Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Vale Wellness, Cowbridge

Inspection date: 17 October 2025
Publication date: 17 January 2026

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Digital ISBN 978-1-80633-972-3

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 Vale Wellness on 17 October 2025.

Our team for the inspection comprised of two HIW healthcare inspectors and a clinical 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. A total of 11 were completed. 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:
Vale Wellness was committed to providing treatments to patients in an environment that was conducive to providing General Practice (GP) services. Staff placed an emphasis on promoting the privacy and dignity of patients and on protecting patient rights when visiting the clinic.

We saw a Standard Operating Procedure (SOP) for the use of chaperones and we saw signs in each clinical room with information about chaperones.

The registered manager and clinicians ensured patients were provided with detailed information pre and post treatment so they could make informed decisions about their treatment.

Staff were dedicated to ensuring patients received a quality experience and this was reflected in the patient feedback with all patients rating the service they received as 'very good'.

There were good processes in place to enable patients to provide their views on the care they had received at the clinic.

There were no provisions to assist communication for patients with sensory impairments such as a hearing loop. However, staff said that they can provide written information in larger print if requested.

The service did not have a translation service. However, staff told us they would access online translation if required.

This is what we recommend the service can improve:

- Improve provisions for patients with sensory impairments
- Improve translations provisions for patients whose first language is not English.

This is what the service did well:

- Clinic environment was easy to locate and well-presented
- Privacy and dignity was promoted throughout the clinic
- Chaperones were well promoted throughout the clinic.

Delivery of Safe and Effective Care

Overall summary:
The clinic environment was mostly well maintained, free from obvious hazards, and warm and welcoming. However, we noted repair was required to the countertop in one of the consultation rooms. The general ambience in the waiting room was of a high standard and thought had been put into the layout.

We found the management of environmental and clinical risks to be inappropriate, particularly in respect of fire safety assessment and mitigation measures. The fire risk assessment was not up to date and there was no evidence of regular fire alarm testing or fire drills. The registered manager had not made appropriate precautions against the risk of fire.

Medicines management processes were inadequate. We found expired medication and equipment, and medication was stored in unlocked areas.

The medicines management policy needed to be expanded to include storage of medications and disposal of expired medications.

The clinic appeared visibly clean, however, on closer inspection we found blood stains on an inspection lamp. We also found sharps boxes stored in inappropriate areas.

All patients said that the clinic was clean and that infection control measures were being followed.

The clinic had the right equipment and medical devices to meet the needs of patients. However, there was no evidence that equipment had been maintained or calibrated.

The clinical records were well organised and easy to understand. They were clear, accurate and legible. An electronic record system was used at the clinic and the records management system allowed for authorised staff to view records.

Immediate assurances:

- We were not assured that fire safety measures were sufficient to safeguard staff and visitors
- Medication was inappropriately stored and we found expired medication and equipment
- Equipment had not been appropriately cleaned and decontaminated.

This is what we recommend the service can improve:

- Further development of the medicines management policy was required
- IPC processes need to be tightened to ensure appropriate decontamination of equipment.

This is what the service did well:

- Clinic was generally well maintained
- Medical records were well organised and contemporaneous.

Quality of Management and Leadership

Overall summary:
We found the registered manager was patient focused and had appropriate skills and knowledge to deliver safe treatments to patients.

We viewed staff training records and found that staff had completed mandatory training.

The clinic had a range of policies and procedures in place. These were found to be well organised and easy to navigate. However, these needed to be reviewed and updated.

The clinic had an up-to-date complaints policy which was available both at the clinic and on the clinic website.

Immediate assurances:

- There was no evidence that staff had received recommended immunisations.

This is what we recommend the service can improve:

- Policies and procedures required review
- The registered manager should perform clinical audits.

This is what the service did well:

- Appropriately skilled and knowledgeable registered manager
- Mandatory training compliance rates were appropriate.

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

3. What we found

Quality of Patient Experience

Patient feedback
HIW issued a questionnaire to obtain patient views on the care at Vale Wellness for the inspection in October 2025.

In total, we received 11 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 11 responses.

All respondents agreed their comments could be published anonymously within the HIW inspection report.

