Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Fairwater Health Centre, Cardiff and Vale University Health Board

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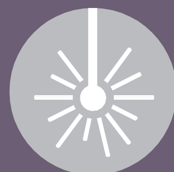

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

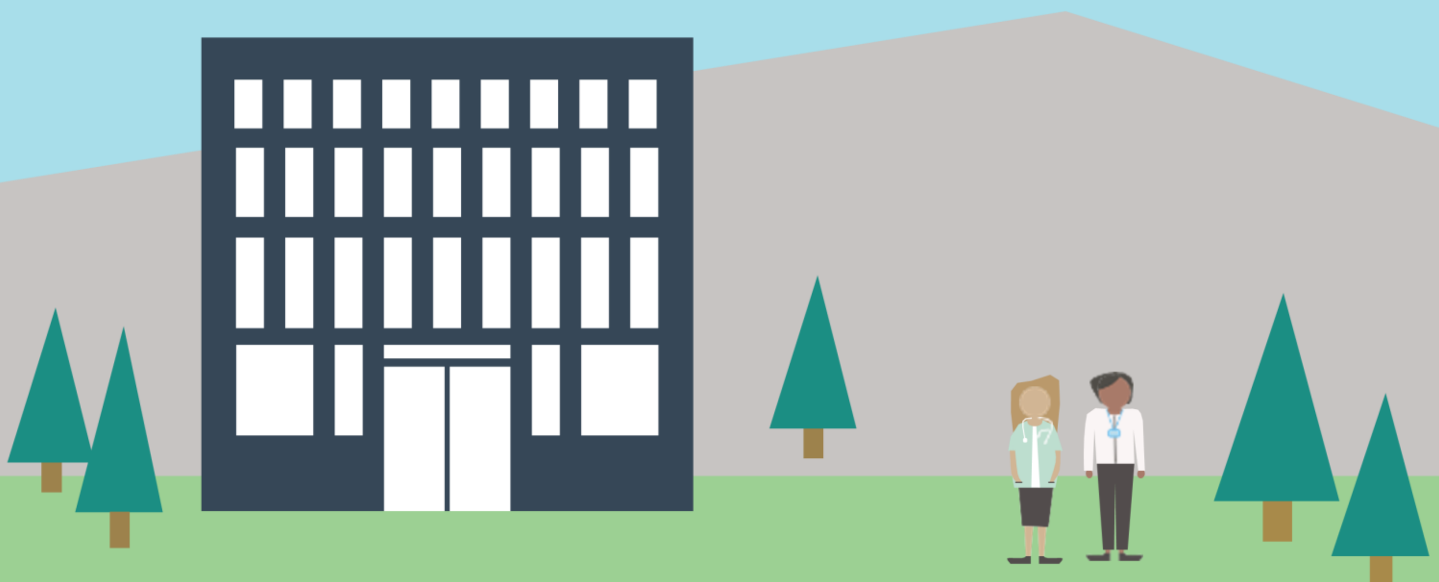
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 Fairwater Health Centre, Cardiff and Vale University Health Board on 22 January 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers and a practice manager 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 25 questionnaires were completed by patients and 4 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:
In general patients reported a positive experience of care and access to appointments, although some would prefer more choice with respect to appointment format and practitioner. The practice had been trialling nurse-led clinics and care navigation and health promotion also supported patients to receive timely information and care. Suitable measures were in place to preserve privacy throughout consultations. However, some patients felt that confidentiality within the reception area was compromised. The building was accessible and a language line was available to support communication with patients unable to understand and speak English or Welsh. However, more could be done to implement the Welsh language Active Offer.

This is what we recommend the service can improve:

- Better promote self-check-in or a separate room for more in-depth discussions with reception staff are better promoted as options to preserve confidentiality
- Ensure that a chaperone is actively offered prior to every intimate examination or procedure, implemented in line with patients consent and documented to protect patients and staff
- Check policies and procedures to ensure they promote rights and equality for all patients.

This is what the service did well:

- Suitable triage processes supported the provision of safe and timely care
- A detailed patient information leaflet was available.

Delivery of Safe and Effective Care

Overall summary:
The practice was generally clean and well-maintained. However, some concerns with the storage of items and the standard of cleaning found on inspection and had also been noted within previous audits. A comprehensive Business Continuity Plan was in place to support staff in the event of major service disruption. Patient safety alerts would be circulated throughout the team to inform practice. However, hazards within the physical environment needed to be more clearly signposted to staff and patients. Staff awareness also needed to be raised regarding the safeguarding arrangements for the practice, steps to take following a needlestick injury and incident reporting. Patient records were found to be of a

good standard. However, firmer arrangements for the clinical supervision of non-medical prescribers were required.

This is what we recommend the service can improve:

- Reduce clutter and improve storage arrangements for liquid nitrogen, clinical waste and cleaning equipment
- Update clinical rooms and cleaning schedules to support Infection Prevention and Control
- Comprehensively review their safeguarding arrangements in line with national guidelines including Royal College of GP Safeguarding Standards (2024).

This is what the service did well:

- Emergency equipment and drugs were available and checked on a weekly basis in line with guidelines
- Robust cold chain and ambient room temperature monitoring were implemented to ensure medicines remained suitable for use
- Systems and information sharing in place to support efficiency.

Quality of Management and Leadership

Overall summary:
Practice leaders were visible and accessible to staff should they have concerns or suggestions. All staff demonstrated a commitment to the delivery of safe and quality care and a positive environment contributed to staff retention. However, several systems required strengthening including policy version control, appraisal arrangements, meeting documentation and patient feedback and complaints management.

This is what we recommend the service can improve:

- Ensure staff receive regular appraisals and updated job descriptions
- Promote patient feedback mechanisms and maintain comprehensive complaints records
- Improve version control and regular review of policies as scheduled.

This is what the service did well:

- Maintained strong teamwork both within the practice and the wider cluster
- Undertook comprehensive pre-employment checks and implemented robust induction programmes for new staff.

