Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Independent Healthcare Inspection Report (Announced)

## Cardiac Health Diagnostics Limited, 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.

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# 1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Cardiac Health Diagnostics (CHD) Limited on 3 December 2025.

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

The inspection was completed using our methodology for a medical agency without premises. This involved the setting completing a self-assessment form and through speaking with the Registered Manager and Responsible Individual. In addition, we viewed hard copies of documentation used to support the screening services.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. However, none were completed.

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:
We were told that information was provided to patients during the screening, considering patient demographics and lifestyle factors. However, no health promotion leaflets on topics such as healthy eating or smoking cessation were available.

Patient privacy and dignity were promoted using mobile screens or private rooms. Patients were greeted individually and personal information was handled discreetly. Modesty gowns were available and chaperones were offered for all procedures. Assistance was provided for patients with hearing or visual impairments.

Senior staff told us that patients received clear information prior to screening, including consent forms and medical questionnaires. Consent was appropriately documented and forms were available in English and Welsh. Patients under 18 required written parental consent and an accompanying adult.

Information about procedures, costs and treatment options was available online and in hard copy. Fully funded screenings were offered to patients aged 16–25. All patients underwent electrocardiogram (ECG) testing, with further investigations as required and cardiologist consultations. The service was exploring options for patients with sensory or cognitive difficulties.

We were told that venues used ensured disabled access and staff completed equality and diversity training. Patient feedback was actively sought and overwhelmingly positive, highlighting friendly staff and efficient service. However, feedback results were not published or included in patient guides, which also lacked information such as terms and conditions and inspection summaries.

This is what we recommend the service can improve:

- Making health promotion materials available at screening sessions
- Publish patient feedback results on the clinic website and include in the patient guide, as well as promoting these results at screening sessions
- Ensuring the patient guide is complete with all the relevant sections.

This is what the service did well:

- Promoting patient dignity and respect during screening and consultations ensuring privacy throughout the screening sessions
- Providing clear and accurate information prior to screening, including consent forms and medical questionnaires
- Seeking patient feedback, which was overwhelmingly positive, with comments highlighting friendly staff, efficient service and the overall quality of care provided.

## Delivery of Safe and Effective Care

Overall summary:
We were told that screening venues were checked by the Registered Manager prior to events and staff were briefed on emergency procedures and safe working practices. Health and safety norms were followed and venues had their own procedures. However, a formal health and safety risk assessment was not completed for each venue, an issue previously identified.

Controls were in place to protect staff and patients from infection. Infection Prevention and Control (IPC) training and consumables were available in sufficient quantities. Beds were cleaned between patients, personal protective equipment was provided and reusable equipment was appropriately managed. The IPC policy required updating to include cleaning of pads, couches and echo probes.

A safeguarding policy and disclosure barring service (DBS) checks were in place and most staff had completed safeguarding training. The policy also required updating to identify a safeguarding lead and a safeguarding lead was not nominated for each screening event.

We were told that screening equipment was fit for purpose and maintained, but maintenance records were not seen during the inspection. Care provided was safe and clinically effective, with early detection and referrals where necessary. No audits were completed and an annual return was not produced as required.

Records checked were generally accurate but lacked sections for medication and allergy history as well as documenting the offer of chaperones. Some consultation notes and signatures were missing. Improvements suggested included adding medication and allergy fields, documenting chaperone offers and ensuring all records are signed and dated.

This is what we recommend the service can improve:

- Ensure documented risk assessments are undertaken prior to screening
- Update the IPC and Safeguarding policies

- Complete patient medical records in full.

This is what the service did well:

- The service provided safe and effective care
- There was a commitment to protecting vulnerable adults and children
- Cleaning routines were carried out on equipment.

## Quality of Management and Leadership

Overall summary:
The service demonstrated clear governance and accountability arrangements, with lines of reporting and decision-making. We were told that the Screening Manager acted as the senior responsible officer at each event, ensuring policies were adhered to and that screening was delivered safely and professionally. Staff were briefed through huddles and online applications and the HIW registration certificate was displayed at every event. However, directors' meetings were not minuted, despite this being highlighted in the previous inspection.

