Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Cowbridge and Vale Medical Practice, Cardiff and Vale Health Board

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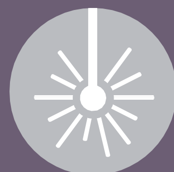

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

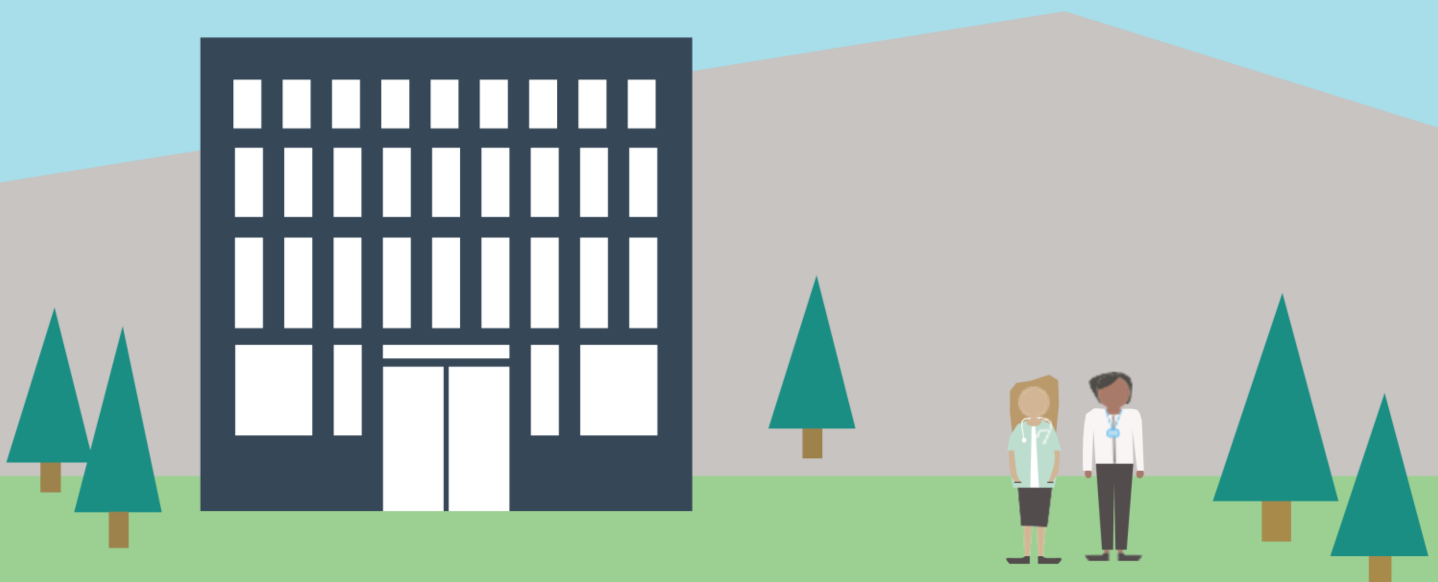
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 Cowbridge and Vale Medical Practice, Cardiff and Vale University Health Board on 17 February 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, two clinical peer reviewers, and one 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 five questionnaires were completed by patients or their carers and eight were completed by staff.

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:
The practice demonstrated a strong commitment to person-centred care, notably through the implementation of digital health promotion initiatives and flexible access arrangements. A diverse range of self-referral services was readily available via the practice website, and seasonal vaccination programmes were actively promoted through multiple channels, including the website, written invitations, and facility posters. However, engagement opportunities for patients without digital access were limited, as health information provision in the waiting area was insufficient.

Patient dignity was respected in consultation rooms, with chaperone information displayed both within each room and in the waiting area. Despite this, documentation of chaperone presence was absent from clinical notes. The appointment system enabled timely access to care, with feedback indicating appointments were generally accessible. Vulnerable individuals and those lacking digital access received appropriate support through tailored appointment scheduling and triage processes. Nonetheless, information regarding supplementary onsite clinical services was limited.

There was minimal evidence of Welsh language use, with only a few information leaflets and website content available in Welsh. It is recommended that the Welsh Government's 'Active Offer' be promoted to enhance accessibility for Welsh-speaking patients.

Regarding equity and inclusion, the practice provided step-free access and excellent parking facilities. The presence of the Public Health Wales Breast Test Wales screening vehicle on site was observed.

This is what we recommend the service can improve:

- Strengthen policies and procedures by updating access and care navigation policies, clarifying delegation in workflow policy, and developing a Patient Consent Policy.
- Document chaperone presence within clinical notes.
- Promote the Active Offer to enable staff to converse in Welsh with patients.

This is what the service did well:

- Provided a wide range of self-referral and support services accessible through a comprehensive digital self-help hub

- Delivered well-organised seasonal vaccination campaigns, using varied communication methods to reach patients with and without digital access.
- Provided a hearing loop in all areas.

Delivery of Safe and Effective Care

Overall summary:

We reviewed ten electronic patient records, which were stored securely and password protected from unauthorised access. Overall, the records were clear and written to a satisfactory standard. Records were contemporaneous and information was easy to understand for other clinicians reviewing the records. Where chronic disease was recorded, these records contained a full summary of conditions, including all past and continuing problems, as well as the medication being taken. We found the continuity of care to overall be good.

