Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Panteg Health Centre, Aneurin Bevan University Health Board

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In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Panteg Health Centre, Aneurin Bevan University Health Board on 04 March 2026.

Our team for the inspection comprised two HIW healthcare inspectors and one clinical peer reviewer and one practice manager peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. Unfortunately, only one patient questionnaire was completed and no staff questionnaires were submitted. As a result, there was insufficient information to contribute to 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:
Panteg Health Centre is a welcoming practice located entirely on the ground floor, providing convenient access for all patients. The facility offers very good accessibility, ensuring that individuals with impaired mobility and wheelchair users can easily reach its services. The patient waiting area is clean, spacious, and well-equipped with informational materials, including digital access codes for those who prefer paperless options.

The environment is designed to preserve patient privacy and dignity, and patients are treated respectfully. Although some conversations at reception may be overheard, staff refrain from discussing identifiable patient information.

Patients benefit from readily available information that supports health promotion and wellbeing, both within the practice and via its website. Communication is clear and accessible, tailored to meet individual needs and empower patients to make informed decisions regarding their care.

However, we found that the availability of chaperones during an appointment was not always offered or documented within clinical notes.

The practice promotes equality and diversity through its culture, processes, policies, and staff training.

This is what we recommend the service can improve:

- Ensure patients speaking at reception can do so in a way that upheld their privacy and confidentiality
- Inform patients of the availability of chaperones in all treatment and consultation rooms.

Promote the Welsh language Active Offer more fully.

This is what the service did well:

- Patients were observed to be treated with dignity and respect

- Good health information available
- Waiting areas clean and spacious.

Delivery of Safe and Effective Care

Overall summary:
During our inspection, we identified a general lack of consistent and systematic approach to audits across the practice.

Overall, the Infection Prevention and Control (IPC) arrangements in place were acceptable; however, some areas need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

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 or that they had achieved an appropriate level of immunity response.

Processes were in place to ensure the safe prescribing of medication, and the process to request repeat medication was clear. However, the review of patient medication and patient's conditions should be strengthened and monitored more consistently.

During the inspection, we found two fridges within the practice nurses' room to be locked; however, the keys were kept in the locks and therefore they were not secure. We saw that daily temperature checks and monitoring of the fridges were being carried out robustly by the duty nurses.

We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear and written to a good standard.
Our assessment revealed that the emergency resuscitation equipment was outdated, and the defibrillation pads had surpassed their expiration date.

Additionally, we noted outstanding essential training requirements for staff across all levels.

Immediate assurances:
We identified several areas which needed to be addressed through our immediate assurance process, where we wrote to the practice within two working days of our inspection requesting an immediate improvement plan. The issues included:

- We found Emergency equipment was obsolete. must be replaced immediately
- We identified missing or overdue compliance with essential training requirements across all staff groups.
- A register of all staff who requiring Hepatitis B immunity must be maintained, including appropriate risk assessments if necessary for those who have failed to achieve immunity.

Details of the immediate improvements are highlighted in Appendix B.

This is what we recommend the service can improve:

- Fridge keys must be removed from refrigerators when not in use and stored securely
- Implement a structured audit matrix to ensure all recommended audits are conducted promptly and efficiently
- Establish a system to ensure regularly formal review of patients' conditions and clinical finding.

This is what the service did well:

- Patients had several options to access information regarding their medical conditions. Guidance was available online through websites or QR codes, and written leaflets were also provided in the waiting area
- Patients are provided with efficient access to healthcare services, and appointments are typically available on the same day.

Quality of Management and Leadership

Overall summary:
There were processes in place to support effective governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

We were told clinical and staff meetings were routine and formally recorded, with a record of actions recorded to enable action owners to understand what was required of them.

The practice had adopted a suite of policies developed by Aneurin Bevan University Health Board (ABUHB) which did not fully reflect the needs and day-to-day operation of the practice.
Additionally, not all staff had completed essential training requirements. This included missing or overdue training updates.
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 and outcomes are on file for the clinicians; however, not all staff had been subject to a DBS check.
We were provided with an overarching training matrix which identified poor compliance with essential training across all staff groups.