The services' patient satisfaction survey indicated 99% positive feedback and version control was maintained for all policies. Processes for managing concerns and complaints were effective. A complaints policy was in place and patients were informed of the procedure through the patient guide. Two complaints were received in the past year and resolved promptly. The complaints policy included all required details, including HIW contact information and support arrangements.

Recruitment practices required improvement, whilst DBS checks were available for all staff, pre-employment records lacked proof of identity, references, contracts and updated job descriptions. Evidence of professional qualifications and regulatory body registration was incomplete.

Workforce planning ensured sufficient qualified staff were present at each screening session and events were postponed if replacements were unavailable. Staff induction was documented and training compliance was generally good, though one member of staffs' record lacked supporting evidence. A training matrix was being developed, but the service must maintain up-to-date mandatory training records.

This is what we recommend the service can improve:

- Complete and maintain on file all relevant recruitment checks
- Maintain evidence that staff remain suitably trained and qualified
- Minute directors' meetings.

This is what the service did well:

- The service was well-led with lines of reporting and decision-making
- Ensured that policies were followed and screening events were delivered safely and professionally
- Having a comprehensive complaints policy in place and patients were informed of the procedure.

# 3. What we found

# Quality of Patient Experience

**Health protection and improvement**
We were told that during the consultation with the cardiologist, in addition to the blood pressure of the patient being taken, there would be a discussion around the results of the electrocardiogram (ECG) and echocardiogram (Echo) tests. During this consultation patients could ask any questions they had and would be given advice as requested around any lifestyle issues that may be raised.

Calon Hearts, a heart screening and defibrillator charity, arranged the screening events and Cardiac Health Diagnostic (CHD) was effectively contracted to provide the screening services. Calon Hearts carried out promotion, around heart health and how important it was, especially in young people.

Through conversation with the Registered Manager (RM) and the Responsible Individual (RI) we were told that leaflets were not offered to patients promoting a healthy lifestyle, such as healthy eating, exercise or smoking cessation. This was also reported as an issue in the previous report dated 15 May 2018.

**The employer must ensure that relevant health promotion information is displayed and available to patients at the screening sessions.**

**Dignity and respect**
A self-assessment form (SAF) was completed in advance of the inspection and described how patient privacy and dignity was promoted at the locations selected for screening and consultations. This also described how the screening facilities were set-up to ensure staff safety. We were told that common health and safety norms were adhered to, for example the avoidance of creating trip hazards and ensuring corridors and fire exits were kept clear. The venues used had their own local health and safety procedures which would be used as required.

Senior managers we spoke with confirmed that patients were greeted individually as they arrived by the screening administration team who were usually presented with completed medical questionnaires and consent forms by the patient. However, in some cases patients did not bring the completed documents, in such cases patients were given blank forms to complete and were afforded privacy to do confidentially. In either case, personal information was not discussed openly. Screening would take place behind appropriately positioned mobile screens or within closed rooms to ensure the dignity and privacy of the patient. Modesty

gowns were available and patients could choose to be accompanied during the screening. Consultation with the cardiologist also took place in a suitably private location to allow discussion without compromising privacy and dignity. CHD only used venues which allowed for all the above.

We were told that assistance for deaf or hard of hearing patients was available on the screening day along with assistance for anyone who was visually impaired.

There was a brief chaperoning policy which stated that all patients would be offered a chaperone to accompany them during the testing procedures and the consultation. Additionally, the patient guide and online information about screening events referenced this. We were told that every screening event would be staffed by at least one qualified chaperone. For patients aged under 18, a responsible adult needed to accompany the patient and remain with them through the screening and consultation process.

**Patient information and consent**

We were told that patients were sent information about the screening day in advance explaining the procedure and the clinic details. Once a booking was made, patients received a patient guide and fact sheet along with the consent form and medical questionnaire to complete in advance of the screening. Medical staff would ask for clarification of information provided on the medical questionnaire as necessary.

Whilst there was not a detailed consent policy, the screening consent form viewed stated that the screening would not take place without a completed consent form. It also stated that those under 18 needed written permission from a parent or guardian and that an adult had to be present at the screening. The consent forms were available in English and Welsh.

The patient records checked showed that valid consent was obtained with appropriate consent forms with relevant details contained within the records.