Processes were in place to ensure the safe and effective prescribing of medication, and the process for requesting repeat medication was clear. We found notable examples of safe monitoring of medication and chronic illness management, and clear narrative with evidence of patient centred decision making.

Overall, the IPC arrangements were satisfactory but lacked attention to detail. Some arrangements required strengthening, and others needed restructuring to ensure the practice consistently upheld the required IPC standards to maintain the safety of staff and patients.

We found that safeguarding measures were not robust. Staff were not aware of an existing policy or the referral system required to ensure the safety of individuals who required safeguarding.

We found two fridges within the clinical treatment room to be unlocked, with the keys left in the locks. We found that temperature checks were being carried out appropriately. However, we noted that the data loggers were only being reviewed once a week. We requested that this process be reviewed to ensure any breach of the cold chain could be identified sooner.

Some clinical items had been stored beyond their expiry date, for example, blood bottles. We requested that these items be removed and disposed of immediately during our inspection.

A separate area was available in the waiting room where patients were able to use the blood pressure machine. Patients could hand in their results, which would then be recorded in their patient record. This is an area of noteworthy practice, as patients can access it at any time the surgery is open. Unfortunately, this area and the machine were found to be soiled.

We were not assured about the practice's oversight of the Hepatitis B immunity status of clinical staff. A record was not in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity response.

We found that there was a well-equipped trolley available for use in the event of a cardiac arrest or medical emergency. Unfortunately, this was housed within a clinical treatment/minor operations room, which was regularly occupied by staff and patients. We were not assured that the trolley could be accessed without compromising dignity and respect and we therefore requested that it be moved to an accessible location for all staff.

We identified a lack of robust systems for managing complaints and incidents. Although we were informed that the practice used a Datix system and kept a separate folder of incidents, we were not able to access these during the inspection. However, we saw written evidence of two incidents that had occurred in recent weeks, one of which was a serious untoward incident. We were not assured that this had been investigated to the level required or escalated through the appropriate channels to ensure such an incident did not recur.

The practice should ensure that a structured approach towards audits are implemented.

Immediate assurances:
We identified several areas which needed to be addressed through our immediate assurance process: The issues included:

- Soiled blood pressure machine in a shared area between two practices
- Aspects of safeguarding training and clinical management
- Storage of vaccines and medications in clinical fridges, was not robust, which could pose an immediate patient safety risk
- Poor records to evidence that clinical staff had received their Hepatitis B vaccinations and immunity status recorded
- Storage of emergency equipment
- Complaints and investigation processes must be implemented.

This is what we recommend the service can improve:

- Aspects of IPC arrangements need strengthening to maintain the safety of staff and patients
- Introducing an annual audit programme

This is what the service did well:

- A separate area was available in the waiting area where patients were able to use the blood pressure machine
- Good process in place to ensure the safe prescribing of medication and chronic illness management.

Quality of Management and Leadership

Overall summary:
Staff were clear about their roles and responsibilities and the importance of working within their scope of practice.

We were told clinical meetings, such as their multidisciplinary team meetings were formally recorded and we saw evidence of such meetings for a 3-month period.

We reviewed a standard selection of policies and procedures. There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice. Some a staff were not aware of the availability of the policies or where they could be sourced.

There was an appropriate structure in place for documentation on recruitment policies and procedures. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. However, during our inspection we saw no evidence of such checks being undertaken on all staff.

Management did not have robust oversight of training requirements nor its compliance. As a result, we were not assured that staff maintain skills and knowledge in a range of key training subjects. Staff files were made available to us during the inspection and there was a significant gap in essential training for some staff.

We saw no evidence displayed in the waiting area indicating the way a patient can submit feedback. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.

Immediate assurances:

- Disclosure and Barring Service (DBS) checks were not conducted at the appropriate level for all staff members.
- A training matrix or system to identify inadequate compliance with training across all staff groups was not in place.

This is what we recommend the service can improve:

- Establish a comprehensive document control system to manage policies and procedures effectively.
- Ensure patient feedback is systematically collected and thoroughly evaluated to support ongoing service improvement initiatives.

This is what the service did well:

- Whilst limited patient feedback was received, patients provided positive feedback about their experiences in a range of areas.

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

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care and services provided at Cowbridge and Vale Medical Practice prior to the inspection that took place in February 2026. In total, we received five responses. Responses were overall positive, with all respondents who answered rating the service as ‘very good’ or ‘good’. Due to the low number of responses, it is not possible to provide comprehensive feedback.

Person-centred

Health promotion

The practice had a wide range of written health promotion information available for patients. The information was not displayed in the patient waiting areas but on the way into the consultation rooms. Information was also promoted through the practice website. We saw health promotion information on a variety of topics including mental health services, vaccinations and carers information.

We were told the practice engaged with several agencies to improve access to various healthcare professionals. These included access to physiotherapists, specialist diabetic nurses and a number of Public Health Wales screening clinics.