3. What we found

Quality of Patient Experience

Patient feedback

Responses given by patients to the HIW questionnaire were generally positive, with most rating the service provided as ‘very good’ or ‘good’.

Most respondents were satisfied with the opening hours, ability to contact the practice and access appointments. However, some patients indicated they would prefer easier access to face-to-face appointments than telephone-based care they had experienced. Some patients also told us that their identity and medical details were not always confirmed at the beginning of clinical discussions.

There were mixed responses on privacy when talking at reception, but most felt privacy was protected during consultations.

All respondents agreed that the building was accessible and that the practice displayed health promotion materials. A language line was available to support communication with patients unable to understand and speak English or Welsh. However, opportunity for patients to communicate in Welsh could be better promoted.

Patient comments included:

> *“The initial appointment is always by telephone. I would prefer to be given the choice”*
>
> *“Would prefer to see a GP of my choice not always able to do so. Also not always possible to book a routine appointment within a reasonable time period - sometimes weeks in advance…”*
>
> *“The centre provides a first class service, I have no complaints.”*

Person-centred

Health promotion
We saw a range of information raising awareness of health condition symptoms, self-help and sources of health and lifestyle support for patients and their carers was available. Patients could view information on posters within the practice

premises or take information leaflets away. However, we found that some QR codes displayed within the premises and website links to online information were not working correctly, creating a barrier to patients accessing information and support they were seeking.

The practice should ensure that health promotion information made available to patients is kept up to date.

Child health was overseen in collaboration with health visitors. The annual flu vaccination programme for children and other high risk groups had been completed by the practice by the time of inspection.

A cluster pharmacist visited each week and supported asthma surveillance and reviews of specific types of medication. However, only a small number of hours were allocated to the practice which we discussed as a barrier to the implementation of clinical guidelines, for example the NICE (2024) guidelines for asthma. The practice informed us they were taking steps to increase clinical time focused on chronic disease management relevant to the patient population, for example trialling nurse-led clinics for certain conditions.

The practice should continue to increase clinical time for chronic disease management to ensure that clinical guidelines can be implemented.

We were told that Did Not Attend rates for practice appointments were generally very low. A was not brought policy was in place to follow up when children or other vulnerable patients were not brought for appointments and the principal of phone follow-up was also applied to lower risk patients who had not attended as planned. When the practice was notified that a child registered at the practice had attended an emergency department or a patient had missed a hospital appointment GPs would action follow-up on an individual basis.

Dignified and respectful care

We observed all staff welcoming patients to the practice in a professional and friendly manner. Most respondents to the HIW patient questionnaire agreed they were treated with dignity and respect and involved in decisions regarding their care.

Clinical rooms were fitted with suitable window coverings and privacy curtains to preserve patient privacy and we observed that doors were kept closed during consultations.

Phone calls were answered away from the reception area to preserve confidentiality. A self-check-in screen was available for patients arriving for appointments at the premises should they prefer this to speaking with reception

staff, and signs were displayed informing patients on the premises of why reception staff needed to discuss symptoms with patients and offering a separate room to be made available for this purpose if needed. However, we saw that the screen was too high to be easily accessed by patients attending in a wheelchair or who were shorter in stature and many respondents to our questionnaire indicated that they did not feel they could speak with reception without being overheard.

The practice should ensure that:

- **The offer of self-check-in or a separate room for more in-depth discussions with reception staff are better promoted as options to preserve confidentiality**
- **The self-check-in screen is suitably positioned for patients with a range of needs.**

The practice had identified within their future development plans that a virtual noticeboard would help to display this type of patient information more easily. We observed that a self-service blood pressure machine was positioned within the waiting area. This was not currently working. However, if this machine was available again in future the practice should position this away from other patients or provide privacy screening to ensure patient confidentiality during use.

The patient information leaflet indicated to patients the gender of practitioners so that patients were aware and able to request a preferred practitioner if they felt this would best support them.

An appropriate chaperone policy was in place and promoted through posters in reception and clinical rooms. However, not all respondents to our patient questionnaire indicated that the offer of a chaperone had been discussed prior to intimate examinations or procedures.

The practice should ensure that a chaperone is actively offered prior to every intimate examination or procedure, implemented in line with patients consent and documented to protect patients and staff.

Timely

Timely care

The practice had a suitable system for patients to access timely appointments including same day and face to face consultations when appropriate. Planned nurse appointments were offered as required by patients to ensure flexibility that a rigid clinic-based approach would not support. The majority of respondents to our questionnaire indicated that they could access urgent and routine

appointments at the practice when they needed and we saw that appointments were available on the day of the inspection.

Patients were able to contact the practice regarding their health concerns and register appointment requests by phone, in-person, the website or written letter. Contact could also be made by a patient’s family member if the patient required and with their consent. Patients with long-term conditions that could flare up or advance were provided with safety netting advice and information regarding when they should contact to alert clinicians of a change in medical condition and seek additional support.

Reception staff were trained in care navigation and able to signpost patients to emergency services, pharmacy first, and first contact physiotherapy when appropriate. However, reception staff had not undertaken any mental health awareness training assist them in effective signposting to mental health services and one patient also commented that consideration of hidden disabilities within communication at reception could also be improved.

The practice should enable reception staff to complete training relevant to communication with a range of patients and the care navigation role. This may include mental health awareness and autism awareness.

The reception team were aware of symptoms of some physical conditions to initiate an emergency response. Staff could escalate to clinicians if they were unsure regarding a potential emergency or routine health care need.

A triage policy was in place. Triage for appointment requests was operated by GPs throughout the day to ensure an appropriate response via the practice or the health board Urgent Care Centre for any patients who were assessed as requiring a same day consultation. An on call system allowed timely responses to home visit requests, including to care homes and independent living centres, and calls from paramedics and notifications of deaths in the community.