**Communicating effectively**

There was evidence from speaking with senior staff and the SAF that patients generally received clear and accurate information when they needed it and in a way they could easily understand.

We were told that the statement of purpose (SoP) was made available to patients in hard copy on the day of the screening along with the patient guide. English was typically used as the primary language during the screening processes, but assistance in Welsh would be provided when the attending administrative or clinical staff were Welsh speakers.

There was an up-to-date policy on provision of information to patients included in the records management policy.

Information was available to people about the costs of treatments and services they were required to pay, on the Calon Hearts website. This included information about ECGs and Echo's, what they were and the differences between these. Additionally, information was available on the website about screening options, and any post screening instructions. Fully funded heart screenings were available free for patients aged 16 to 25 years. This included an ECG with an Echo, if the ECG detected any abnormalities, or at the discretion of the cardiologist.

**Care planning and provision**
We were told that all patients would see a cardiologist on the day of the screening, unless, due to time constraints, they needed to come back the next day to see the cardiologist. Where a patient needed to be referred to another healthcare service for investigations, the original procedure was to give the patient a letter to give to their GP. However, the service have now implemented a process where the clinic would ask the patient if they wanted a copy and would email the patient's GP. We were told that the clinic did not have the option to treat patients with sensory problems or cognitive difficulties, but they stated that this was being investigated.

**Equality, diversity and human rights**
The SAF stated that all patients were treated with utmost respect and in a very professional manner, which was also evidenced by the completed feedback questionnaires. We were told that CHD only used screening venues which allowed disabled access and patients would be accompanied through the screening processes if they wish. The service should consider asking patients in advance if they had any special requirements and by making language line and British Sign Language interpretations available if required.

There was a relevant equality, diversity and inclusion policy in place.

**Citizen engagement and feedback**
Evidence was provided that showed the views of patients who used the service were actively sought and used to improve the service. The principal means was by the patient feedback questionnaire completed after the screening. We were told that patients often made comments to the administrative and medical staff. Anything relevant would be passed on to the Screening Manager. Feedback received was overwhelmingly positive, as evidenced by the sample of completed feedback questionnaires reviewed. Comments from a sample of completed questionnaires viewed included:

*"Amazing staff."*

*"Very polite and friendly."*

*"Fantastic service."*

*"Very little wait time."*

*"Friendly staff but long wait (x1 patient)."*

*"Great service, glad it exists."*

*"Easy booking, although slots go fast.*

*"Very happy with my experience, all staff very friendly. I think it is amazing that this service is offered."*

*"Quick service, warm room, polite staff. However not much privacy for verbal conversations. Slight gaps in partitions."*

*"Room cold (x 1 patient)."*

However, the results from the feedback were not publicised formally, neither were the results included in the patient guide as required by the Independent Health Care (Wales) Regulations 2011.

The RM said staff at the events were encouraged to look through feedback forms and to pick up any learning if applicable. We were told that patients said that sometimes the screening went on longer than they thought and that patients were now told, and advised in the online appointment booking service, to allow around two hours for the appointment from arrival to the end of the consultation. If the patient needed to leave, before the consultation, then the patient would be asked to return the next day or called later that week by the cardiologist.

Whilst the SoP checked contained all the relevant sections required by the Independent Health Care (Wales) Regulations 2011, the patient guide was missing relevant sections. These included, a summary of the SoP, the terms and conditions of the services provided, a summary of the views of patients and the most recent inspection report from HIW.

**The employer must ensure that the results of patient feedback are published on the website, publicised at screening events and included in the patient guide.**

# Delivery of Safe and Effective Care

**Environment**
The SAF provided stated that the Screening Manager and RI would ensure the screening facilities were set-up in a manner which would ensure patient safety. The RM would always visit a screening venue before an event, to ensure that necessary venue staff were available to provide input on local emergency procedures and relevant information about the venue. Venues used had their own local health and safety procedures which would be used as required.

We were told that staff were informed of procedures for the screening session and informed of any relevant aspects specific to the location at the start of the session. Clinical staff had input into the set-up at each screening venue. Common health and safety norms were adhered to, for example the avoidance of creating trip hazards and ensuring corridors and fire exits were kept clear.