All patients agreed that their GP explained things well to them and answered their questions. In addition, all respondents felt they were listened to, and they were involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care

We found patients were treated with dignity and respect throughout their GP journey. All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Clinical rooms provided patients with privacy with doors kept closed during consultations and all but one of the treatment rooms had privacy curtains. However, we found that the privacy screens were not disposable and were soiled.

The practice must ensure that privacy curtains are installed which are either disposable or are labelled and monitored when cleaned.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass, which offered some level of privacy from the waiting area.

The practice offered chaperones in all appropriate circumstances, and there was a chaperone policy in place. The policy states that the practice should document when a chaperone is offered and who is present and if a chaperone was offered. We saw inconsistent evidence of this being recorded in the medical records. A chaperone information notice was displayed in the waiting area and within all clinical treatment rooms, indicating that this service was available.

The practice must ensure patients are offered a chaperone where appropriate and that it is documented in the clinical records.

Timely

Timely care

There were processes in place to ensure patients could access care and with the most appropriate person in a timely manner.
Non-urgent appointments may also be scheduled via the website form. This process facilitates efficient access, eliminating the wait associated with telephone calls.

We were told a large number of home visits are common due to the demographic age of the area.

A number of same-day appointments are provided by the practice for those with urgent clinical needs. These patients are triaged by a general practitioner to help ensure that the patient receives the most appropriate appointment format.

There were processes in place to support patients in mental health crisis. Where appropriate, patients are referred to the local community mental health team (CMHT) or child and adolescent mental health service (CAMHS). Alternative support and signposting were also available for patients needing mental health support.

Equitable

Communication and language

It was observed that staff communicated clearly and utilised language tailored to patient requirements. Furthermore, information was provided in a manner that enabled patients to make informed choices regarding their care. The surgery was

equipped with a hearing loop to support individuals experiencing hearing difficulties.

Patients were commonly notified about the services available at the practice via the website and during scheduled appointments. For those without digital access, information was communicated through mailed letters and telephone calls.

It was noted that certain staff members at the practice are able to communicate in Welsh. While some posters were provided in Welsh, the practice information was available exclusively in English. The practice should review how it continues to meet its duties towards the Welsh Language Standards for primary care providers.

The practice should ensure that the Active Offer of Welsh is promoted to patients.

Rights and equality

The practice provided convenient access for patients. Patient areas, including treatment rooms, as well as an accessible toilet, were situated on the ground floor and shared with the adjacent practice. Additionally, this area was equipped with an emergency call bell, which functioned effectively when activated during our inspection.

We saw evidence of an equality and diversity policy in place; however, it was unclear whether all staff had completed equality and diversity training.
All patients responding to our questionnaire thought the building was easily accessible and said they had not faced discrimination when accessing or using this service.

Delivery of Safe and Effective Care

Safe

Risk management

The practice was clean and tidy, free of clutter, recently decorated and in a good state of repair. There were processes in place to protect the health, safety and wellbeing of all who used the practice services.

We were unable to review the business continuity plan (BCP) in its entirety; however, we saw adequate cover in business partnership risk and pandemic risk. The practice also demonstrated cluster collaboration to ensure patient care could continue in the event of an extreme situation.

It was reported that patient safety alerts are distributed to staff electronically and discussed during meetings. However, the documentation provided did not demonstrate evidence of these practices.

We discussed the action taken when patient home visits are requested and found staff triaged and risk assessed all home visits before attending.

We found expired single use equipment (urine sample bottles and blood bottles) in one treatment room. These were removed and discarded appropriately on the day of inspection.

The practice must:

- **Distribute patient safety alerts to all staff members and ensure each alert is acknowledged accordingly.**
- **Ensure staff are reminded to dispose of used equipment without delay and conduct comprehensive spot checks in all rooms to verify that expired single-use equipment is promptly removed.**

Infection, prevention and control (IPC) and decontamination

Overall, the IPC arrangements in place did not meet expected standards. Some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

There was an IPC policy in place which was specific to the practice as well as specific local policies for the management of blood borne viruses, cold chain management and sharps management.

A needlestick injury policy was in place however we found that needlestick injury advice posters were not on display in any of the clinical treatment rooms, to support staff in the event of such injury.

We were told that the practice employs external contractors to provide the cleaning. On the day of the inspection there were no cleaning schedules available. However, we found all public and clinical areas to be visibly clean and tidy. Patient toilets although clean, required new toilet brushes due to being worn and soiled.

The practice must ensure:

- **Needlestick advice posters are on display in all clinical areas**
- **Weekly cleaning schedules are implemented**
- **Patient and staff toilets have suitable cleaning equipment**

We saw no evidence that an annual IPC or any associated audits had been completed. We recommend that an annual IPC audit is completed, with consideration given to completion of associated audits, including hand hygiene and aseptic non-touch techniques.

The practice must ensure that IPC audits are completed, at the minimum this must include an annual audit.

There was no training matrix for monitoring staff training, with all documentation held in individual staff folders. We found that not all staff had completed IPC training relevant to their roles. **This was addressed under our immediate assurance process at Appendix B.**

A separate area was available in the waiting area where patients were able to use the blood pressure machine. Patients were able to hand in their results which would be recorded in their patient record. This is an area of noteworthy practice, since patients can access this anytime the surgery is open. However, the current portable machine poses as an IPC risk as the sleeve was visibly dirty, stained and not disposable. We also suggested placing antibacterial wipes and hand gel in the area.