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.
This is what we recommend the service can improve:

- Implement a robust document control system for policies and procedures

- Ensure Patient feedback is routinely collected and considered to inform learning and improvement

This is what the service did well:

- Staff spoke highly of their peers and their ability to undertake their roles. They felt there was opportunities for future professional development

3. What we found

Quality of Patient Experience

Patient feedback

HIW distributed a questionnaire to gather patient feedback regarding the care and services at Panteg Health Centre before and during the inspection. However, there was an insufficient response rate for publication.

Person-centred

Health promotion

The practice provided an extensive array of written health promotion materials for patients. These resources were displayed in patient waiting areas and actively promoted on the practice website. Health information covered numerous topics, including mental health services, vaccinations, and support for carers.
Additionally, the practice collaborated with multiple agencies to enhance patient access to healthcare professionals. This included facilitating appointments with psychological practitioners, physiotherapists, and specialist diabetic nurses.

Dignified and respectful care

Clinical rooms ensured patient privacy by keeping doors closed during consultations, and all treatment rooms were equipped with privacy curtains. Additionally, one consultation room featured a sliding door that could be secured from within, thereby maintaining dignity throughout examinations.
Reception staff consistently welcomed patients in a courteous and professional manner. To uphold confidentiality, telephone calls were conducted in the administration office, separate from the reception area. The reception desk was partitioned with glass, providing a degree of privacy for those in the waiting area; however, certain conversations could still be overheard.
The practice maintained a comprehensive chaperone policy, offering chaperones in all relevant situations. The policy stipulates that documentation should occur

whenever a chaperone is offered, specifying the individuals present. This process was not always evident in the medical records reviewed. While a chaperone information notice was displayed in the waiting area to inform patients of its availability, such signage was not present in every clinical room.

The practice must ensure patients are offered a chaperone where appropriate and it is documented in the clinical records. Signage should be displayed in clinical rooms.

Timely

Timely care

There were processes in place to ensure patients could access care and with the most appropriate healthcare professional.

Appointments can be made by telephone and in-person. Appointments comprised of urgent the same-day appointments or routine bookable appointments. We were told that the practice offered bookable appointments where possible. All appointments are delivered face to face.

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 mental health crisis team/child and adolescent mental health service for urgent crisis support. Alternative support and signposting were also available for patients needing mental health support.

Equitable

Communication and language

We found that staff communicated in a clear manner and in language appropriate to patient needs. They also provided information in a way that enabled patients to

make informed decisions about their care. The surgery had a hearing loop to support those with hearing difficulties.

Patients were usually informed about the services offered at the practice through the website and by sharing information at appointments. Where patients are known not to have digital access, letters would be sent to individuals, and communication through telephone calls.

The practice serves a diverse community and staff confirmed that language and translation support were used as needed, to support both staff and patients to communicate effectively.

It was reported that one staff member could speak Welsh but did not make this known. Additionally, only limited information was available in Welsh throughout the practice. The practice should consider further promoting the 'Active Offer' to patients. Services must encourage staff providing services in Welsh to visibly indicate their language ability, such as by wearing a badge or lanyard, and ensure Welsh-language versions of all documents are accessible. No documentation within clinical notes indicated patients' language preferences.
The practice should ensure that the Active Offer of Welsh is fully promoted to patients.

Rights and equality
The practice provided convenient access for patients, with all patient areas including treatment rooms and an accessible toilet situated on the ground floor. There was documented evidence of an equality and diversity policy; however, it was not evident that all staff had completed the corresponding equality and diversity training.
Although only a small number of staff responded to our questionnaire, they indicated that the practice promotes equality, diversity, and inclusion, and reported fair and equal access to workplace opportunities.

Delivery of Safe and Effective Care

Safe

Risk management

The practice was clean and tidy, free of clutter and in a good state of repair.