Patients identified as requiring urgent secondary mental health assessment could be referred to the appropriate service by phone with an electronic referral made afterwards. This ensured that patients could be seen the same day or, where this was not possible, for a clear action plan to be implemented to keep patients safe while awaiting specialist assessment. Suitable communication mechanisms between the practice and mental health services ensured continuity of clinical oversight of patients accessing mental health support. There was concern expressed by the practice that mental health liaison nurses, counselling and some third sector services had been recently reallocated to other health board areas or

decommissioned altogether and that the practice population would benefit from increased availability of mental health support.

Patients with drug and alcohol problems would be referred to health board services and two GPs within the practice were also trained in prescribing and administering long acting opioid medications to support patients withdrawing from illicit opioid use.

A detailed patient information leaflet, the practice website, answerphone message and social media platforms provided patients with comprehensive details regarding access to practice, emergency and out-of-hours care. We were told that the phone system had recently been updated so that additional staff could join the pick-up group to aid a quicker response to calls. We considered this noteworthy for patient experience.

Patients were made aware by the phone welcome message that all calls were recorded. The practice manager was a phone system superuser and could access these recordings for training and monitoring. However, allocation of a second superuser would ensure the continuity of quality mechanisms in the practice manager’s absence.

The practice should consider allocating a second phone system superuser to deputise with respect to quality monitoring of phone calls in the absence of the practice manager.

Equitable

Communication and language
Information about the practice and updates regarding the services it provided was shared with patients through the practice website, signs within the premises and written information sent to patients homes when considered necessary.
We noted that a hearing loop was available to patients requiring this for communication with the practice team. We also saw that some signage was provided in English, Welsh and braille.

The practice information leaflet indicated that two members of the clinical team Welsh speakers. However, there was nothing to visually highlight that patients were welcome to speak in English or Welsh. No respondents to our patient questionnaire indicated that they had been offered the opportunity to speak Welsh throughout their patient journey despite three indicating that they would prefer to communicate in Welsh.

The practice should consider using mechanisms such as 'Iaith Gwaith' signage or a 'Who's who' board to promote the Welsh language Active Offer to patients and indicate which members of staff would be able to provide clinical consultations in Welsh.

We were told a language line was available to support communication with patients unable to understand and speak English or Welsh and that a double appointment would be allocated to ensure this would be effective. However, discussion with staff and reviews of clinical records indicated that although language preferences would be accommodated the practice did not proactively seek or routinely confirm patient language choice.

The practice should ensure that language preference is routinely recorded to ensure effective patient consultations conducted in the language of their choice.

Rights and equality
We saw evidence that staff had undertaken relevant Equality, Diversity and Inclusion (EDI) training.

A contract was in place for the practice to oversee the care of patients accessing the Adult Transgender Local Enhanced Service delivered by the health board and provide an annual review. The practice would raise requests for name and pronoun changes with shared services.

We were told that the practice offered annual reviews to patients with learning disabilities to screen for medical problems. Patients were invited to attend with a carer and appointments were booked at a time convenient to the patient, carer and the practice.

The practice environment was accessible to people with a range of physical needs. The practice was fitted with an automatic door at its entrance and access to all patient facilities was level throughout. Chairs within the waiting area were suitable for people of varying needs and accessible toilets and a baby changing facility were available. A lowered section of the reception desk enabled wheelchair users to speak with reception staff. We were told that should patients find clinical rooms difficult to access clinicians would provide help or source a more accessible room ahead of the appointment or on the patient's arrival depending on when the patient's needs were identified. Clinical equipment of different sizes and weight capacities was available.
In a review of policies and procedures we found references to EDI and protected characteristics. However, we found that the practice consent policy needed updating to ensure that it promoted the Lasting Power of Attorney (Health and

Welfare) as of potential benefit to all patients should their mental capacity to make decisions regarding their health become compromised instead of emphasising this specifically for older patients.

The practice should review the language used within their consent policy to ensure this it is applicable to all patient groups.

Staff we spoke with stated they were treated fairly in the workplace.

Delivery of Safe and Effective Care

Safe

Risk management
We saw the practice was generally clean and well maintained. Clinical rooms were tidy. However, there was clutter within staff areas which had also been noted within a recent health board Infection Prevention and Control audit and in-house monthly waste management audits. Packaging waste awaiting collection presented fire and trip hazards and objects in the receptionists' area would hinder access to the emergency equipment and drugs.

The practice should ensure that the premises are free of clutter.

A fire risk assessment had been undertaken by an external company and clearly signposted emergency exit routes and suitable fire extinguishers were in place. However, the practice floor plan did not indicate the locations of medical gases and there was no sign on the door to the room where Oxygen cylinders were kept.

The practice should ensure that there is clear signage regarding medical gases kept on the premises.

We were told that should an incident occur on the premises staff would raise an alarm through the computer system which all staff present would respond to by moving to assist at the location of the incident if it were safe for them to do so.

The practice had identified that the Datix reporting system should be used more frequently when incidents had occurred. However, at the time of inspection there were still no Datix reports that had been completed.

Incidents were discussed at practice meetings and the practice kept a record of all significant events discussed. However, through staff discussions we found there had been at least one incident which could have been identified as a significant event but did not follow the formal significant event pathway which may have resulted in less reflective opportunity for learning and future action planning.

The practice should provide clarity around their definition of significant events so that these can be easily identified and the formal pathway for reporting, reflective discussion and action planning is triggered when appropriate.

Suitable processes were in place to ensure that any patients whose medical condition deteriorated while attending the practice would be kept under close

clinical assessment and care while awaiting emergency transport. We were told that as the ambulance service considered the practice a place of safety and waits for their assistance could be long. The practice should utilise Datix when they determine an incident or opportunity for learning to have occurred.

The practice manager had responsibility for receiving patient safety alerts and distributing these throughout the practice team as required. We discussed that maintaining a central shared folder for these documents would enable them to be referred to at a later time if required.