The practice should ensure that all equipment in the blood pressure area is included in the practice cleaning schedules.

During our inspection we were not assured about the practice's oversight for the Hepatitis B immunity status of clinical staff. A record was not in place to evidence that clinical staff had received their Hepatitis B vaccinations and immunity response. **This was addressed under our immediate assurance process at Appendix B.**

There was a process in place for the management and disposal of all waste, and a policy was in place to support this. The waste was observed to be in a secure compound which was accessible over a wall. The large clinical waste bin was overflowing and was not able to be locked for security. It appeared that other teams were using the same bin and not their own.

The practice must ensure that clinical teams not associated with the practice use their own clinical waste bins as allocated and that the container is secured.

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. However not all patients were aware of the notification process.

Medicines management
Processes have been established to ensure medication is prescribed safely. The procedure for patients to request repeat prescriptions is clearly defined. Staff indicated that most patients submit prescription requests either directly through the practice or via online platforms. Suitably trained clerks process prescriptions, with pharmacy technicians authorising any reauthorisations.

Local pharmacies typically collect prescriptions, though they may also be collected at the reception desk. A log is maintained to ensure a clear audit trail for all collected prescriptions.

The practice had established policies for prescribing and medicine management; nevertheless, our review of staff training documentation indicated that no medicine management training had been completed. Additionally, while there was evidence of a log being maintained for the prescription boxes, such documentation was not observed for the prescription pads.
We saw that oxygen cylinders were in date, with appropriate stock levels however no arrangements were in place for reporting any incidents. We referred staff to a recent safety alert regarding staff training requirements for the use of oxygen and ensuring cylinders are correctly opened. Not all staff had completed the appropriate portable oxygen cylinder online training. **These issues were addressed under our immediate assurance process at Appendix B.**

All necessary emergency equipment was in place. An automated external defibrillator (AED) was in place and was fully charged. A poster was displayed in reception and in every clinical room stating where the emergency equipment was located. However, the equipment was stored within the main treatment room therefore if the treatment room was in use the trolley would be inaccessible. **This was addressed under out immediate assurance process at Appendix B.**

There were appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as cardiac arrest. We saw evidence that the checking of the drugs and emergency equipment was being recorded monthly. However, we recommended this be done weekly in accordance with the Resuscitation Council UK guidance. **This was addressed under our immediate assurance process at Appendix B.** We also noted that the emergency drugs were not stored in a tamper-evident container.

The practice must ensure that the emergency drugs are stored in tamper-evident containers.

Not all staff had undertaken appropriate basic life support training. **This was addressed under our immediate assurance process at Appendix B.**

We were not assured that appropriate measures were in place for the safe storage of vaccines and medications in the fridges, which could pose an immediate patient safety risk. During the inspection, we found both fridges were well stocked but the keys for both fridges were left in the locks therefore not locked. We found that twice daily temperature checks of the fridge were being carried out.
We recommended that keys were removed from both fridges and stored in a secure location. This was resolved during our inspection, and further details can be found in Appendix A.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. However, no staff when questioned were aware of the onsite policy or who the safeguarding lead was.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns, however they did not follow a suitable safeguarding pathway. This included looked after children. There was little information on multi agency communication on safeguarding cases and no joint meetings to discuss cases.

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level.
Safeguarding overall was addressed under our immediate assurance process as seen in Appendix B.

Management of medical devices and equipment

The practice had processes in place to safely maintain electrical equipment. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement. Portable Appliance Testing (PAT) electrical checks had been carried out as appropriate.

Effective

Effective care

Processes were in place to support safe and effective care, and this included the process for receiving treatment or care across the GP cluster and wider primary care services. We found notable examples of safe monitoring of medication and chronic illness management, and clear narrative with evidence of patient centred decision making.

We saw evidence of two serious incidents within the practice which had not been fully investigated. We did not believe that the same incidents had been resolved appropriately to an acceptable level and lessons learned as a result. There was no visible system for reporting incidents, including actual or near misses.

This was addressed under our immediate assurance process, detailed in Appendix B.
We were told that any safety notices, changes or new guidance is shared with staff via email and discussed with staff as appropriate.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patient records
We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were written to a satisfactory standard with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

The patient records where chronic disease was recorded contained a full summary of conditions, including all past and continuing problems, as well as the medication being taken.

We found the continuity of care was good, with close oversight and supervision of patients and patients records by all the GPs. The records seen evidenced satisfactory patient consultations.

From the notes reviewed we found that the patient's language choice was not always recorded, however we found that in new patient registrations, language choice was recorded.

The practice must ensure that patient language preference is recorded and easily identified in their clinical records.

Quality of Management and Leadership

Staff feedback

Eight respondents participated in the staff survey. The majority reported receiving sufficient training and completing an annual appraisal in the past year. Overall, staff members affirmed the availability of resources, staffing, and ICT necessary for delivering quality care, while acknowledging difficulties in managing competing demands.

Involvement by staff in decision-making processes and opportunities to propose improvements were broadly recognised. Staff consistently agreed that patient confidentiality and dignity is maintained, and that patients are involved in decisions affecting their health.