All respondents rated the overall service as very good, with 64% providing positive comments praising professionalism, care quality, communication, and staff support.

Patient comments included:

> *"I would highly recommend Vale Wellness. The service was professional and I felt listened to and looked after."*
>
> *"Dr Alison and Jo Llewellyn Jones have been a completely critical lifeline to both myself and my family. We are commencing through the process of an international job. Their support and advice and care has been outstanding and exemplary in helping us meet tight deadlines and complete any necessary treatments needed. They are outstanding. We are lucky to be supported by these amazing ladies."*
>
> *"Nothing can be improved. Service excellent, clinic, clinician, people beyond lovely and helpful.*

Health protection and improvement
Patient information leaflets covering a range of topics were available in the reception area. We recommended expanding the range of health-related information to include subjects such as smoking cessation, safe alcohol consumption, and healthy eating, to further support service users in improving their health in line with National Minimum Standards for Independent Healthcare.

The registered manager should include patient information on safe alcohol consumption, healthy eating habits and smoking cessation.

We were told the initial screening process involves a telephone triage at the time of booking to gather information regarding the reason for the appointment. Patients are also asked to complete questionnaires prior to or during consultations. During face-to-face consultations, the clinic provides patient information leaflets, opportunistic interventions, and healthy lifestyle advice. Patient education was a key component within the clinic, and appropriate screening, including lifestyle blood tests, was offered where clinically indicated.

Dignity and respect
We noted the clinic was light, airy and clean. All rooms had lockable doors and windows fitted with blinds for privacy. We were told that dignity drapes were used to cover patients during intimate examinations and procedures.

The clinic had a chaperone policy. We saw signage throughout the clinic informing patients of their option to have a chaperone present.

The service saw a reduced number of patients on the day of our inspection; however, we were told that patients were greeted on arrival and informal introductions are made with staff.

All the survey respondents strongly agreed that staff treated them with dignity and respect, protected their privacy, explained procedures, listened to them, and involved them in healthcare decisions.

Patient information and consent
We reviewed a sample of five patient records and saw that consent was gained appropriately. The clinic had a consent process in place for procedures and consultations, with consent documented on separate hard copy forms where appropriate. These forms included key information such as likely outcomes, alternative options, benefits and risks, and confirmed the voluntary nature of the procedure, in line with professional guidance.

Patients were given the time and information to make informed decisions, and capacity was assessed prior to treatment. A written policy on obtaining informed consent was available. However, this required review. Dedicated consent forms were provided for clinicians to use as required.

The clinic used written questionnaires and history-taking during consultations to check for changes in medical history.

Arrangements for sharing relevant information with other healthcare professionals, such as GPs, include telephone communication and referral letters, with patient consent obtained for this process.

A review of clinical notes on the Semble system and hard copy consent forms confirmed that the necessary information for obtaining consent is recorded. While the consent process is robust, improvements could be made to support patients with language and communication needs.

Among those who underwent procedures, all strongly agreed they received sufficient information about treatment options and risks, clear cost information, medical history checks, and signed consent forms. None stayed overnight as inpatients.

Communicating effectively
The registered manager provided us with copies of the clinic Statement of Purpose (SOP) and Patient Guide (PG). We noted that both the SOP and PG contained all the required information.

Signage within the clinic was in English only and we were told that this can be provided in Welsh if required. However, there was no dedicated language line or Welsh-speaking staff, which may present challenges for patients with language barriers.

The clinic had not made provisions for patients with sensory impairments. While patient information is available through leaflets and other formats, there was no dedicated facilities such as a hearing loop or assistance for visually impaired patients. However, patients are encouraged to bring a friend or family member for support. Most correspondence was sent to patients via e-mail. We were told documents can be printed and provided with larger print if requested.

The Registered Manager should consider adopting communication tools for the service to ensure patients with communication barriers are given equal access to the service.

Most patients reported receiving clear aftercare instructions and guidance on infection and emergency contacts, with most strongly agreeing and agreeing on receiving aftercare instructions, and 75% strongly agreeing and 25% agreeing on receiving emergency guidance.

Care planning and provision
Staff we spoke with said that patients were provided with information about their care and treatment, at all stages of the treatment.