We saw that a comprehensive Business Continuity Plan was in place to support staff should major disruption to service provision occur. We found there was clear succession planning and multiskilling of staff which supported staff retention. To prevent adding pressure to the team unplanned absences were covered by previous employees or locums familiar with the practice where possible. A Health and Safety Executive poster was displayed in a staff area to raise awareness of employer and employee responsibilities within the team. The required sustainability framework and linked escalation level reporting were regularly completed by the practice.

Infection, prevention and control (IPC) and decontamination
We saw that an IPC policy was available and that staff were aware of their roles and responsibilities with respect to IPC. A practice IPC lead was in place and IPC support was also provided by the health board who had recently undertaken an IPC audit. Updates to IPC expectations and practices received from the health board would be circulated to relevant staff by the practice IPC lead, who also monitored completion of relevant IPC training by clinical staff.

A waste management policy was in place and monthly waste management audits completed. However, we observed that clinical waste awaiting collection for disposal was kept in the same area as clean items.

The practice should ensure that clinical waste awaiting collection for disposal is completely segregated from clean items.

Suitable foot-operated clinical waste bins were used within clinical rooms. However, these requiring labelling for the disposal of clinical waste only.

The practice should ensure that all waste bins are labelled to support appropriate waste disposal by staff and patients.

Hand sanitiser was provided for staff and patients throughout the building and signs displayed promoting its use. All respondents to our questionnaire confirmed that healthcare staff washed their hands before and after providing treatment and hand washing facilities were available in all clinical rooms. However, some of the taps required updating to be non-touch operated in line with current IPC standards.

The practice should explore updating any hand operated taps within clinical areas to elbow operated or non-touch models within a reasonable timeframe.

Privacy curtains within clinical areas were observed to be disposable, dated, clean and in good condition. However, some clinical rooms had carpeted floors. These do not allow for effective IPC and there was no evidence to show chemical cleaning was taking place to reduce risk.

The practice should explore arrangements for the replacement of carpets with flooring that enables effective cleaning within a reasonable timeframe.

We saw signs within clinical areas which were not laminated and therefore could not be cleaned.

The practice should ensure that all signs within clinical areas are wipeable to allow for decontamination.

All chairs and couches were wipeable. However, chairs, couches and taps were not included in cleaning schedules. Cleaning schedules also did not specify what cleaning products or procedures should be used for each area of the practice or equipment.

The practice should ensure that cleaning schedules provide sufficient detail regarding how all areas of the practice and equipment should be cleaned.

A suitable range of cleaning materials was available. Locked storage prevented unauthorised access. However, we saw that storage areas were over-filled, impacting on the safety of staff requiring to access cleaning items. There were no signs indicating the presence of substances hazardous to health. Mops were not colour-coded for use in different areas of the practice, required decontamination or replacement in order to be suitable for use, and were inappropriately stored.

The practice should ensure that:

- **Cleaning materials, including mops, are appropriately stored to protect staff safety**

- **Mops are colour-coded for use in different areas of the practice and suitably clean for use**
- **Storage areas containing substances hazardous to health are labelled.**

Blood-borne virus and needlestick policies were in place. However, needlestick flow charts included in the policy and displayed within clinical areas did not signpost staff to the appropriate service for assessment and support should a needlestick injury be sustained. Staff we spoke with were not sure who they should contact if assistance in relation to a needlestick injury was required.

The practice should ensure that the needlestick policy and flow chart displayed in clinical areas both provide clear guidance to staff on actions to take and where to go for assessment and support in the event that they sustain a needlestick injury.

Systems were in place to ensure that relevant staff were offered appropriate vaccinations to maintain and promote their own and patients' health. A register of clinical staff Hepatitis B vaccination and antibody levels was also seen.

Medicines management

Auditable processes were in place for the safe prescribing of medication. Patients could request repeat prescriptions via electronic or manual forms. A trained and experienced prescription clerk was employed to ensure patients received a timely response to repeat prescription requests. Close working with GPs ensured that any requests that required reauthorisation or whose timing may indicate over-use were escalated for medical review. All prescribing activity was documented within patient records.

However, we identified that signs informing patients that they could collect prescriptions after 48 hours required rewording to ensure patients understood that only the prescription, and not the medications, would be ready within this timescale. The practice prescribing policy was also out-of-date and the clinical governance arrangements for non-medical prescribers working from the practice for set sessions each week also needed formalising with the health board.

The practice should ensure:

- **signs clearly inform patients that expected timescales for prescription preparation relate to the paper prescription only and not the medication**
- **the prescribing policy is up-to-date and scheduled for review at regular intervals**
- **non-medical prescribers working from the practice have formal clinical supervision and audit arrangements in place for assurance that patient assessments and medication prescriptions are completed in line with the latest clinical guidance.**

The practice had moved to electronic prescribing within the last 12 months. This had significantly reduced the use of manual prescriptions, but these were still required for GPs to prescribe medication during home visits or in relation to specific medications used to treat opioid misuse. We saw a Standard Operating Procedure for the handling of paper prescriptions. However, our review of the practice prescription audit indicated that that prescription pads and reams were logged in and out of the practice premises but not when distributed throughout the practice. Furthermore, clinical staff we spoke with were not all fully aware of the processes for the secure storage and tracking of prescriptions.

The practice should ensure that the Standard Operating Procedure for the handling of paper prescriptions:

- **comprehensively defines the need and local mechanisms for secure storage and tracking of all types of prescription**
- **is shared with all relevant members of staff for implementation**
- **is appropriately audited.**

We reviewed the equipment and drugs used to manage medical emergencies. A schedule was in place to indicate what equipment and drugs should be available and all items were present, in date and suitable for use. Records were kept documenting the completion of weekly checks of all emergency items and their expiry dates. Clinical staff were aware of how to use the defibrillator and oxygen available and had undertaken suitable training to support this.

We saw signage indicating the location of the defibrillator and other emergency equipment and drugs. However, signs were not placed on the door of the room where these items were stored.

The practice should ensure there is a sign on the door of the room where the defibrillator and other emergency equipment and drugs are stored.