Staff agreed that patient care was principal priority for the practice, most respondents stated they would recommend the practice. Additionally, staff noted that their roles do not adversely affect their health and highlighted strong support from the practice regarding wellbeing, work-life balance, incident reporting, fairness, and inclusion.

Leadership

Governance and leadership

Established processes did not support effective governance and accountability, with staff demonstrating a clear understanding of their roles, responsibilities, reporting structures, and the necessity of operating within their scope of practice. The practice had mechanisms for sharing information among staff; however, there was no documented evidence of staff meetings, The team appeared challenged to cohesive collaboration and communication.

Clinical meetings, including multidisciplinary team sessions, were reported as formally recorded, yet we observed minimal evidence to corroborate this claim. Our review encompassed a comprehensive range of policies. Notably, document control systems were limited, and certain policies had not been adapted to meet the specific requirements of the practice. Additionally, some staff members were unaware of the existence of these policies.

The practice must strengthen governance arrangements to ensure all policies and procedures are relevant to the practice, in date, reviewed regularly, and have been read and understood by staff.

Workforce

Skilled and enabled workforce
Whilst staff reported they were happy in their place of work; we were not assured that measures had been taken to enable the workforce to deliver their role to the best of their ability.

It is advised that training, as well as its accessibility and participation, be prioritised for all employees. Regular staff meetings should be conducted to ensure that personnel remain informed about any developments within the workplace.

Culture

People engagement, feedback and learning
We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

We were told appraisals had been completed for administrative staff and that clinical supervision or annual appraisals were taking place for clinical staff. The practice uses locum GP's and conducts orientations for new starters.

There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members of staff before they joined the practice. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. During our inspection we were told that the practice was in the process of ensuring that DBS checks/ outcomes are on file for the clinicians; however, none of the administrative staff had been subject to a DBS check. **This was addressed under our immediate assurance process, as detailed in Appendix B.**

We are also not assured that the management and oversight of training compliance was robust to ensure all staff remained competent to perform their roles safely and appropriately.

During our inspection we requested details of staff training. We were provided with an overarching training matrix which identified poor compliance with training across all staff groups. **This was addressed under our immediate assurance process at Appendix B.**

Information

Information governance and digital technology
The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this; however, we saw no evidence that staff had completed training on this topic.

The practice's process for handling patient data was available for review on the website.

Learning, improvement and research

Quality improvement activities
The practice engaged in learning from internal and external reviews through cluster activity. We saw evidence of three such projects after 2024 Equality Impact Assessment, Supporting Healthy Behaviours and Chronic Kidney Disease. We were told learning from cluster activity was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development
We found evidence of partnership working with the practice's collaboration within a GP cluster. Medical staff attended cluster meetings and provided services on a cluster wide basis.

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
Expired blood and urine bottles	Could impact blood/urine test results activating a false reading	Practice manager was asked to remove all expired containers	This was done during our visit and supervised by one of our reviewers

Appendix B - Immediate improvement plan

Service: Cowbridge and Vale Medical Practice

Date of inspection: 17.02.26

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

Findings 1:

We were unable to locate the Complaints Procedure or the associated folder, even under the guidance of the Practice Manager. However, we did see two handwritten Serious Untoward Incidents in the policy folder. Theses dated from November and December 2025. There was no evidence of a robust investigation, no indication that the incidents had been reported on Datix, and no evidence of learning or actions taken as a result. One incident involved a patient receiving a vaccine that had already been used on another patient, with the needle re-sheathed and returned to the fridge.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice must ensure all complaints and incidents are recorded, investigated, acted upon and share outcomes with the wider team for learning in the set timeframe by NHS Wales Patient Safety	Health & Care Quality Standards (2023) Effective: Person centred: Safe	Introduction of an updated Complaints spreadsheet/action log stored on the practice shared folder/management. Complaints scanned to shared folder complaints file and corresponding complaint number logged. Complaint log contains Datix ref no if appropriate.	Emma Barnett Deputy Practice Manager	Implemented

			Multiple tabs within spreadsheet, includes themes, risk level, action plan - screenshots below. Learning identified is within the first page of spreadsheet, however, this was not clear from the first screenshot I uploaded. Action required and evidence of completion, also included on same page. These would be used to show if a complaint was discussed in a practice meeting, if any learning, process changes or message dissemination etc were to happen. Complaint policy also included as evidence. S:\Policies and Procedures\Complaint procedure patient.docx		

Findings 2:
During our inspection and general tour, we identified that the two large drug fridges, both containing substantial stock, were located in the minor operations suite alongside several other essential emergency equipment.

Both fridges were unlocked, with the keys left in the locks. We advised the team immediately to lock the fridges and remove the keys and store appropriately. Despite this, the inspection manager and several members of the team had to repeat this request multiple times throughout the day. When we were leaving the premises, the fridges were still not secure.