We reviewed a sample of five patient records and saw that care was planned appropriately in line with relevant guidelines.

Patients' health and well-being needs were identified through telephone triage, consultations, questionnaires, and feedback, enabling tailored care based on individual medical conditions.

Care and treatment plans were developed according to the patient's specific needs and presenting health concerns, with management aligned to evidence-based medicine and best practice guidelines. Patients receive information about their care and treatment options through leaflets and other resources, and pre-treatment discussions include risks, benefits, side effects, prognosis, and the proposed treatment plan.

To manage complications outside normal service hours, the clinic operates a dedicated out-of-hours phone carried by the clinic doctor and a staff member.

We were told abnormal results were communicated via face-to-face appointments, letters, or telephone calls. Although there is no formal SOP for this process, documentation shows that clinicians discuss results and management plans directly with patients.

Referrals to other healthcare services were managed through referral letters, internal and external processes, and dedicated portals for specific services such as phlebotomy. Overall, there is an acceptable system in place for care planning and provision, including referrals and investigations during patient management.

Equality, diversity and human rights
The majority of respondents to the survey found the building fully accessible. None reported discrimination or difficulty accessing healthcare regardless of protected characteristics. We were told that patients were all treated equally regardless of protected characteristics.

Access to the clinic was street level and therefore suitable for patients with mobility issues. These patients were assessed within the ground floor consultation room. In addition, there was an accessible toilet on the ground floor. Staff stated that they would help patients where necessary to ensure they could access the clinic. This showed that staff provided care in a way that promoted and protected people's rights.

The clinic has an equality and diversity policy in place, and staff have completed relevant training. Equality and diversity may be addressed through patient questionnaires. Staff reported that discrimination is not tolerated within the service, and this is reflected in policy.
Reasonable adjustments included disabled access via the front entrance and treatment rooms located on the ground floor, with chairs that have armrests

available. We were told of plans to expand the premises to include a larger car park and ramp access at the rear.

We were told that preferred pronouns for transgender patients were recorded in patient notes, and staff confirm how patients wish to be addressed in correspondence. While an equality and diversity policy exists, it lacks version control and an implementation date, and forms part of a larger document.

Citizen engagement and feedback

Patient feedback was collected through digital forms sent after every appointment. Feedback is actively used to inform service improvements. For example, patients previously expressed discomfort with attending a beauty salon setting at a former location, which led to the service relocating to its current premises. Patients also requested opportunities for confidential conversations; in response, signage was introduced advising patients to ask the receptionist for a private discussion, and an additional staff member was employed to facilitate this.

We were told the registered manager plans to publish feedback results on the clinic website. When changes are made based on patient comments, the clinic contacts the individual to inform them of the improvement.

Delivery of Safe and Effective Care

Environment
Vale Wellness provided private General Practice (GP) services during the day on Wednesdays and on Thursday evenings. Services such as physiotherapy, male and female wellness and psychology were offered throughout the week depending on demand.

The clinic was situated over three floors of a converted house and accessed through a secure intercom system. The clinic environment was warm and welcoming. The layout of the clinic consisted of a reception room on the ground floor, and a consultation room used for patients with mobility issues or children. There was a disabled toilet and staff area with a kitchen. There were three consultation rooms on the first floor along with a medication storage room, small kitchenette and small store cupboard. There were three rooms on the second floor with only one used for patient assessment.

Managing risk and health and safety
The premises appeared safe and secure. Doors were lockable, and keys were held by the practice manager. The area was visibly clean, with hard flooring that allowed for adequate cleaning. The reception area was light, airy, and provided ample seating.

A current gas safety certificate confirming gas appliances were safe to use was seen, as was a five-year electrical installation inspection and test report confirming the installation was safe.

During the inspection the registered manager was unable to provide a log of fire safety processes on the day of the inspection. We were not assured that appropriate precautions were made to reduce the risk of fire. There was a fire risk assessment in place that had been undertaken prior to the clinic being used as a GP service. Therefore, this was no longer valid. These issues were addressed under our non-compliance process highlighted in Appendix B.