**Managing risk and health and safety**
There was a CHD Screening Event Set-up and Staff Induction Procedure. This included the actions taken by management and staff such as explaining the layout of the venue and relevant emergency procedures to the administrative and medical staff.

We were told that all attending staff were required to ensure that the health and safety of patients and staff were protected. The Screening Manager would conduct a health and safety check before the scheduled arrival of patients, looking for items like trip hazards and inappropriately set-up furniture or equipment. Staff also maintained safe working practices throughout the screening event and would deal with any issues that would affect this as they arose. However, whilst the Screening Manager would ensure that the venue was fit for purpose, an appropriate documented health and safety risk assessment was not completed for each venue. This was also raised as an issue in the previous report.

**The employer must ensure that a documented health and safety risk assessment is undertaken prior to screening and that a record of this is maintained on file.**

**Infection prevention and control (IPC) and decontamination**
We were told that CHD informed staff that IPC was the responsibility of all staff at the organisation. Members of staff were given clear instructions in relation to best practice guidelines of hygiene, as well as specific cleaning instructions.

The SAF stated that appropriate consumables (ultrasound gel, ECG tabs, modesty gowns, bedroll, hygienic cleaning materials etc) were always available in sufficient quantities to ensure patient care was not compromised.

The arrangements for the cleaning, decontamination, transportation and storage of reusable medical devices and equipment were described by senior staff. We were told that equipment used was fit for purpose and used by suitably qualified staff. Patient couches were cleaned between patients and personal protective equipment was available. No sharps were used and medication was not prescribed. There was an in-date IPC policy in place that needed to be updated to include reference to cleaning pads, couches and echo probes.

**The employer must ensure that the IPC policy is updated to include reference to the cleaning of pads, couches and echo probes.**

**Safeguarding children and safeguarding vulnerable adults**
We were told that both the RM and RI had the appropriate safeguarding training. There was also a relevant safeguarding policy in place, with the relevant staff having appropriate disclosure barring service (DBS) checks. However, the safeguarding policy did not include the safeguarding lead in place nor who would be the nominated safeguarding lead for each event. We were also told that at least two members of the administrative staff present at the screenings would have appropriate safeguarding training.

**The employer must ensure that a safeguarding lead is nominated in the safeguarding policy and that a safeguarding lead is nominated for each screening event.**

**Medical devices, equipment and diagnostic systems**
We were told that the service had the relevant equipment to meet the requirement of the screening. The SAF stated that the service used its own screening equipment, a Mindray M7 Diagnostic Ultrasound machine and two GE Healthcare MAC 800 ECG machines. These were regularly Portable Appliance Tested (PAT) and maintained in accordance with manufacturers' instruction.

The arrangements for servicing, maintaining and calibrating equipment were discussed. However, the maintenance records were not seen during the inspection.

**The employer must forward copies of the documents to support the maintenance and PAT of the equipment to HIW by return.**

**Safe and clinically effective care**

We were satisfied that the service offered a safe and clinically effective service due to the benefits for the patients with early detection and referrals for preventative measures.

**Participating in quality improvement activities**
A sample of the patient feedback questionnaires given to patients to complete after the screening was reviewed. We were told that the administrative team also checked the paperwork from screenings after the event to identify any issues. We were not provided with a copy of the annual return required by the relevant regulations and were told that this was not routinely completed. This was also identified at the previous inspection.

There was no evidence provided of any audits, including clinical audits, completed by the service, neither was there an audit policy. A clinical audit is a systematic process used to measure the quality of care against agreed standards to evaluate against best practices and if not, take actionable steps to improve.

**The employer must ensure that:**

- **An annual return is produced and forwarded to HIW by return**
- **An audit policy, including clinical audits, is drafted**
- **Audits are completed on a regular basis as required by the audit policy.**

**Records management**
We checked a sample of 15 patients screening records and noted that they were mainly accurate and managed properly. Paper records were maintained for all patients.

We were told that all patient records were managed by Calon Hearts Screening and Defibrillators. Administration for the screening events and the Screening Manager were employees of Calon Hearts, which was registered with the Information Commissioner's Office. Calon Hearts kept all hardcopy patient records in its secure offices in an appropriately identified and organised filing system.