Although data loggers were present in both fridges, they were checked infrequently. We advised the practice manager that these should be checked daily to identify any breaches in cold chain.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The practice must ensure that all medicines are monitored, stored, dispensed and kept secure appropriately according to medicines management protocol.	Health & Care Quality Standards (2023) Medicines management: Safe practice	Fridges are locked at all times unless items are being taken out. Keys are removed and stored in utility room key safe. Key log (detailing taken/returned/reason) next to key safe that GPs must use if accessing fridges. Spot checks to be undertaken weekly to ensure keys aren't in fridges and that the fridges are locked. It is Cardiff & Vale protocol which recommends that data loggers are downloaded and reviewed on a Monday morning to check there has been no breaches over the weekend. There is no requirement for this to be done daily. The manual twice a day readings will detect any breach on that day. If the manual readings are out of range then you would check the data logger, but if they are within range then this is not necessary.	Daniella Howard Gemma Kelly / Holly Thomas All nursing Team. Nursing Assistant has admin time each Monday for this.	Implemented Weekly Implemented

Findings 3:
We identified several areas within the practice that were non-compliant with infection prevention and control requirements. They were:

- There was no audit available
- Clinical areas were soiled with long standing dust
- Privacy curtains were non disposable and were visibly soiled with blood
- There were no evidence that equipment was being cleaned between patients. The blood pressure machine located in the 'patient pod', used by all patients to use prior to appointments was worn and visibly soiled.
- One consultation room had a carpeted floor.
- We noted a small fridge in one consultation room that was being used as a personal item by a member of staff for the storage of expressed breast milk. This should not be located within a clinical area.
- Several posters around the practice asked patients and staff to sanitise their hands, however, there were no sanitiser products or dispensers available to enable this.
- Water temperatures in several clinical areas did not appear to meet recommended levels for effective handwashing. There was no evidence that this was being monitored or audited.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The practice must ensure that all infection prevention and control guidance is adhered, monitored and findings acted upon swiftly. Clinical areas must be maintained to an appropriate The practice must:	Health & Care Quality Standards (2023) Safe workforce	IPC Audits completed and will be sent as evidence. IPC audit spreadsheet created to include more detail and action plan. IPC audit folder created on shared drive within IPC folder to ensure all staff have oversight. IPC policy updated to include weekly IPC audit undertaken.	Gemma Kelly Gemma Kelly Gemma Kelly Miriam Grant/ Gemma Kelly Gemma Kelly	To be uploaded Implemented Implemented Implemented

	• Implement IPC audits and send HIW a completed copy • Confirm that all clinical areas that were soiled and had dust have been cleaned and are included onto practice cleaning schedules. • Confirm that curtains have been washed and are placed onto routine cleaning schedule or that disposable curtains have been ordered • Implement a process for cleaning in-between appointments and at the end of each day • Confirm what steps will be taken to replace carpeted clinical areas within a reasonable timeframe • Confirm that the personal fridge has now been relocated • Confirm that hand sanitiser products and dispensers have been put up or signage removed		Clinical areas have been cleaned by nursing team and admin. Meeting held with cleaning company on 26/02/2026 and cleaning audit carried out. Cleaning log added to every clinical room on the back of each door. Areas added to cleaning schedule to include under couch headrests. Storage of cleaning items addressed. Deep clean to be scheduled (will be carried out following floor replacement) by cleaning company. Curtains removed and replaced by disposable. Hygiene and date check added to audit specification. < Image evidence provided but removed for publication > Posters added to clinical rooms reminding clinicians to clean in between patients. Cleaning log added to the back of each door. Hand hygiene posters added to all clinical rooms. Hand sanitiser added to each clinical room. < Image evidence provided but removed for publication >	Gemma Kelly Gemma Kelly Gemma Kelly Gemma Kelly Gemma Kelly PHP Estates Management Gemma Kelly	Implemented Implemented 30/04/2026 Implemented

	• What will be done to ensure that water temperatures are appropriate for a healthcare setting and its on-going monitoring, which must include a periodic legionella risk assessment.		Patient BP machine has had a deep clean and is now on the cleaning schedule for daily cleaning. Disposable long arm gloves are provided to patients as well as disinfectant wipes, along with a sign for patients to follow a cleaning process prior and after use. < Image evidence provided but removed for publication > Landlord has been contacted regarding carpet replacement. Also working through recommended flooring fitters to arrange measurements and quotes. Interim measures implemented - pharmacists (who do not have face to face patient contact) now work from the carpeted room. Therefore no patient examinations take place. Personal Fridge removed and now located within another room < Image evidence provided but removed for publication > Hand sanitiser signs removed from areas where no sanitiser was available. Water temperature Log Book on site containing risk assessments, temperature recording and little used outlet flushing records.		Implemented 06/03/2026

			Walk around scheduled with engineer to check accuracy of temp recordings < Image evidence provided but removed for publication >		