Clinical staff were responsible for checking the non-emergency equipment and drugs kept within their designated room and home visit bag. All drugs we saw within the practice were clearly marked with expiry dates. No drugs had expired. Single use equipment was procured so that items would be sterile and suitable. However, we found some out of date dressings and suture cutters and one out of date vaginal pessary. This was escalated to the practice for items to be taken out of clinical areas on the day of the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

We were told that drugs kept at the practice were reordered in advance of expiry dates so that a replacement supply was available and ready to be used when

required. However, there was no formal process implemented for staff to check and record the suitability of equipment.

The practice should implement a process for the checking and reordering of both drugs and equipment to ensure suitable stock and enable timely replacement.

We were told that no controlled drugs were kept on the premises. However, we found no formal log of medications accepted to the practice, administered or disposed of so there was no means of readily identifying what was available or if any items of stock went missing. Keeping an inventory and log would ensure security and also assist in the monitoring and ordering of drug supplies.

The practice should implement an inventory and logging system to provide an audit trail of drugs taking into the practice, stored, administered and disposed of.

Procedures were in place for the acceptance of non-emergency drugs used by the practice to ensure that any vaccinations or other drugs requiring to be stored at a low temperature were immediately refrigerated in dedicated, locked, fridges. Data loggers and fridge thermometers were used to confirm fridge temperatures were within range. Twice daily checks were fully documented and fridges were also calibrated annually and regularly cleaned.

We saw evidence that the cold chain policy and cold chain disruption flow chart in place had been followed appropriately following a cold chain breach in 2024. This incident had also been reported as required.

Room thermometers were in place within clinical rooms where medications which did not require refrigeration were stored and temperatures were suitably monitored and recorded.

We found the arrangements for the disposal of drugs within the practice to be suitable. The practice also had suitable procedures for raising any concerns around oxygen use or drugs, including reporting adverse drug reactions via the yellow card scheme.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice and found that a safeguarding lead was in place and staff had undertaken relevant training. However, although staff expressed an awareness that safeguarding concerns would require escalating to support patient safety, we found a lack of clarity regarding relevant contacts and pathways. We also found that safeguarding lead activity

tended to focus on children, with no clear mechanism for identifying adults at risk, sharing relevant information regarding adults at risk with other members of the multidisciplinary team or learning from safeguarding incidents.

The practice must comprehensively review their safeguarding arrangements in line with national standards, including Royal College of GP Safeguarding Standards (2024).

We were informed that Looked After Children (LAC), children at risk, and children on the child protection register would have appropriate digital flags attached to their patient record. However, we found less certainty that digital flags would also be attached to relevant family contacts.

The practice should ensure that digital flags are used to highlight relevant family contacts of LAC, children and adults at risk, and children on the child protection register.

Management of medical devices and equipment
We found that medical devices at the practice were clean and had been calibrated within the last 12 months. Systems were in place to ensure faulty or broken devices would be repaired or replaced as quickly as possible. However, as no formal, recorded, device checks aside from annual calibration were completed device faults or failure could go unnoticed delaying corrective action.

The practice should implement regular, recorded, checks of all medical devices to ensure they remain fit for purpose or can be repaired or replaced at the earliest opportunity.

We observed that liquid nitrogen kept within the practice for cryotherapy was stored inappropriately. There was also no risk assessment, policy or signage in place to ensure staff and patients were aware of liquid nitrogen as a hazard or specify precautions to be taken around this resource.

The practice should ensure that:

- **A risk assessment regarding the storage, use and handling of liquid nitrogen is completed**
- **A policy is in place to guide staff on the safe use, handling and storage of liquid nitrogen**
- **Liquid nitrogen is appropriately stored and its presence indicated through signage.**

Effective

Effective care

Information sharing supported the safe and effective care of patients.

We saw evidence that the practice received and processed clinical information from other healthcare services in a timely and auditable way. Incoming mail was distributed to the relevant clinicians who would then ensure patients were offered follow-up assessments and appropriate opportunity to discuss test results.

Clinicians took responsibility for completing and documenting agreed referrals to other services within appropriate timescales and ensuring effective communication with patients once test results or other clinical information was received. Support was available to ensure processes were also followed by any locums working at the practice.

The practice told us that audits of referral rates had been undertaken but that as standalone information this did not confirm effective practice. Nursing staff maintained a register of all patients taking Disease-Modifying Antirheumatic Drugs to ensure that the blood monitoring these patients required was kept up to date.

Best practice and national and professional guidance received by clinicians would be shared with other relevant members of the team via practice meetings, meeting minutes and messaging systems as appropriate.

Regular meetings with attached teams, such as health visitors and palliative care professionals supported continuity of care and opportunity for multidisciplinary team reviews when a patient had passed away.

Patient records

We examined a sample of ten electronic patient records which were kept within the secure IT system.

Records and note summaries were considered to be of good quality. Clinical records indicated the name of the clinician, place and date of consultation and that person-centred assessments, examinations, investigations, treatments, referrals and reviews were offered and provided with consent. All records reviewed had up to date problem lists and appropriately detailed repeat medication and allergy information where required. Administrative staff who completed notes summarising and READ coding had undertaken suitable training.

We saw that effective systems were also in place to protect patient information. Electronic and paper records were suitably protected from unauthorised access.

Efficient

Efficient

We found that opportunities for patients to self-refer to services such as physiotherapy, podiatry, contraception advice and smoking cessation were promoted by the practice. This enabled the practice to provide relevant information without creating further administrative responsibilities.

Provision of near patient testing and a proactive approach to reviewing patients with chronic conditions also enabled symptom management and timely community-based treatment to prevent escalation to secondary care services.

Quality of Management and Leadership

Staff feedback

Due to the low number of staff responses, it is not possible to include findings in full. However, all respondents to the HIW staff questionnaire told us that they were satisfied with the quality of care and support given to patients, that patient care was the practice's top priority, and that they would recommend the practice as a good place to work. All indicated that they felt able to influence decisions and make suggestions within the practice and that there was a learning culture whereby staff were encouraged to report incidents or near misses to enable improvements to be made. However, the majority of staff indicated that they had not had an appraisal within the last 12 months.