Records checked included information on who was making the record at each contact, the date, any decisions made and actions agreed along with who was making the decisions and agreeing the actions. Patients' records were completed contemporaneously after care and treatment.

Whilst staff had the option to record the information, there was not a requirement to declare medication history and allergy history. The screening questionnaire

enabled certain specific risks to be identified such as-body mass index (BMI) along with any potential symptoms in general. We were told that following the screening and investigations at the clinic, relevant advice, where necessary would be provided to patients, for example lifestyle modifications and keeping hydrated. Where a patient needed further investigations for example from a hospital, the results were communicated to the patients' GP. However, the results of "normal" investigations were not made know to the patients' GP, this should be considered.

Whilst chaperones were offered to patients, evidence of this offer was not documented on the patient records. Additionally, not all ECGs were signed by the relevant healthcare professional, this was referenced in the consultation notes and signed. In two of the patient medical records the consultation notes were not in the pack. We were told that this would have been sent as part of the referral to secondary care for further management. Most of the patient notes provided had good screening information along with relevant information captured.

**The employer must ensure that:**

- **Medication history and allergy history is included as part of the medical questionnaire**

- **All consultation records are signed and dated**

- **Evidence of the offer of a chaperone is documented.**

# Quality of Management and Leadership

**Governance and accountability framework**
From speaking with senior staff and reviewing the SAF, it was clear that the service was well led with clear lines of reporting and a clear framework for decision making. The screening events were arranged and patients invited by the charity Calon Hearts who effectively contract CHD to provide the screening services. CHD was registered with HIW to provide mobile heart screening services.

The lines of reporting, accountability and responsibilities at the screening sessions were clear. We were told that the Screening Manager was responsible for ensuring that policies were adhered to and that the event provided a safe and professional screening service. All administrative staff and clinical staff at a screening event reported directly to the Screening Manager who would provide the necessary guidance and instruction.

The RM was responsible for reviewing and agreeing policies and procedures before they were implemented. Version controls were used on these policies and procedures. We were told that the RM was also responsible for ensuring that staff were aware of any changes or new policies and procedures. A policies and procedures manual would be available to all staff at the screenings. Information messaging groups were also used to communicate any relevant changes. There were also huddles at the start of the day when any changes would be highlighted.

The RM and RI were both the directors of the service and we were informed that they met regularly to discuss the running of the service. However these directors' meetings were not minuted to ensure appropriate accountability. This was also noted as an issue in the previous report.

**The employer must ensure that regular meetings held by directors are scheduled and minuted with actions to be taken recorded, to ensure appropriate accountability.**

We were told that hard copy HIW registration certificate were displayed at every event.

The SAF required in advance of the inspection was also completed in full and forwarded in a timely manner.

**Dealing with concerns and managing incidents**

The service had effective processes for managing concerns. There was a policy in place for dealing with concerns and managing incidents, as well as an up-to-date whistleblowing policy.

Patients would be made aware of the complaints procedure through the patient guide made available when the booking was made and the guide was available at the screening day as well as the complaints procedure in place. The RM said that the complaints procedure would be made available in different formats to meet the communication needs of people, on request.

The SAF stated that two complaints had been received in the last 12 months, which were both dealt with on the day of the complaint. We were told that minor complaints were also occasionally made about waiting times at screening events, as events could be very busy and waiting times could extend to a couple of hours. We were told that the Screening Manager would always keep patients informed of expected waiting times and patients would be offered telephone consultations after the screening event if they could not wait to see the cardiologist.

The complaints policy provided included the relevant information needed including details of how people could make a complaint, who it could be made to, the contact details of HIW and the stages of the complaints process. This included the contact details of other agencies who could provide help and support.

**Workforce recruitment and employment practices**
The service had a suitable and up to date recruitment policy in place. However, evidence of the pre-employment checks was not available in full for the five records checked. This included a lack of proof of identity including a recent photograph, no references from each of the persons' two most recent employers and no contract of employment nor an up-to-date job description. This was also noted as an issue in the previous report.

The SAF completed, stated that those personnel considered to carry out the duties during screening were suitably recruited and qualified, this included an initial meeting with the RM or RI and proof of skill and qualifications. They would then follow the documented induction process before taking part in a screening event.