We reviewed the business continuity plan (BCP), which adequately covered the business partnership risk, pandemic risk and appropriately detailed contingencies for long-term sickness absence.

The process in place for managing patient safety alerts and significant incidents was robust. Patient safety alerts are received and disseminated to staff electronically and communicated in meetings.

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

Infection, prevention and control (IPC) and decontamination

Overall, IPC arrangements were satisfactory.

A comprehensive IPC policy was established for the practice, alongside specific local policies addressing blood borne virus management, cold chain procedures, and sharps handling.

A needlestick injury protocol was implemented, with advisory posters displayed throughout all clinical treatment rooms to provide guidance to staff in the event of such incidents.

Cleaning duties are performed by external contractors. At the time of inspection, weekly cleaning schedules were not available; however, public areas and clinical rooms were visibly clean. Additionally, water temperature monitoring was observed and documented to support IPC and legionella risk management. Nursing and medical staff were responsible for infection control requirements within their

own clinical area. We saw no evidence of such monitoring, however most clinical rooms appeared clean and tidy and clutter free.
The practice must ensure the implementation of general weekly cleaning schedules and a system for monitoring IPC for each clinical area.

Evidence indicated regular completion of IPC-related audits, including assessments of hand hygiene and aseptic techniques.
It was noted that some staff had not completed IPC training relevant to their roles. **This issue was addressed through the immediate assurance process outlined in Appendix B.**
Procedures for waste management and disposal were in place, with waste observed to be securely managed. We found that the clinical waste disposal units were stored outside the practice in a locked waste disposal bin. However, this was not secure and could be removed by a member of the public.
The practice should ensure that waste disposal bins are secured.

Staff were aware of what appropriate measures should be taken to segregate individuals with potentially transmissible infections, thereby reducing the risk of cross-infection.

Medicines management
Established protocols were implemented to support the safe prescribing of medications. The procedure for patients to request repeat prescriptions was well-defined; staff indicated that most patients submit requests either directly through the practice or via an online platform. Prescriptions are handled by clerks who had received appropriate training.
Upon reviewing patient records, we observed inconsistencies related to medication reviews for certain chronic conditions. In several cases, the required medication review was not conducted within the prescribed timeframe.
There were appropriate arrangements in place for the oversight of paper prescription pads and an audit trail for the collection of prescriptions, including prescriptions with high-risk medications and those picked up by third-parties.

We saw that oxygen cylinders were in date, with two cylinders available and located one in reception and one in a storeroom adjacent to a clinical area 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.
This was addressed under our immediate assurance process at Appendix B.

Emergency drugs were 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 appropriately and this was completed weekly. However, we found that the emergency drugs were not stored in tamper-evident containers, and we were not assured that appropriate security measures were in place.

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

We found limitations in the practices ability to respond to a medical emergency. The defibrillator within was obsolete and associated products which would enable safe delivery of immediate life support had expired. Not all staff had undertaken appropriate basic life support training, or their training renewal date had expired with no planned date for renewal.
This was addressed under our immediate assurance process at Appendix B.

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. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.
However, on review of patient records we identified unclear safeguarding documentation processes. This included a lack of records for adult concerns or

child protection status updates. Additionally, there was no formal review process for coding or summarising clinical records. We also noted there no documentation of formal meetings between the disciplines involved.
The practice must ensure detailed information is documented in the clinical notes on each safeguarding case

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

Management of medical devices and equipment
The practice had processes in place to safely maintain equipment. We found all equipment was in good condition and well maintained, with appropriate electrical checks carried out. There were contracts in place for maintenance and calibration of equipment as appropriate, and for any emergency repairs and replacement.

Effective

Effective care
Processes were in place to support safe and effective care. We found notable examples of safe monitoring of medication and chronic illness management, and clear narrative with evidence of patient centred decision making.

There was an appropriate system in place for reporting incidents, and any shared learning was completed within team meetings.