Findings 4:
We identified that not all relevant clinical staff were up to date with safeguarding training. It was also noted that there was an extremely low number of young people on the child protection register within the practice (six) of a population of 8400. While this may reflect the practice's patient cohort, one case reviewed by our team highlighted that appropriate follow up had not been undertaken. Documentation relating to this case was also poor and did not demonstrate adequate safeguarding oversight.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
4.	The practice must monitor all staff compliance with safeguarding requirements, and all clinical staff need to ensure they are up to date with training requirements, in line with Royal College of GP guidelines The practice must review the child protection register with the safeguarding lead to ensure that	Health and Care Quality Standards (2023) - Safe; workforce; information	Training log implemented to include recording of any online training sessions undertaken. Currently working through adding all certs to spreadsheet. Clinicians contacted to provide all in date certs. Training scheduled for those needing to complete. < Image evidence provided but removed for publication >	Holly Thomas Gemma Kelly / Anne Alison Holly Thomas Anne Alison	20/03/2026

	it remains accurate and complete.		Health Visitors, Safeguarding and Child Protection teams, Family Compass@VOG have been contacted to cross reference patients on our Child Protection register. Response from Health Visitors is that they have no children under 5 on the register who are registered with our practice. Safeguarding has passed the query on to the Head of Safeguarding and advised us to contact the Health Visitor (we had already done this). The Child Protection Team are yet to respond to my query. VOG Childrens Services are looking into the query. Safeguarding Lead is reviewing all patients currently on the register.		13/03/2026

Findings 5:
We saw that although a list of clinical staff had declared their vaccination status, antibody levels were not recorded. As a result, there were no indication of whether further vaccination, follow-up testing, or individual risk assessments were required for each individual.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
5.	The hepatitis B register was not up to date as it did not reflect the status of all current staff at the practice. The Practice Manager must ensure that staff	Health & Care Quality Standards (2023) - Safe	Occupational Health contacted by Mark Townend GP partner. No response to queries as yet. Practice has arranged to draw bloods privately (with consent) from all clinicians to obtain baseline	Anne Alison / Gemma Kelly	31/03/2026

	have been appropriately screened and that a up-to-date register is maintained. This includes adopting a documented, risk assessed approach for any staff who decline to participate.	UK Gov - Hepatitis B: the green book, chapter 18	antibody levels. Vaccines will be given to any staff who need a booster. Hep B log will be kept and bloods rechecked every 5 years. Staff Hep b policy to be created to include process for new clinical staff joining the practice.	 Gemma Kelly	 06/03/2026

Findings 6:
The emergency drugs and equipment are stored in the minor operations room. When this room is in use, it is unclear how the emergency equipment could be accessed promptly without compromising a patient's privacy and dignity. The practice expressed reluctance to relocate the equipment due to advice they had received regarding fire regulation.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
6.	The practice must source a suitable position for the emergency trolley to ensure that it can be immediately accessed, whilst minimising any risk to patient dignity.	Health & Care Quality Standards (2023) – Safe; Timely; Information	The emergency trolley has been moved out of the Minor Ops room and placed near the utility rooms. The clinicians are discussing the downsizing of the trolley. Oxygen stands ordered, delivery due. <Image evidence provided but removed for publication>	Gemma Kelly Clinical Team Gemma Kelly	Implemented 31/03/2026 16/03/2026

Findings 7:
We were not assured that the systems and procedures in place were sufficiently robust to ensure appropriate governance of Disclosure Barring Service (DBS) checks. For example, we did not see DBS checks for all staff employed at the practice.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
7.	The practice must ensure that full and enhanced DBS checks are undertaken prior to appointment of staff and ensure that there is a system in place for staff to declare any changes that may affect their status. For example, an annual self-declaration.	Health and Care Quality Standards (2023) - Safe; workforce; information	DBS log has been created and saved to the practice shared folder/management. DBS certificate numbers being added to log. Annual update service has been signed up to and we are working through the staff annual renewal process. Employment contract states 'You are required to notify your Manager immediately if you are questioned or arrested by the police or charged, cautioned, or convicted in connection with any criminal matter.' (Page 4 admin, Page 3 Clinical). A DBS practice policy is being implemented.	Gemma Kelly Emma Barnett Gemma Kelly	Implemented 31/03/2026 13/03/2026

Findings 8:
During our inspection, we requested details of mandatory staff training. From the information provided, we identified poor compliance across several required training areas. For example, the records showed that staff were not up to date with:

- Infection Prevention and Control (IPC)
- Safeguarding
- Cold chain and medicines management

It was noted that key clinical staff had recently undertaken Basic Life Support training. However, evidence within the staff file indicated that this training had been overdue by four years.
This level of non-compliance posed a potential risk to the safety and wellbeing of patients.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
8.	The practice must identify substantive training requirements for clinical and non-clinical staff, considering national and professional guidelines, individual roles and responsibilities, and local population needs. This includes establishing the appropriate level of training and the frequency with which it should be completed.	Health and Care Quality Standards (2023)- Safe; workforce; information	All staff have been asked to submit/resubmit training certificates or evidence of attendance. Potential gaps identified, training being undertaken. A mandatory training handbook is currently being created. A training matrix which includes renewal due dates, has been implemented to ensure all training is recorded centrally on the management shared folder.	Emma Barnett Gemma Kelly Holly Thomas	20/03/2026 20/03/2026 Implemented

	Once determined, staff should be made aware of what is expected of them, and robust arrangements should be in place to monitor compliance and ensure completion.		Resuscitation training is undertaken annually through C&V resus team who visit the practice. 2025 was delayed by 3 months due to the training being cancelled. It was originally booked in for Aug 25. Staff who are unable to attend the practice session are booked into C&V resuscitation services through https://cavresustraining.cymru.nhs.uk/ Resuscitation training spreadsheet implemented to include confirmation that the certificate is held on staff file. < Image evidence provided but removed for publication >		

Findings 9:
We found that checks on the emergency drug and equipment are being completed; however, these checks are only carried out monthly.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
9.	Checks must be completed weekly in line with the resus council guidance	Health and Care Quality Standards (2023) - Safe	The emergency trolley protocol has been updated to detail weekly checks. < Image evidence provided but removed for publication >	Cath Pembridge	

Findings 10:
During the inspection, we found clinical waste bags stored in a locked compound outside the practice. However, the clinical waste bin was overflowing, with the lid open and not securely locked. Although the compound was locked, access could still be gained by climbing the surrounding wall, meaning the waste was potentially accessible to patients or members of the public.