We were told that the service was in the process of checking that healthcare professional's registration with their regulatory body was current and that the staff working for or on behalf of the service were suitable trained, experienced and qualified to carry out their duties. There was evidence of a DBS certificate (at the appropriate level) available for the sample checked. The RM also needed to be satisfied that there have been no changes to the check since it was originally applied for.

**The employer must ensure that**

- **The relevant recruitment and pre-employment checks are completed and available on file for all employees and those working on behalf of the service**

- **All those working on behalf of the service remain registered and suitably trained and qualified**

- **There is an annual certification of the DBS status of staff.**

**Workforce planning, training and organisational development**
The service ensured that there were sufficient appropriately qualified, experienced and competent staff to provide people with screening at each location. We were told that screening would not go ahead without qualified ECG, Echo and cardiologist staff in attendance. CHD had screened over 1700 people in the last 6 months, running one or two sessions most weeks and there had not been any major incidents. The main issue had been occasionally when clinical staff called in sick on the day of screening, which had resulted in the screening session being postponed if replacement suitably qualified staff were not available.

There was an appropriate documented staff induction procedure. This was incorporated as part of the screening event set up process, which explained the actions taken by the screening manager and the staff at the screening.

A check of a random sample of four staff records showed that 75% of staff had completed the subjects checked including equality and diversity, fire safety awareness, IPC, resuscitation and safeguarding. The percentage compliance was 75% as one member of staff in the sample selected did not supply their training compliance. We were told that a training matrix was being developed and that the service relied on training completed by staff within their primary job in the NHS. During the previous inspection, we discussed this with the RM and were assured that staff would be asked to bring in their training records for copying. This we understood would be actioned immediately.

**The employer must ensure that the service has relevant training records of the mandatory training undertaken by staff and that they are assured that all staff are sufficiently trained and updated for the work they carry out.**

# 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 on this inspection. | | | |
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| | | | |

# Appendix B - Immediate improvement plan

**Service:** Cardiac Health Diagnostics

**Date of inspection:** 3 December 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. | No immediate non-compliance issues were identified. | | | | | |

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: Cardiac Health Diagnostics

## Date of inspection: 3 December 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. | Leaflets were not offered to patients promoting a healthy lifestyle, such as healthy eating, exercise or smoking cessation. | The employer must ensure that relevant health promotion information is displayed and available to patients at the screening sessions. | National Minimum Standards (NMS) 3 - Health Promotion, Protection and Improvement | CHD will source appropriate material and make it available at all screening events. | R Sacks | Mar 26 |
| 2. | Whilst the SoP contained all the relevant sections required by the Independent Health | The employer must ensure that the results of patient feedback are published on the website, publicised at screening events and | Independent Health Care (Wales) Regulations 2011, regulation 7 (1) (e) | The CHD Patient Guide will be updated accordingly. Summaries of patient feedback will be | R Sacks | Mar 26 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Care (Wales) Regulations 2011, the patient guide was missing relevant sections. These included a summary of the SoP, the terms and conditions of the services provided, a summary of the views of patients and the most recent inspection report from HIW. | included in the patient guide. | | included in the Patient Guide, on the Calon Hearts website and made available at all screening events. | | |
| 3. | Whilst the screening manager would ensure that the venue was fit for purpose, an appropriate documented health and safety risk assessment was not completed for each venue. This was also | The employer must ensure that a documented health and safety risk assessment is undertaken prior to screening and that a record of this is maintained on file. | Independent Health Care (Wales) Regulations 2011, regulation 19 (1) (b) | CHD will create a standard template for H&S risk assessments for screening venues and complete an assessment for each venue, to be available at that venue for staff and patients. | R Sacks | Feb 26 and ongoing |

| | | | | | | |
|---|---|---|---|---|---|---|
| | raised as an issue in the previous report. | | | | | |
| 4. | The IPC policy needed to be updated to include reference to cleaning pads, couches and echo probes. | The employer must ensure that the IPC policy is updated to include reference to the cleaning of pads, couches and echo probes. | Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (n)<br><br>NMS 13 - Infection Prevention and Control (IPC) and Decontamination | CHD's IPC policy will be updated accordingly. | R Sacks | Mar 26 |
| 5. | The safeguarding policy did not include the safeguarding lead in place nor who would be the nominated safeguarding lead for each event. | The employer must ensure that a safeguarding lead is nominated in the safeguarding policy and that a safeguarding lead is nominated for each screening event. | NMS 11 Safeguarding Children and Safeguarding Vulnerable Adults | CHD's safeguarding lead will be named in its policy document and an individual nominated for each screening event. | R Sacks | Feb 26 |
| 6. | The arrangements for servicing, maintaining | The employer must forward copies of the documents to | Independent Health Care (Wales) | All relevant CHD equipment was most | R Sacks | Jan – Mar 26 |