Infection prevention and control (IPC) and decontamination
We found that IPC processes at the clinic required improvement. During the inspection, blood residue was observed on an examination lamp in assessment room 3. Additionally, the worktop in the same room was damaged, preventing effective cleaning. These issues were addressed under our non-compliance process highlighted in Appendix B.

We noted that personal protective equipment (PPE) was available throughout the clinic. The environment was generally found to be in a good state of repair, visibly clean and free from clutter. We saw evidence of the cleaning schedules and cleaning checklists. Fabric cushions made from various textile materials were observed in consultation rooms. As these were not made from wipe clean material, we advised the use of clinically approved items in clinical areas to maintain good infection control standards, and this recommendation was well received by the clinic team.

Each room had a sink for handwashing. Whilst staff were mindful of maintaining good hand hygiene, there were no visible prompts such as hand hygiene signage within the facility. PPE was accessible and used appropriately, and staff were observed wearing scrubs during clinic hours.

The clinic used a cleaning service for the general cleaning. However, as we found clinical equipment had not been properly cleaned, we advised that the registered manager needs to confirm what areas the cleaning company is responsible for and what areas need to be cleaned by clinicians.

We did not see evidence that reusable equipment had appropriate decontamination processes. The registered manager told us that reusable equipment was cleaned by the clinician before and after use. However, there was no record of this.

The registered manager must develop a system where reusable equipment is identified as clean.

We found suitable arrangements in place with a waste carrier company. Sharps bins were available. However, they were not stored appropriately. We found full sealed sharps bins in drawers and cupboards. We recommended that these are stored in one area when sealed to await collection.

The registered manager must ensure sharps bins are appropriately stored when full, in preparation for collection by a waste management service.

All patients who responded to the survey rated cleanliness as very clean. All confirmed infection control measures were followed.

Medicines management
Medicines used by the service were ordered through a local pharmacy, and prescriptions are issued on private scripts. Medicines were administered by an appropriate clinician. Records of medicines administered were maintained using the Semble software where possible. Prescribing practices included documenting

prescriptions and any changes within the patient's Semble profile, with communication to patients via letter.

Prescribers access advice on medicines management through online clinical resources and consultation with the local pharmacist. The service uses a designated pharmacist who provides feedback on potential incidents or concerns.

During our inspection we found medicines management processes at the clinic required significant improvement. We found medication including Diazepam and Lidocaine stored in unlocked cupboards. This posed a risk of unauthorised access to potentially harmful medication.

There was a secure storeroom for medicines, including in a dedicated refrigerator maintained at the manufacturer-recommended temperature to ensure safety and compliance. However, we found expired medication including Vitamin B infusions and Iodine in the treatment rooms and the medication storeroom. Expired urinalysis sticks and phlebotomy collection bottles were also found in one of the consultation rooms and medication storeroom. This posed a risk to patients due to investigations being inaccurate and treatment being delayed or wrongly administered. These issues were addressed under our non-compliance process highlighted in Appendix B.

We saw that medicines were prescribed and administered by suitably qualified staff. The clinic had a medicines management policy. However, this required more detail in the management and storage of medicines.

The registered manager should review the medicines management policy and include detailed information on the storage, checking and disposal of medicines.

Additionally, some storage areas could be better organised to prevent mixing items that are in date with those that are out of date.

Safeguarding children and safeguarding vulnerable adults
There was safeguarding policy in place, which included information on local services with relevant contact details. However, this required review. The clinic had a designated safeguarding lead who had level 3 safeguarding training in adults and children. Staff said they would be informed of any safeguarding concerns to coordinate any action required. Staff had up to date training in Safeguarding.

Medical devices, equipment and diagnostic systems

The registered manager was unable to provide evidence of equipment maintenance or calibration. These issues were addressed under our non-compliance process highlighted in Appendix B.

The clinic operated a dedicated phlebotomy service. Infusion therapy was offered only on rare occasions by the practice nurse, with one example being the administration of an iron infusion. There were no arrangements in place for the use of blood transfusions, alternatives, or adjuncts, as these were not part of the service.

Records relating to medicines and infusions were maintained within the Semble system, and HR compliance documentation confirmed staff training where relevant.

