on the website.	Workflow Coordinator and Lead Administrator	30/11/2025
3.	A screen was in place at the reception desk impeded communication,	The practice must ensure measures are put in place to enable effective and private communication with	Health and Care Quality Standards – Person Centred	A Hearing Loop and Microphone system have been installed. A separate, private telephone hub has	Practice Manager	Complete

	resulting in both staff and patients having to use raised voices.	patients at the reception desk.		been created away from the reception area to maintain confidentiality and reduce background noise.		
4.	Information about the availability of chaperones was provided on the practice website but was not clearly displayed at the premises.	The practice must review and update the chaperone policy and clearly display information about the service to patients.	Health and Care Quality Standards – Person Centred	Chaperone details will be displayed in all patient facing areas.	Practice Manager	30/09/2025
5.	No patient information was offered or seen to be available in alternative formats, such as large print.	The practice should review whether any patient information could be provided in large print format.	Health and Care Quality Standards - Equitable	As per Point 1, A review of available formats will be undertaken, and information points signposting patients to alternative formats	Lead Administrator and Lead Receptionist	31/10/2025
6.	A Business Continuity Plan was in place, however this required review to ensure it was up-	The practice must review the Business Continuity Plan to ensure it is up-to-date, relevant to the practice and includes	Health and Care Quality Standards – Safe	A Review of the Business Continuity Plans will be undertaken and amendments made as necessary. A thorough	Health Services Manager and Practice Manager	1/12/2025

	to-date, relevant to the practice and to include document control information.	document control information.		A thorough Review of the Business Continuity Plans will b		
7.	Flowcharts showing the process to follow in the event of a needlestick injury were not on display in clinical rooms.	The practice should ensure that flowcharts showing the process to follow in the event of a needlestick injury are displayed in clinical rooms.	Health and Care Quality Standards – Safe	Laminated copies will be produced and displayed in all clinical areas	Practice Lead Nurse Matron for Managed Practices	30/09/2025
8.	Formal processes were not in place to assess and audit the consultations and prescribing carried out by locum GPs and non-medical prescribers.	The practice should ensure that the consultations and prescribing carried out by locum GPs and non-medical prescribers are formally audited.	Health and Care Quality Standards – Safe	A SOP for non-medical prescribers has been developed in line with Royal Pharmaceutical society, and NMC guidelines and is being presented for approval governance processes. This includes yearly audits of prescriptions. The SOP will be implemented.	Clinical Lead GP Head of Pharmacy Matron for Managed Practices	31/11/2025

9.	An up-to-date cold chain process document was in place However, this did not include references to national policy or include document control information such as a review date.	The practice should review the cold chain policy document to ensure it refers to relevant national policy and includes document control information.	Health and Care Quality Standards – Efficient	We will carry out an immediate review of existing cold chain process documentation, and related policies- ensuring version control.	Practice Lead Nurse Matron for Managed Practices Head of Pharmacy	30/09/2025
10.	There was no signage to indicate the presence of the AED.	The practice should display signage to indicate the location of the AED.	Health and Care Quality Standards – Safe	Signage has been produced and displayed to indicate the presence and location of the AED	Practice manager	Complete
11.	A review of patient records found one instance of an anti-sickness medicine being prescribed by a locum GP, where the requirement to do so was uncertain and not	The practice should circulate current guidance on the prescription of domperidone to all prescribers, including locum GPs.	Health and Care Quality Standards – Safe	The current guidance has been circulated to all prescribers, including Locum GPS regarding domperidone prescribing. We have discussed during our local 'win and whinge' clinical meeting.	Clinical Lead GP Health Services Manager	Completed Email/minutes have been shared

	in line with current guidance.					
12.	Staff told us that recruitment and retention of staff in recent months was a considerable and ongoing issue.	The practice must make every effort to ensure staffing numbers are appropriate for the services provided.	Health and Care Quality Standards – Workforce	We have recently recruited a Health Service Manager, and 2 full time permanent Reception/ Admin Staff to join the team. The Practice Manager will complete daily staffing reviews to ensure safe levels of staffing, and submit daily staff submission to Head of Service for assurance	Head of Health Board Managed Practices	31/10/2025
13.	We found that some staff were not sufficiently clear about their roles, responsibilities and the importance of working within	The practice must ensure that roles and responsibilities are clearly set out and understood by staff.	Health and Care Quality Standards – Workforce	A Workforce Plan is being developed. All staff have had a one-to-one meeting to outline their roles and responsibilities in line with their job descriptions.	BCU West IHC Directors Head of Service for Health Board Managed Practices	31/11/2025

	their delegated responsibilities.				People Business Partner	
14.	A range of health board policies and procedures were in place. Where local policies and procedures were used, there was a lack of document control information, such as publication and review dates, version history and document owner.	The practice must review their policies and procedures to ensure they: • are specific to the practice where appropriate • are up to date and contain document control information	Health and Care Quality Standards – Efficient	We will identify any health board policies applicable to the practice which may not be within date, and escalate to the corporate team. All local policies and procedures will be reviewed; version control, publication and review dates and author will be included. A list of local policies will be developed and included on the governance meeting business cycle.	Health Services Manager Head of Service for Managed Practices	30/11/2025
15.	The practice used the health board	The practice should consider implementing a local induction process to	Health and Care Quality Standards – Workforce	All new staff will be entered onto the Health Board	Practice Management Team	Completed

	recruitment and induction policies.	include matters relevant to the practice.		Corporate Induction; this will also include relevant Mandatory training requirements. A local Practice Induction has been devised and is being implemented as new people start their roles.		Local registers for induction
16.	Verbal complaints or feedback were typically addressed informally by the reception team or practice manager as appropriate.	We recommend that verbal feedback and complaints be routinely discussed at team meetings.	Health and Care Quality Standards – Learning, Improvement and Research	We will include feedback of recent complaints at monthly team meetings for learning and action.	Practice Manager Clinical Lead GP	30/10/2025 Minutes
17.	The practice did not have a mechanism to share with patients if and how feedback had been acted upon.	The practice should consider sharing with patients how their feedback has been acted upon, such as using a 'you said, we did' board.	Health and Care Quality Standards – Learning, Improvement and Research	We will share our learning from patient feedback via: Patient Participation Group Patient Information Boards throughout the building on specific themes	Health Services Manager, Practice Manager and Workflow Coordinator	30/11/2025

18.	A review of staff training records indicated that six members of staff did not have up-to-date training on information governance.	The practice must ensure that staff complete mandatory training on information governance.	Health and Care Quality Standards – Workforce	Will remain a continued focus on the completion of staff mandatory training to ensure minimum 85% standards are achieved and exceeded	Practice Management Team	31/10/2025 Reported via LDG

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): **Chris Couchman**

Job role: **Associate Director of Primary Care**

Date: **10th July 2025**