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| | and calibrating equipment were discussed. However, the maintenance records were not seen during the inspection. | support the maintenance and PAT of the equipment to HIW by return. | Regulations 2011, Schedule 3 Part II 3 (c) | recently PAT tested in Jan 26.ECG machines are being calibrated w/c 16 Feb 26. Arrangements being made to calibrate the Echo machine early Mar 26. | | |
| 7. | We were told that an annual return was not routinely produced as required by the relevant regulations and HIW.<br><br>There was no evidence of any audits completed by the service, neither was there an audit policy. | The employer must ensure that:<br><br>• An annual return is produced and forward to HIW by return<br><br>• An audit policy, including clinical audits, is drafted<br><br>• Audits are completed on a regular basis as required by the audit policy. | Independent Health Care (Wales) Regulations 2011, regulation 9 (o) and 19 (2) (c) (ii) | An Annual Return will be submitted in Feb 26. An audit policy will be created in Mar 26. | R Sacks | Feb – Mar 26 |

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| 8. | There was not a requirement to declare medication history and allergy history.<br><br>Not all ECGs were signed by the relevant healthcare professional.<br><br>Whilst chaperones were offered to patients, evidence of this offer was not documented on the patient records. | The employer must ensure that:<br><br>• Medication history and allergy history is included as part of the medical questionnaire<br><br>• All consultation records are signed and dated<br><br>• Evidence of the offer of a chaperone is documented. | Independent Health Care (Wales) Regulations 2011, regulation 23 | CHD will take advice from its Cardiologists concerning asking about medication history and allergy information. If they agree that the medical questionnaire should ask about these matters, the questionnaire will do so in an appropriate way.<br><br>Each patient's records pack is signed-off by a Cardiologist, this has been added to the Cardiologist report form. Either this report or the ECG read-out, or both, will be signed and dated by the Cardiologist. | R Sacks | Mar 26 |

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| **9.** | Evidence of the pre-employment checks was not available in full for the five records checked.<br><br>There was evidence of a DBS certificate (at the appropriate level) available for the sample checked. The RM needs to be satisfied that there have been no changes to the check since it was originally applied for. | The employer must ensure that<br><br>• The relevant recruitment and pre-employment checks are completed and available on file for all employees and those working on behalf of the service<br><br>• All those working on behalf of the service remain registered and suitably trained and qualified<br><br>• There is an annual certification of the DBS status of staff. | Independent Health Care (Wales) Regulations 2011, regulation 21(2) and Schedule 2 | CHD has created a database of the necessary information for all clinical staff. This will be maintained as necessary. | R Sacks | Ongoing |
| 10. | The directors' meetings were not minuted to ensure | The employer must ensure that regular meetings held by directors are scheduled | NMS 1 Governance and accountability framework | Directors' meetings will be held regularly and minuted. | R Sacks | Ongoing |

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| | appropriate accountability. | and minuted with actions to be taken recorded, to ensure appropriate accountability. | | | | |
| **11.** | A check of a random sample of four staff records showed that 75% of staff had completed the subjects. The percentage compliance was because one member of staff in the sample selected did not supply their training compliance. We were told that a training matrix was being developed. | The employer must ensure that the service has relevant training records of the mandatory training undertaken by staff and that they are assured that all staff are sufficiently trained and updated for the work they carry out. | Independent Health Care (Wales) Regulations 2011, regulation 20 (2) (a) | This will also be captured in the clinical staff database mentioned above. | R Sacks | Ongoing |

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):** **Richard Sacks**

**Job role:** **Director, CHD and HIW Responsible Individual**

**Date:** **12 Feb 26**