Staff comments included:

> *"I feel this practice puts patients as top priority. Trying whenever possible to meet their demands."*

Leadership

Governance and leadership
Processes were in place to support the governance and accountability of sustainable, safe and effective care.

The practice manager and partners provided visible leadership. Practice leaders informed us they aimed to enable continuity of care for patients accessing the practice and wider health services and manage demand and capacity. We were told that the practice frequently ran close to capacity which didn't feel unsafe but made assigning time to non-clinical activity difficult. In addition, we were told there was no formal provision for time for staff training which presented a barrier to meeting mandatory and individual development needs. The practice had identified the need for the practice to designate clinical leads for specific areas of practice and this was beginning to be actioned through relevant meeting discussions.

Staff were clear about their roles and lines of reporting and told us they felt able to approach the management team with any issues or concerns. Staff were also aware of how to access occupational health advice. Hot desking was discussed as a strength to enable administrative team members to move between responsibilities for varied and motivating work. However, we also identified this as a barrier to staff accessing bespoke seating or other personal workplace equipment.

The practice should ensure that personal workplace needs are identified and reasonable adjustments identified implemented.

Staff could access relevant policies and procedures. However, some required updating. We also found that fully documented version control was not in place and that many policies did not name the practice they related to.

The practice should ensure that policies are appropriately updated and that each new version:

- **Is clearly linked to the practice**
- **Identifies the name of policy on each page**
- **Has a specified owner, date of creation, review schedule and update history.**

We discussed implementing a matrix or other systematic approach to tracking policy and procedure updates, staff training and professional obligations.

We were told that clinical updates would be provided informally to ensure timely information sharing. We also saw a schedule of practice meetings where different topics would be discussed with relevant personnel. Minutes were taken and circulated to relevant staff. However, we found meeting minutes did not specify the type of meeting being reported or attendees; timescales for actions were also not consistently provided, and the use of abbreviations made discussion points difficult to understand.

The practice should ensure that meeting minutes fully capture discussions to provide clear information that relevant staff can refer back to as required.

As a training practice, medical students would undertake clinical audit activity and share findings with relevant members of the practice team. The practice also reported on performance and activity via all required mechanisms and engaged with the cluster to implement agreed changes and make recommendations for future projects.

Workforce

Skilled and enabled workforce

We observed good working relationships at the practice and discussions indicated a well-supported team who aimed to deliver patient centred care. Staff told us they were able to work within their scope of practice, felt there was a good skill mix within the team, and were confident to seek advice if they needed. Trainee doctors had access to a room to complete their academic studies and exams within the familiar and supportive practice environment.

A comprehensive recruitment policy and pre-employment checklist were in place and evidence seen within staff files indicated these had been fully implemented within the recruitment of the most recently appointed staff. We discussed continuing this robust implementation in future rounds of recruitment. Generic and role-specific induction programmes were in place for new staff. However, some job descriptions found in staff files needed checking for accuracy as they had been in place for over 10 years.

The practice should ensure that all staff have up-to-date job descriptions.

GPs underwent an annual appraisal with an external peer through which continuous professional development, professional obligations and good character were confirmed. We saw that regular Disclosure and Barring Service checks were completed for other staff. Confidentiality agreements were also in place within personnel files.

Culture

People engagement, feedback and learning

We reviewed the complaints policy and mechanisms for collecting patient feedback. A feedback box was available within the waiting area. However, this was hidden by free-standing banners promoting other primary care services. Many respondents to our patient questionnaire were also unaware of how to raise a complaint about the practice and there was also no 'You said We did' board to reassure patients that their feedback and concerns were listened to and acted on.

The practice should ensure that all mechanisms for providing feedback to the practice are visibly promoted and that information is displayed regarding actions taken in response to feedback, concerns and complaints received.

A lead for investigation complaints and a lead for learning from complaints were in place to ensure complaints were followed up correctly and outcomes communicated with relevant members of staff. However, we saw that documentation of the processes and timescales for complaints investigation, communication with complainants, resolution and learning was minimal.

The practice should ensure that comprehensive records in relation to complaints are maintained so that who has completed each stage, how, and the timescale of completion are clear, auditable, and can be used for broader practice learning regarding complaints and complaints handling.

A duty of candour policy and process were in place but implementation had not been required by the time of inspection. We were told that in general the annual

patient survey captured a high level of patient satisfaction with the practice and that staff appreciation letters were also received and kept as positive feedback for the team.

A whistleblowing policy was in place for staff should this be needed. We observed all working at the practice striving to foster a positive working environment and found that there was a strong history of staff maintaining employment at the practice for many years.

Information

Information governance and digital technology
Work and information flow diagrams had been developed and were accessible to staff on induction and subsequently within their day-to-day work. Staff we spoke with were clear on processes for handling all types of data and felt they had access to suitable digital technologies to undertake their work. A suitable, external, Data Protection Officer was in place. However, the practice information governance policy required review as this had been scheduled for 2025 but not completed.

The practice should ensure the information governance policy is reviewed. Future reviews should be completed as scheduled.

Learning, improvement and research

Quality improvement activities
We were told that in general the practice would participate in three Quality Improvement (QI) projects each year as part of health board and cluster activity. QI activity and practice learning from pieces of work were also identified as areas for further development within practice self-assessment. However, we noted there were questions raised by the practice regarding how effective some projects were as data was reported but no particular outcomes shared after the project end, and how relevant projects were as the demographic of the practice patient population was different from other cluster practices.

Whole-systems approach

Partnership working and development
Staff told us that partnership working within the practice was strong, and that externally the practice also particularly engaged with other local practices within the cluster. Practice management held monthly virtual meetings and kept in touch to seek advice or share suggestions in between.

The practice was positive about supporting trainee doctors to contribute to the development of the overall primary care workforce.