We were told that any safety notices, changes or new guidance is shared with staff via email and discussed with staff as appropriate, and the information is stored on the shared drive for all staff to access.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation and 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 clear, written to a fair 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 acceptable, with close oversight and supervision of patients and patients records by all the GPs. However, we identified though analysis of a number of clinical notes gaps to be addressed, which included inconsistent follow-up for test results. On professional discussion and analysis of clinical findings we identified the absence of a home visit safety protocol which is aimed to protect staff from risk during off-site visits. It would require risk assessments and emergency and communication plan.

The practice must implement a home visit safety protocol to be established

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

Leadership

Governance and leadership

There were processes in place to support effective governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and the importance of working within their scope of practice.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were stored on the shared drive, and all staff would be told about any changes via team meetings.

Management confirmed that there was an open-door policy for staff to share concerns and ideas for the practice.

We were told clinical meetings, such as multidisciplinary team meetings, were formally recorded.

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.

The practice must strengthen governance arrangements to ensure policies and procedures accurately reflect the needs and day-to-day operation of the practice. All policies and procedures must be in date, reviewed regularly, and available to staff.

Workforce

Skilled and enabled workforce

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. We also saw an induction programme for new starters.

There were appropriate recruitment policies and procedures in place, and the practice manager described suitable 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. It was not evident that management maintained effective oversight of essential training compliance to ensure all staff continued to demonstrate competency in safely and appropriately performing their duties. We were provided with an overarching training matrix which identified missing or overdue compliance with training across all staff groups.
This was addressed under our immediate assurance process at Appendix B.

Culture

People engagement, feedback and learning

We saw no evidence displayed in the waiting area indicating how patients 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.
- Patients' feedback is used to help inform service improvement and enhance the patient experience.

The practice had a patient complaints policy; however, this was not aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy. However, the name of the previous practice manager was listed.

The practice must ensure that the complaints policy is aligned with the NHS Wales 'Listening to People' process (previously called 'Putting Things Right')

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place. However, the records we reviewed showed that not all staff had not completed training on this topic.

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, and we saw evidence that most 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

We were told learning was shared across the practice via regular staff meetings to make improvements. We saw evidence of clinical audit undertaken by one of the practice nurses which was notable.

Whole-systems approach

Partnership working and development

We were informed that several managerial and operational changes had occurred within the practice in the months leading up to our inspection. Senior staff members had departed, and efforts were underway to appoint individuals to fill these positions. Some employees had received promotions and were transitioning

into new responsibilities as they familiarised themselves with their roles. We understand that there are developmental plans in place and progress is being made toward upcoming initiatives.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: Panteg Health Centre

Date of inspection: 4 March 2026

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

Findings

We found that the Automated External Defibrillator (AED) and defibrillation pads for safe introduction of potentially life- saving electric shock were:

- Out of date
- Obsolete

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	The practice manager and partners must ensure that the immediate purchase of a fully functioning AED is available at the practice.	Health & Care Quality Standards (2023) – Safe; Timely.	AED purchased 09/03/2026 – due to be delivered 10/03/2026 See attached invoice as proof of purchase	Helenna Parfitt	1 week

Findings

We found that mandatory training for all staff was not up to date. Many subjects were missing or out of date by a number of years e.g. Safeguarding at all levels, Basic Life Support, Infection Prevention Control, Mental Capacity Act and Duty of Candour.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
2.	The practice manager must monitor all staff compliance with practice training requirements including those listed in our findings.	Health and Care Quality Standards (2023) – Safe; workforce; information	Full review of the training requirements and completion dates carried out on 09.03.2026. Please see attached plan to ensure full compliance over the next month with all mandatory training commitments.	Helenna Parfitt	1 month

Findings
We found no documented evidence of Hepatitis B immunity among staff members