Appropriate labelling and transport procedures were followed after phlebotomy and other procedures to ensure correct patient identification. Learning from any incidents was shared during team meetings.

Safe and clinically effective care
We reviewed the process by which patients were assessed and treated. We saw an appropriate process with clinical guidelines imbedded.

We were told that safety bulletins were sent to the registered manager and disseminated to relevant team members verbally or via email.

Participating in quality improvement activities
We found the practice had safe arrangements for the treatment of patients and we were assured that regulatory and statutory guidance was being followed when treatment was provided. However, there was no evidence of clinical audits being undertaken.

The registered manager should undertake audit activities to ensure quality and improvement is considered.

Information management and communications technology
The clinic uses a digital Customer Relationship Management (CRM) system, and appointment bookings are managed through the Semble platform. This system supports efficient scheduling and secure record-keeping. The clinic did not have a GDPR policy in place, which we advised should be implemented.

Remote consultations are not routinely used within this service. We were informed that only triage prior to an appointment is conducted by telephone, and all consultations take place face-to-face at the clinic. As a result, intimate examinations are not carried out remotely. Where remote interactions occur, such as telephone triage, confidentiality protocols are followed to ensure safety and

security. The service does not use video consultations; however, if images or recordings are required, these are managed securely through the Semble software in line with GMC guidance.

Records management

We reviewed a sample of five patient records. Patient records were generally of good quality, accurate, up to date, complete, and accessible when required. The service has secure storage arrangements compliant with data protection regulations and uses the Semble software for digital record management. While most data was captured effectively, some items, such as consent forms, were maintained as separate hard copies rather than being fully integrated into the digital system. This could be improved to enhance consistency and efficiency.

Quality of Management and Leadership

Governance and accountability framework
A clear management structure was in place to support the effective operation of the service. The Registered Manager was supported by the practice manager and nurse practitioner.

Meetings were attended by the two staff members who were employed at the clinic. The wider team do not usually attend meetings as they only visit the clinic when required. We were shown minutes from these meetings, which are circulated to staff via email. We saw staff working well together as a team.

We found a range of policies and procedures in place. However, these had not been reviewed regularly.

The registered manager should ensure that all policies and procedures are reviewed regularly to confirm they remain current and relevant in line with the regulations.

The service provider has a Statement of Purpose available for patients, which is up to date and includes all required information in line with the regulations. Observations confirmed that services are being delivered in accordance with this Statement. A Patients' Guide is also available and has been reviewed.

Dealing with concerns and managing incidents
A complaints policy was available; however, while the policy met regulatory requirements, it did not include version control or an implementation date. Learning from complaints would be shared with staff through meetings and a WhatsApp group.

The complaints procedure was outlined in the service's SOP and PG and was also accessible via a dedicated tab on the clinics website. Staff confirmed that complaints would be managed in line with the procedure, although no complaints had been received in the past year. If a complaint were about the registered manager, it would be referred to another doctor for investigation.

The service did not have a documented Significant Event Analysis (SEA) policy or a register of reportable events. We advised the development of such a policy to include reportable events.

The registered manager should develop a Significant Event Analysis (SEA) policy to ensure incidents are investigated and reported appropriately.

We noted that the clinic had recorded several incidents over the past 18 months. These were managed appropriately despite not having an SEA policy. We saw documented evidence of lessons learned and changes implemented as a result.

Workforce recruitment and employment practices
There were two staff members employed at the clinic, including the registered manager. In addition, doctors provided clinical services on a contracted basis rather than as employed staff.
We reviewed a sample of five staff files We examined staff files for pre-employment checks, which included references, job descriptions and contracts. The disclosure and barring services (DBS) check on all members of staff was not completed for all staff. We found the following;

- No staff had a contract of employment
- One staff member did not have proof of identity
- One staff member did not have evidence of DBS check
- Two staff members did not have references on file
- Three clinical staff did not have evidence of qualifications.

There was no evidence of pre-employment health screening for two clinicians. This issue was addressed under our non-compliance process highlighted in Appendix B.

The registered manager must ensure thorough pre-employment checks are completed and contracts of employment are kept on file.