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
Out of date dressings and suture cutters and one out of date vaginal pessary found.	Using expired equipment presents risk to patients such as healthcare acquired infection or harm through equipment failure.	Raised this with relevant clinical staff.	Equipment removed from clinical area for replacement with in-date items.

Appendix B - Immediate improvement plan

Service: Fairwater Health Centre

Date of inspection: 22 January 2026

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.	No immediate assurances were found on this inspection.					

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: Fairwater Health Centre

Date of inspection: 22 January 2026

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.	Some QR codes and website links to health surveillance and support services not working correctly.	Health promotion information made available to patients to be kept up to date.	Health and Care Standards (2023) - Effective	• Review QR codes • Cover or update QR codes • Update website links	Alistair Brook	30.06.26
2.	Clinical capacity for chronic disease management potentially too low to effectively implement clinical guidelines.	Clinical time for chronic disease management to continue to be increased to ensure that clinical guidelines can be implemented.	Health and Care Standards (2023) - Safe	• Increase Practice Nurse input on Chronic Disease management: Diabetes, Asthma, Kidney and vascular disease	Dr Nick Travaglia	30.06.26

				• Increase number of GP sessions to increase clinical capacity.		
3.	Options for self-check-in or the use of a separate room for confidential conversations with reception staff need better promoting.	• Self-check-in and the offer of a separate room for confidential discussions with reception staff to be better promoted • Self-check-in screen to be suitably positioned for patients with a range of needs.	Health and Care Standards (2023) – Person-centred	• Notice offering confidential discussion moved to above check in screen. • Lower centre point of touch screen by 150mm to comply with part M building regulations (1150mm above floor).	Alistair Brook	30.06.26
4.	Some patients told us that the offer of a chaperone had not been discussed with them prior to an intimate examination or procedure.	The chaperone service to be actively offered, implemented in line with patient consent and documented in relation to every intimate examination and procedure.	Health and Care Standards (2023) - Safe	• Change in clinician practice to ensure that chaperone is offered to all patients before intimate exam. • Circulate updated SOP.	Dr Shon Phillips	30.06.26

5.	Reception staff would benefit from additional training to support their communication and care navigation roles.	Relevant training to be completed to ensure all staff are equipped for their roles.	Health and Care Standards (2023) - Effective	Online training courses on learning@wales website at the next available protected learning session: Understanding Autism, Introduction to the Mental Health (Wales) Measure.	Alistair Brook	30.06.26
6.	Practice Manager the only phone system superuser able to access recordings for training and quality monitoring.	Allocation of a second phone system superuser to deputise with respect to training and quality monitoring of phone calls in the absence of the practice manager.	Health and Care Standards (2023) - Efficient	Office Manager permissions to be updated to superuser and training provided.	Alistair Brook	31.05.26
7.	Limited promotion of the Welsh language Active Offer.	Mechanisms such as 'Iaith Gwaith' signage or a 'Who's who' board to be implemented to promote the Active Offer to patients and raise awareness of clinical staff able to provide consultations in Welsh.	Health and Care Standards (2023) - Person-centred	• Information on Welsh speaking staff to be included in slide deck to be displayed on waiting room TV screen (to be purchased). • Change in staff practice: ask if the patient	Dr Cathryn Thomas	30.06.26

				would wish to consult in Welsh and record language preference in patient records.		
8.	Patient language preference not proactively sought or confirmed.	Proactive and routine confirmation and recording of language preference to be implemented.	Health and Care Standards (2023) - Person-centred	• Language preference already included in new patient questionnaire. • Language preference of existing patients: staff to check language preference at appropriate opportunities and ensure language preference is recorded when an interpreter is asked for.	Alistair Brook/ Emma Enticott	30.06.26

9.	Clutter seen in staff areas presenting fire and trip hazards and obstruction to emergency equipment.	Premises to be kept free of clutter.	Health and Care Standards (2023) - Safe	• Contracted cleaners have been asked to store cardboard boxes waiting to be collected to be stored in an appropriate cupboard. • Location of emergency trolley has been moved within reception for easier access.	Alistair Brook	Done
10.	Signage indicating the locations of emergency equipment and drugs insufficient.	• Signs to be placed on doors of rooms where emergency drugs, equipment medical gases are kept • Medical gases to be indicated on the practice floor plan.	Health and Care Standards (2023) - Safe	• AED location sign has been added to reception door. • Medial gases to be added to Practice floor plan. • Oxygen cylinder sign to be added to reception door.	Alistair Brook	30.06.26

11.	At least one incident which could be considered a significant event not identified or dealt with as such.	A clear definition and process to be in place to ensure easy identification of significant events and triggering of the formal pathway for reporting, reflective discussion and action planning when appropriate.	Health and Care Standards (2023) - Safe	• Update significant event SOP & ensure Practice Staff have read it. • Datix training from CAV Health Board and share with staff. • Include details of were and how to access Datix in the significant event SOP.	Alistair Brook	30.06.26
12.	Some issues with waste management.	• Bins to be clearly marked to indicate the type of waste they are for • Clinical waste awaiting collection for disposal to be completely segregated from clean items.	Health and Care Standards (2023) - Safe	• Appropriate labels added to bins. • Clean items stored in a separate room to clinical waste.	Helen Sinsbury	Done