As a result, we were not assured that appropriate measures were in place for the safe storage of clinical waste, which could pose an immediate risk to patient safety and or members of the public.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
10.	The practice must ensure that all waste products are disposed of and managed appropriately and securely	Health and Care Quality Standards (2023) - Safe	Excess clinical waste collected.	SRCL	25/02/2026
			Discussion had with the cleaners to ascertain why the clinical waste bin was not locked. Key is missing,	Gemma Kelly	26/02/2026
			SRCL have been contacted to request a new key. Temporary lock in place by way of chain lock.	Emma Barnett	Implemented
			Discussion had with all building domain users to ensure they communicate with their cleaning teams and advise they use their allocated bins rather than placing all clinical waste bags into one bin.	Gemma Kelly	23/02/2026
			Clinical waste bin check added to weekly IPC audit to ensure compliance.	Nursing Team	Weekly

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): Gemma Kelly

Job role: Practice Manager

Date: 27.03.2026

Appendix C - Improvement plan

Service: Cowbridge and Vale Medical Practice

Date of inspection: 17.02.26

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
As part of the "Active Offer" for Welsh patients, all practice information and signs should be bilingual. We saw that some posters were available in Welsh, however, the practice information was available in English only.	The practice should ensure that the Active Offer of Welsh is promoted to patients.	Health and Care Standards (2023)	Website is available in Welsh via language drop down menu. Practice leaflet is also available in Welsh language. Health promotions displayed via calling in screen are available in both English and Welsh where provided. Posters, where available are provided in English and Welsh Language.	Holly Thomas	Implemented

	We found expired single use equipment (urine sample bottles and blood bottles) in room one.	The practice must complete a thorough stock check of all rooms to ensure expired single use equipment is removed.	Health and care Standards (2023) Infection Prevention and Control	Stock checks completed weekly by the nursing team.	Miriam Grant and wider nursing team	Implemented
	There were no weekly cleaning schedules available.	The practice must ensure weekly cleaning schedules are implemented	Health and Care Quality Standards (2023) – Safe (infection prevention and control / environment).	Weekly cleaning schedules available within the Cleaners folder. Daily cleaning checklist on each clinical room door and completed daily	Cleaning Company - Weekly schedule Clinicians - daily checklist	Implemented
	We saw that although a Chaperone policy was advocated it was not always documented in the clinical notes	The practice must ensure that appropriate documentation of chaperone is written in the notes	Health and Care Quality Standards (2023) Safe, Person-centred, Effective, Timely.	All clinicians have been informed that chaperone codes/documentation must be used when offering a chaperone, even if the offer is declined.	All clinicians	Implemented - ongoing ad hoc spot checks to ensure compliance

	Patient's language choice was not always recorded in the clinical records	The practice must ensure that patient language preference is recorded and easily identified in their clinical records	Health and Care Quality Standard (2023) Safe, person centred care	New patient questionnaire and templates have a language preference question. Preferences are coded. Call handlers are asking preferred language during telephone calls and recording preference where no previous records are held. Patients with a preferred language that isn't English is recorded in the patient alert pop up.	Holly Thomas	Implemented

	We reviewed a comprehensive suite of policies and procedures. There were, however, limited document control systems in place, and some policies had not been implemented to align with the specific needs of the practice or specifically for Wales.	The practice must strengthen governance arrangements to include robust document control and review process, to ensure all policies and procedures are in date, reviewed regularly, are Wales specific and are available to staff and relevant to the practice.	Health and Care Quality Standards (2023) - Leadership (Governance and leadership)	All staff to sign policies and procedures awareness and agreement form. Policies to be reviewed for Wales specific content.	Emma Barnett Gemma Kelly Partners	30/06/2026
	We saw no evidence displayed in the waiting area indicating the ways a patient can submit feedback. We also found no evidence to demonstrate that patient feedback is routinely used by the practice to learn and inform service improvement.	The practice must ensure that: Information is displayed in the waiting area detailing how people can feedback on their experiences; and Patients experience feedback is used to help inform service improvement and enhance the patient experience.	Health and Care Quality Standards (2023) – Person-centred	Patient feedback survey completed annually. Invitation to complete is advertised in the waiting room, website and links are sent by text. Patient comments/suggestions box reintroduced in the waiting room.	Gemma Kelly/Holly Thomas Emma Barnett	Completed for 2025/26 Implemented

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): Gemma Kelly

Job role: Practice Manager

Date: 10/04/2026