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
3.	The Practice Manager must provide us with an up-to-date register including appropriate risk assessments if necessary.	Health & Care Quality Standards (2023) – Safe Hepatitis B: the green book, chapter 18	Confirmation of 7 Members of staff verified by medical records. Plan in place for blood tests over the next 2 weeks to ascertain levels of the remaining staff before administration of the vaccination. Please see attached spreadsheet for monitoring.	Helenna Parfitt	3 weeks

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: Helenna Parfitt

Name (print): Helenna Parfitt

Job role: Practice Manager

Date: 09.03.26

Appendix C - Improvement plan

Service: Panteg Health Centre

Date of inspection: 4 March 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.	There was inconsistent documentation of chaperone and policy.	The practice must ensure patients are offered a chaperone where appropriate and it is documented in the clinical records.	Health and Care Quality Standards (2023) Safe; Person-centred; Effective; Timely.	Improved signage throughout the public areas and in all consultation rooms.	Helenna Parfitt	Complete
2.	The Welsh Language active offer was not indicated to patients.	The practice should ensure that the Active Offer of Welsh is promoted to patients.	The Welsh Language (Wales) Measure 2011.)	Liaison with head of the Welsh language unit within ABUHB to improve all aspects of accessibility.	Helenna Parfitt/Dr Naoko Koto	2 months

3.	We found there were no weekly cleaning schedules for the practice.	The practice is required to ensure the implementation of weekly cleaning schedules.	Health and Care Quality Standards (2023) – usually Safe; infection prevention and control; environment.	Weekly cleaning schedules implemented following initial visit.	Helenna Parfitt	Complete
4.	Clinical waste bins were mobile and stored outside the premises therefore were not secure.	Waste disposal bins should be secured to a stable structure.	Health and Care Quality Standards (2023) - Safe; safe environment risk management; safe storage of clinical waste.	Clinical waste bins now secured to a stable structure on the exterior of the building.	Helenna Parfitt	Complete
5.	We found that emergency drugs were not stored securely.	The practice must ensure that the emergency drugs are stored in tamper-evident containers.	Health and Care Quality Standards (2023) - Safe Medicines management.	All emergency drugs are now stored in appropriate containers.	Helenna Parfitt	Complete

6.	We found there was no home visit protocol.	The practice must establish a home visit safety protocol.	Health and Safety at Work etc. Act (1974), supported by Management of Health and Safety at Work Regulations (1999) Risk assessment; safe systems.	Home Visit protocol (document withheld)	Helenna Parfitt	Complete
7.	We found there was no system to monitor document control for policies and procedures.	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 available to staff and relevant to the practice.	Health and Care Quality Standards (2023) – Leadership Governance and leadership.	The practice has created a review document which is currently being populated with each policy a hyperlink and review date as each policy is reviewed.	Helenna Parfitt	2 Months
8.	We found there was no current complaints procedure for the practice.	The practice must ensure that the complaints policy is aligned with the NHS Wales Putting Things Right process.	Health and Care Quality Standards (2023) – Leadership, Person-centred, Information NHS Wales Putting Things Right.	Complaints procedure (documents withheld)	Helenna Parfitt	Complete

9.	Information is displayed in the waiting area detailing how people can feedback on their experiences; however, we saw no evidence of this being actioned.	The practice must facilitate patients experience feedback. This can be used to help inform service improvement and enhance the patient experience.	Health and Care Quality Standards (2023) – Person-centred.	Patient feedback information will be updated and visible in the public areas and clearly signposted.	Helenna Parfitt	2 Months
10.	Details within safeguarding cases lacked detail and clarity. There was no evidence to suggest that multiprofessional meetings about cases had occurred.	The practice must ensure detailed information is documented in the clinical notes on each safeguarding case.	Health and Care Quality Standards (2023) – Safe; workforce; information.	Review and reflection of safeguarding cases with all clinicians complete. New protocol written and shared regarding identification, discussed and recording.	Helenna Parfitt	1 month

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: Helenna Parfitt

Name (print): Helenna Parfitt

Job role: Practice Manager **Date: 30/04/2026**