13.	Barriers to effective cleaning identified.	• Updates to clinical rooms required to ensure effective IPC • Cleaning schedules to provide sufficient detail to support the effective cleaning of all practice areas and equipment • Cleaning equipment and materials to be stored appropriately • Mops to be colour-coded for use in different areas of the practice and in a suitable condition for effective cleaning • Areas where substances hazardous to health are stored to be clearly labelled.	Health and Care Standards (2023) - Safe	• Replacement of carpets and taps included in estates development plan. • Cleaning schedule to be updated. • COSHH risk assessments to be up updated to include any new substances introduced. • Discuss COSHH and storage of cleaning items with contract cleaners. • Discuss mops & mop buckets (yellow for clinical areas) with contract cleaners and who is	Helen Sinsbury/ Alistair Brook	30.06.26

				responsible for providing them.		
14.	Needlestick policy and flow chart did not provide clear information regarding where staff should seek assistance in the event of a needlestick injury.	Needlestick policy and flow chart displayed in clinical areas to provide clear guidance to staff on where to go for assistance in the event that they sustain a needlestick injury.	Health and Care Standards (2023) - Safe	Flow chart with contact details on where to seek assistance in place at time of inspection.	Alistair Brook	Done
15.	Some procedures related to the issuing of prescriptions required updating.	• Signs informing patients of prescription collection timescale require rewording for clarity • Clear, formalised, clinical governance arrangements to be put in place for any non-medical prescribers working from the practice to ensure appropriate supervision and audit of work	Health and Care Standards (2023) - Effective / Safe	• Update prescription collection sign to include electronic prescribing and paper prescription collection (waiting room & website). • SOP for non medical prescribers. • Continue with audits of paper prescriptions.	Alistair Brook	30.04.26

		• Standard Operating Procedure for the handling of paper prescriptions to be fully implemented.				
16.	Policies required updating, including: • Prescribing policy • Access policy • Information Governance policy • Consent policy.	• All policies to be confirmed as up to date and scheduled for review at appropriate intervals • Access policy to be accurate • Consent policy to be applicable to all patient groups • Future reviews to be completed as planned • All policies to be clearly linked to the practice, identify the name of policy on each page, have a specified owner, date of creation, review schedule and update history.	Health and Care Standards (2023) - Safe / Person-centred / Effective	• Update listed policies. • Include promotion of LPAs for all patients with mental capacity issues in consent policy. • Add version control to all policies/SOPs • Continue with schedule of review	Alistair Brook	30.06.26

17.	No formal processes in place to ensure clinical equipment and medical devices remained fit for purpose.	Processes to be implemented to ensure: • Expiry dates of clinical equipment are regularly checked to enable proactive reordering • Regular, recorded, checks of all medical devices are undertaken to ensure any issues can be rectified via timely repair or replacement.	Health and Care Standards (2023) - Safe	Produce register of clinical equipment including expiry dated and monthly checking schedule	Helen Sinsbury	30.06.26
18.	No formal log kept of drugs received into the practice, stored, administered or disposed of.	An inventory and logging system to be implemented to provide an audit trail of drugs taken into the practice, administered and disposed of.	Health and Care Quality Standard (2023) - Efficient	Produce register of medication and schedule of checks for expired stock/re-ordering. Include section for administering or disposal of medication.	Helen Sinsbury	30.06.26
19.	Lack of clarity regarding safeguarding procedures.	Safeguarding arrangements to be comprehensively reviewed national	Health and Care Standards (2023) - Safe	• Safeguarding concerns reporting flowchart for	Dr Kerry Pearce	30.06.26

		standards, including Royal College of GP Safeguarding Standards (2024).		children and adults. • Promote use of the safeguarding Wales app.		
20.	Practitioners not aware of whether digital flags were used to highlight relevant family contacts of LAC, children and adults at risk, and children on the child protection register.	Clear procedures regarding the use of digital flags to highlight relevant individuals and family members within the patient record system to be created and shared with staff for implementation.	Health and Care Standards (2023) - Safe	• SOP or section within existing child protection policies detailing which SNOMED codes to be added to notes of children and families and when. • Process for reviewing and ending codes when patient is no longer a child or on the child protection register.	Dr Kerry Pearce	30.06.26
21.	Liquid nitrogen stored inappropriately. There was also no risk assessment, policy or signage in place to raise awareness of liquid nitrogen as a	• Liquid nitrogen to be appropriately stored and its presence indicated through signage	Health and Care Standards (2023) - Safe	Practice is investigating cryotherapy alternatives (sealed cartridges) that do not require the storage to liquid nitrogen in a	Dr Nick Travaglia	30.04.26

	hazard or specify precautions to be taken.	• A risk assessment regarding the storage, use and handling of liquid nitrogen to be completed • A policy to guide staff on the safe use, handling and storage of liquid nitrogen to be in place.		dewar. Any chosen alternative will have appropriate risk assessments, COSHH and polices in place.		
22.	Barriers identified to some staff accessing suitable equipment to support them in the workplace.	All staff needs to be considered and any reasonable adjustments identified implemented.	Health and Care Standards (2023) - Safe	• DSE assessments for all workstations/staff. • Reasonable adjustments are currently met when requested by staff.	Alistair Brook	30.06.26
23.	Meeting minutes difficult to understand.	Meeting minutes to provide clear evidence of discussions and information that relevant staff can refer back to as required.	Health and Care Standards (2023) - Safe / Effective	• Attendance list added to meeting minutes. • Details of type of meeting added to meeting header. • Timescales for actions, where	Alistair Brook	Done

				relevant, to be added to meeting notes. • Add more detail to discussion points.		
24.	Some staff job descriptions more than 10 years old.	All staff to have up-to-date job descriptions to ensure these accurately reflect assigned roles and responsibilities.	Health and Care Standards (2023) - Safe / Efficient	Review staff job descriptions to ensure they are up to date.	Alistair Brook	30.06.26
25.	Feedback mechanisms not all effectively displayed and no information provided to patients regarding actions taken in response to feedback, comments and complaints received.	Feedback mechanisms and information regarding actions taken in response to feedback, concerns and complaints to be readily available to patients.	Health and Care Standards (2023) - Person-centred / Effective	Information on how to provide feedback and 'you said, we did' be included in slide deck displayed on waiting room TV screen (to be purchased).	Alistair Brook	30.06.26
26.	Records of complaints investigations and responses lacked detail.	Comprehensive records in relation to complaints to be maintained to ensure the processes followed are clear and records can be used for broader practice learning regarding complaints and complaints handling.	Health and Care Standards (2023) - Effective	Complaints log created and implemented to cover all points raised.	Alistair Brook	Done

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): Alistair Brook

Job role: Practice Manager

Date: 26.03.26