Staff we spoke with confirmed the number and skill mix of staff working at the clinic was sufficient to deliver the services provided at the clinic. We were told that patients were only booked in for appointments when there were sufficient qualified staff working at the clinic. The clinical staff were passionate about the care provided and would spend as much time as patients needed for the consultation.

Workforce planning, training and organisational development
We reviewed a sample of five staff files and found compliance with mandatory training generally good for the two employed staff. However, we did not see evidence of training for the remaining staff.

The clinical staff employed were appraised as part of their re-validation process as staff within the NHS. In addition, clinical staff also received training from the NHS on some topics. However, evidence of these were not available on the day of the inspection.

The registered manager should ensure evidence of mandatory training is kept for staff who provide ad hoc services to patients at the clinic.

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

Appendix B - Immediate improvement plan

Service: Vale Wellness

Date of inspection: 17 October 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.						
2.						
3.						
4.						

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):

Job role:

Date:

Appendix C - Improvement plan

Service: Vale Wellness

Date of inspection: 17 October 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.	While patient information was available, there was an absence of guidance on healthy lifestyle choices.	The registered manager should include patient information on safe alcohol consumption, healthy eating habits and smoking cessation.	National Minimum Standards for Independent Healthcare - Standard 3 Independent Healthcare (Wales) Regulations 2011 - Reg 15 (10)			
2.	During our inspection we noted that there was no access to communication tools for patients with sensory impairment.	The Registered Manager should consider adopting communication tools for the service to ensure patients with communication barriers	National Minimum Standards for Independent Healthcare – Standard 18 (e)			

		are given equal access to the service.	Independent Healthcare (Wales) Regulations 2011 – Regulation 6,7,9 &18			
3.	During the inspection we noted that there was no system in place to identify equipment that was clean.	The registered manager must develop a system where reusable equipment is identified as clean.	National Minimum Standards for Independent Healthcare – Standard 13 a, b & c Independent Healthcare (Wales) Regulations 2011 – Regulation 15 (3)			
4.	We noted that full sharps containers were stored inappropriately which posed a risk to staff and patient safety.	The registered manager must ensure sharps bins are appropriately stored when full, in preparation for collection by a waste management service.	National Minimum Standards for Independent Healthcare – Standard 13 a & d Independent Healthcare (Wales) Regulations 2011 – Regulation 15 (3)			
5.	We observed that the medicines management policy	The registered manager should review the medicines management policy and include detailed information	National Minimum Standards for Independent			

	should be expanded to provide clearer guidance on the safe storage and disposal of medication.	on the storage, checking and disposal of medicines.	Healthcare – Standard 15 (a) Independent Healthcare (Wales) Regulations 2011 – Regulation 9 & 15 (5)			
6.	Our review identified that no audit activity had been undertaken.	The registered manager should undertake audit activities to ensure quality and improvement is considered.	National Minimum Standards for Independent Healthcare – Standard 6 (b) Independent Healthcare (Wales) Regulations 2011 – Regulation 19 (1)			
7.	Upon reviewing the clinic's policies, we noted that they had not been subject to any recent review.	The registered manager should ensure that all policies and procedures are reviewed regularly to confirm they remain current and relevant in line with the regulations.	Independent Healthcare (Wales) Regulations 2011 – Regulation 9 (5)			
8.	We noted there was no policy to support the process to	The registered manager should develop a Significant Event Analysis (SEA) policy	Independent Healthcare (Wales)			

	investigate significant events.	to ensure incidents are investigated and reported appropriately.	Regulations 2011 – Regulation 9 (2) (c)			
9.	We identified that pre-employment checks had not been completed for all staff.	The registered manager must ensure thorough pre-employment checks are completed and contracts of employment are kept on file.	National Minimum Standards for Independent Healthcare – Standard 24 (a) Independent Healthcare (Wales) Regulations 2011 – Regulation 20 (a) and 21 (2) (c)			
10	There was no record of training records for clinicians who provide services at the clinic.	The registered manager should ensure evidence of mandatory training is kept for staff who provide ad hoc services to patients at the clinic.	National Minimum Standards for Independent Healthcare – Standard 24 (c) Independent Healthcare (Wales) Regulations 2011 – Regulation 21 (2) (b)			

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):

Job role:

Date: