

Independent Healthcare Inspection Report (Announced)

FemHaus, Swansea

Inspection date: 18 June 2026

Publication date: 18 September 2026



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Digital ISBN 978-1-80853-317-4

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

Our Purpose

We check the safety and quality of healthcare across Wales.

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 Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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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 FemHaus, Swansea on 18 June 2026.

The inspection was conducted by two HIW healthcare inspectors.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 34 questionnaires were completed. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We found patients received a good level of care at FemHaus. Patients had a full consultation and were provided with adequate information both pre and post treatment to enable them to make informed decisions. Patients were treated in a dignified and respectful manner throughout their patient journey. Robust arrangements were in place to fully support the privacy and dignity of patients with consultations held in a private treatment room. The systems in place to record and respond to patient feedback were satisfactory. We found that the statement of purpose and the patients' guide was missing required information in line with regulations.

Immediate assurances:

- The clinic could not evidence that a patient treatment register was recorded which should include all laser treatments, including treatment parameters, operator details, clinical assessments and aftercare, to ensure safe, consistent and traceable care.

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

This is what we recommend the service can improve:

- To review both the statement of purpose and the patients' guide to ensure compliance with the regulations.

This is what the service did well:

- High levels of positive patient experience feedback
- Able to provide services in other languages, including Polish and Russian
- Written consent was obtained prior to each treatment which was documented in patient's records.

Delivery of Safe and Effective Care

Overall summary:

We found the clinic was very welcoming and well presented in a clean, tidy and organised manner. The setting was delivering treatments using machines which had been serviced appropriately, and the setting had a good relationship with their Laser Protection Advisor (LPA) to the benefit of both patients and staff. We identified that the laser risk assessment had not been updated following the relocation of laser equipment and specified a higher level of eye protection. These issues were raised during the inspection and promptly addressed, with an updated risk assessment issued and appropriate protective goggles provided.

Some equipment in the first aid kit had expired, however these were disposed of and replenished the day after the inspection. As mentioned, the clinic was very clean and organised, however, infection, prevention and control (IPC) cleaning schedules were not formally recorded or retained and training was not completed.

Immediate assurances:

- The clinic could not evidence routine fire-safety checks, staff had not completed fire-safety training, and the rear fire exit was partially obstructed.

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

This is what the service did well:

- Welcoming, clean, tidy and well-organised environment for patients
- The registered manager responded promptly to issues identified during the inspection, including obtaining an updated LPA risk assessment and replacing expired first aid kit items immediately following the inspection.

Quality of Management and Leadership

Overall summary:

The clinic displayed its HIW registration certificates in an area easily seen by patients. We saw a valid employers and public liability insurance was in place, providing assurance that appropriate insurance arrangements were in place.

The clinic actively sought feedback from patients, and the feedback available during the inspection was positive regarding the service provided. Whilst complaints forms were available for patients, the service was unable to provide evidence of a complaints policy or procedure, limiting assurance that complaints would be managed consistently and in line with regulatory requirements.

Immediate assurances:

- We identified significant gaps in the registered manager's mandatory with several essential training courses not completed. In addition, several policies and procedures were either missing or did not accurately reflect current practice, including laser safety arrangements. Following the inspection, the service provided evidence that appropriate protective eyewear had been obtained to support the safe implementation of the clinic's chaperone policy.

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

This is what we recommend the service can improve:

- Implement and maintain a formal complaints policy and procedure to ensure any concerns raised by patients are managed consistently and appropriately.

This is what the service did well:

- Caring, friendly and enthusiastic registered manager
- Positive reaction to feedback and suggestions made during the inspection.

3. What we found

Quality of Patient Experience

Patient feedback

Patients who completed a HIW questionnaire provide positive feedback about the service, with all respondents rating their experience as 'very good'.

Patients also highlighted staff professionalism, clear communication, and the ability to make them feel comfortable, safe, and well cared for.

Patient comments included:

"The service at FemHaus is exceptional. The staff are very helpful and friendly."

"Clinic is clean and very welcoming."

Health promotion, protection and improvement

We were told staff provided clear aftercare advice during consultations to help patients care for their skin following treatment. This included guidance on sun protection and appropriate water intake.

Dignity and respect

The clinic was operational on the day of inspection. All consultations and treatments were undertaken within the designated laser treatment room located on the ground floor, positioned away from the reception area. The room was equipped with a lockable door, and it was confirmed that the door was kept closed and locked during procedures, ensuring a private and secure setting for patients.

All respondents to the HIW patient questionnaire told us they were treated with dignity and respect, that measures were taken to protect their privacy and staff explained what they were doing during their treatments.

We were told patients could bring a chaperone of their choice to attend appointments with them. However, the service did not have a chaperone policy in place to set out the expectations for when chaperones should be offered and how this is recorded.

Although we saw evidence shortly after the inspection that the registered manager had developed a chaperone policy, it was inconsistent with current practice and the available supply of safety goggles for a chaperone. This was raised to the registered manager who updated the chaperone policy to reflect current practice and ensured sufficient safety goggles were available for staff, patients and their chaperone.

Patient information and consent

During the inspection we reviewed a sample of five patient records. We saw that an initial consultation form was completed and signed by patients to consent to treatment. However, a consent to treatment policy and a provision of information to patients' policy was not in place. This was raised to the registered manager who provided us with evidence shortly after the inspection that both policies had since been created.

For each subsequent appointment, the patient records included relevant information about each treatment provided. We were told patients were given clear verbal explanations about pre and post treatment benefits and potential risks ensuring that individuals were able to make informed decisions about their care.

Communicating effectively

The clinic had a statement of purpose (SoP) and patients' guide in place, which were both available to patients upon request either on paper or electronically. The SoP was missing some information required by The Independent Health Care (Wales) Regulations 2011. We also noted that HIW's contact details were missing from the patients' guide.

The registered manager must ensure the statement of purpose and patients' guide contain all the information required by The Independent Health Care (Wales) Regulations 2011.

Patients were able to book appointments by contacting the clinic via social media, over the telephone and in person. The setting demonstrated effective communication and a clear commitment to meeting individual needs.

The clinic did not have a Welsh speaking member of staff, but access to Language Line was available should patients wish to receive information through the medium of Welsh or other languages, if required. The registered manager spoke Russian and Polish.

Care planning and provision

Patient records confirmed that appropriate pre-treatment processes were in place. Where required, patients underwent patch testing prior to commencing a course of treatment, enabling the practitioner to assess the likelihood of adverse reactions and tailor care accordingly.

However, a treatment register for the laser machine was not recorded, which limited traceability of treatments and the service's ability to identify and respond to adverse incidents. We saw evidence after the inspection that the patient treatment register had been introduced. Further information on the remedial actions taken by the service is provided in [Appendix B](#).

The clinic had an Equality, Diversity and Inclusion (EDI) policy in place, to demonstrate its commitment to ensuring that all individuals have fair access to services and are treated equitably. However, the registered manager had not completed EDI training. The registered manager provided evidence shortly after the inspection that the EDI training had been completed.

We were told that there was no consistent approach to recording pronouns for patients. The clinic may wish to consider whether there are ways of recording and communicating this information, where appropriate, to further support person-centred care.

All respondents to the HIW questionnaire said they had not faced discrimination when accessing or using the service.

Citizen engagement and feedback

We were told that patient feedback was obtained either through online reviews or in person at the clinic. The registered manager advised that feedback was constantly monitored with services adjusted accordingly, where feasible. We were told all feedback received had been positive.

Delivery of Safe and Effective Care

Environment

We found the building to be visibly well maintained both internally and externally, with suitable security arrangements to prevent unauthorised access. We saw that internally the premises was newly refurbished to a high standard. The clinic door had a lock to ensure only authorised persons could gain entry.

Managing risk and health and safety

We saw evidence the gas, electrical safety and portable appliances testing certificates were completed within their required time frames and were satisfactory.

We found there was a fire risk assessment in place; however, the clinic could not evidence fire-safety checks which included drills, alarm testing, equipment servicing, required signage and fire safety training had been completed. We were provided with evidence that these findings were addressed and training completed after the inspection. The rear fire exit was also partially obstructed and was unsuitable for wheelchair users. We received evidence after the inspection that the fire exit was cleared of obstruction, and a ramp had been ordered to make it more suitable for wheelchair users. Further information on the remedial actions taken by the service is provided in [Appendix B](#).

The registered manager had completed first aid training and a workplace health and safety advanced diploma. Some equipment in the first aid kit had expired, however, this was disposed of immediately during the inspection and equipment replenished the day after the inspection.

Infection prevention and control (IPC) and decontamination

We found appropriate processes in place to enable the effective cleaning and decontamination of treatment areas and reusable equipment, and a suitable IPC policy was in place. Personal protective equipment was provided to staff and patients used during treatments. We were informed equipment disinfecting and bed wipe downs were routine pre-and-post treatment. However, we found that cleaning checklists were not being recorded or retained, and IPC training had not been completed by the registered manager. We saw evidence that cleaning checklists were created and IPC training was completed shortly after the inspection.

Safeguarding children and safeguarding vulnerable adults

The registered manager had the Wales Safeguarding Procedures application on their phone to stay up to date with the latest information. The service is registered to treat patients aged 18 years and over. The registered manager confirmed that this was complied with and explained that patients were advised when making an appointment

not to bring children as they were unable to leave them unsupervised.

We did not see evidence of a safeguarding policy or training completed by the registered manager; however, these were created and completed shortly following the inspection.

Safe and clinically effective care

The clinic had local rules and a risk assessment in place which had been completed by a Laser Protection Adviser (LPA). During the inspection, we identified that the most recent LPA risk assessment had not been updated to reflect the relocation of the laser equipment to a different treatment room within the clinic. This was raised with the registered manager and the LPA, and a revised risk assessment was subsequently issued. Following review of the amended documentation, we noted that the risk assessment specified a higher level of protective eyewear than was available within the clinic. This matter was raised to the registered manager who promptly arranged for appropriate protective goggles to be purchased. We saw evidence that the local rules had also been revised to reflect the amended risk assessment.

The protective goggles were clean and appeared to be well maintained. However, we did not see evidence that routine checks of the eyewear had been undertaken. During the inspection, arrangements were introduced to include safety goggle checks within the daily equipment checklist and between-patient checks.

We saw appropriate warning signs displayed outside the treatment room to alert others to the use of the laser equipment. Suitable arrangements were also in place to secure the equipment when not in use.

Participating in quality improvement activities

We were told that the registered manager kept themselves up to date with new lines of treatment to help improve and ensure a quality service is provided to patients.

Records management

Patient records were stored in a secure metal box in a locked cupboard. The registered manager described appropriate processes for the disposal of records including data retention periods. Patient records which we reviewed included patient identification, medical history, consent, consultation forms and treatment history.

Quality of Management and Leadership

Governance and accountability framework

The clinic's HIW registration certificate was displayed in the premises. The clinic also had appropriate insurance cover in place, with a current public liability insurance certificate available for inspection.

FemHaus was owned and managed by the registered manager. The registered manager confirmed that they were responsible for all aspects of service delivery, including treatment, oversight of clinical standards, record-keeping, and regulatory compliance.

During the inspection, we identified significant gaps in the clinic's governance arrangements. Several key policies and procedures were either unavailable or incomplete at the time of the inspection. These included policies relating to obtaining patient consent, provision of information to patients, chaperones, safeguarding, whistleblowing, maintenance management, and health and safety.

Although the clinic provided these policies following the inspection, we found that some did not accurately reflect the service being delivered. For example, the chaperone policy stated that chaperones could remain in the treatment room during laser procedures. However, at the time of the inspection we were only shown two sets of laser safety goggles, one intended for the practitioner and one for the patient and were therefore not assured that sufficient protective eyewear was available to safely accommodate a chaperone during treatment. This discrepancy highlighted a lack of effective oversight to ensure that policies and procedures were being regularly reviewed, implemented and aligned with current practice. Further information on the remedial actions taken by the service is provided in [Appendix B](#).

Dealing with concerns and managing incidents

Patient complaints were overseen by the registered manager. A complaints form was available for patients wishing to raise a complaint. There were no complaints or previous incidents for us to review during the inspection.

However, we did not see evidence of a complaints policy or procedure available to patients.

The registered manager must implement a complaints policy and make it available for patients.

Workforce recruitment and employment practices

At the time of the inspection, the registered manager provided evidence of a current Disclosure and Barring Service (DBS) check. The registered manager was the only staff member at the clinic and informed us that they had no intention of future recruitment.

Workforce planning, training and organisational development

We were told that the registered manager maintained their knowledge and skills by completing training at the required intervals and undertaking continuing professional development (CPD) relevant to the treatments provided. The registered manager, as the sole authorised laser operator, had completed device specific training which included Core of Knowledge training.

However, on the day of the inspection, we were not provided with evidence that the following training had been completed:

- Infection Prevention and Control and Decontamination
- Safeguarding Children and Adults
- Fire safety
- Equality Diversity and Human Rights training.

Shortly after the inspection, the registered manager provided us with evidence that these were completed. Further information on the remedial actions taken by the service is provided in [Appendix B](#).

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
First aid kit contained expired equipment.	Increases the risk of delayed or inadequate treatment and may expose patients to avoidable harm.	Raised to registered manager.	The registered manager disposed the expired stock immediately and replenished the day after the inspection.

Appendix B – Immediate improvement plan

Service: FemHaus

Date of inspection: 18 June 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 key policies and procedures were missing or inconsistent. Although updated documents were provided the following day, they did not reflect actual practice—for example, the chaperone policy allowed chaperones in the laser room despite there being insufficient protective goggles.	
Improvement needed		Standard / Regulation	
1.	The service must ensure that all policies and procedures are accurate, consistent with actual practice, and supported by the necessary equipment. A structured system must be implemented to review, update and quality-check policies regularly so they remain current and aligned with best practice.	Regulation 9 of the Independent Health Care (Wales) Regulations 2011	
Service Action:		Responsible officer	Timescale
During the inspection, I demonstrated that the clinic had two pairs of laser protective eyewear available for patients. These included one pair of fully enclosed protective goggles designed to completely cover the patient’s eyes and one pair of specialist laser safety goggles. Appropriate laser eye protection was therefore available for use during treatments.		Registered Manager	Completed
Regarding the chaperone policy, I explained during the inspection that FemHaus has never had a patient			

request a chaperone. However, I was advised that a written chaperone policy should be in place, and I prepared one accordingly. The intention of the policy is that, should a patient choose to bring their own chaperone, the chaperone would only be permitted to remain in the treatment room if they are provided with appropriate laser protective eyewear. The patient would continue to wear the fully enclosed laser eye protection throughout the procedure. I would like to clarify that at no time would I permit anyone to remain in the laser treatment room without appropriate laser safety protection. Patient and visitor safety is my highest priority, and I take all health and safety requirements extremely seriously. Following the inspection, I have reviewed and amended the chaperone policy to ensure it accurately reflects the clinic's practice and the equipment available, removing any ambiguity and ensuring consistency between the written policy and day-to-day operations.		
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Findings		The clinic could not evidence fire-safety checks which included drills, alarm testing, equipment servicing, required signage and fire-training. The rear fire exit was also partially obstructed and was unsuitable for wheelchair users.	
Improvement needed		Standard / Regulation	
2.	The service must ensure that fire safety arrangements are reviewed regularly, including drills, alarm testing, equipment servicing and signage. Staff must also complete fire-safety training. The rear fire exit must be kept unobstructed and arrangements made to make it more suitable for wheelchair users.	Regulation 26 (4) of the Independent Health Care (Wales) Regulations 2011	
Service Action:		Responsible officer	Timescale
During the inspection, the Director had already confirmed that a fire safety specialist had been booked to attend the clinic to inspect and service the fire extinguishers. As the extinguishers were newly		Registered Manager	Completed

purchased, I had understood that, due to the manufacturer's five-year warranty, annual servicing was not immediately required. However, we had already arranged for a fire specialist to attend, as explained during the inspection. The servicing has now been completed, and the certificate is attached as evidence. With regard to 'No Smoking' signs, I have now displayed appropriate signage within the clinic. Following advice from a fire safety adviser, I understand that additional signs are not mandatory throughout every area of the premises. Nevertheless, I have installed signage to further promote fire safety and compliance. In relation to fire safety training, I have completed Level 3 Fire Risk Assessment and Fire Safety Training and am currently awaiting my certificate. In addition, a fire drill has now been carried out at the clinic, and a Fire Drill Log Book has been implemented. Fire drills will be conducted every six months, with all drills and any findings recorded and reviewed. Regarding the rear fire exit, I have discussed this matter with the neighbouring garage. They have agreed to make improvements to ensure the exit route remains clear and suitable for emergency evacuation. At the time of the inspection, a sturdy wooden board was already available, which could be placed over the step to provide easier access, including for wheelchair users, during an emergency. Nevertheless, I appreciate the importance of maintaining a permanently safe and unobstructed escape route and have taken steps with the neighbouring occupier to ensure this is addressed. The safety of patients, visitors and staff is my highest priority. Since the inspection, I have acted promptly to address all concerns raised and have strengthened the clinic's fire safety arrangements to ensure they accurately reflect both legal requirements and best practice.		
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Findings	We were not provided with evidence that essential training including Core of Knowledge, safeguarding, and infection prevention and control (IPC) had been completed.
Improvement needed	Standard / Regulation

3.	The service must ensure that all essential training is completed and reviewed at appropriate intervals.	Regulation 20 (2)(a) of the Independent Health Care (Wales) Regulations 2011	
Service Action:		Responsible officer	Timescale
Alina Skorohoda has successfully completed a Level 4 Laser and IPL course, and the certificate was displayed in the clinic during the inspection. My understanding is that the Core of Knowledge and Infection Prevention and Control (IPC) elements were included as part of this qualification. If HIW requires these to be evidenced by separate certificates, I am willing to complete the additional training. However, this would mean paying for training that I believe has already been completed within my Level 4 qualification. To further demonstrate my commitment to continuous professional development, I have also completed an additional Infection Prevention and Control course and am currently awaiting the certificate. In addition, I am in the process of completing Level 3 Safeguarding Children training and intend to complete Safeguarding Adults training immediately afterwards to ensure full compliance with HIW expectations. As I have stated throughout my response, the safety and wellbeing of our patients is the highest priority at FemHaus. I take my professional responsibilities very seriously and have acted promptly to complete or update any additional training requested, ensuring the clinic continues to provide safe, effective and high-quality care.		Registered Manager	Completed
Findings	The service must implement and maintain a complete and accurate patient treatment register that records all laser treatments, including treatment parameters, operator details, clinical assessments and aftercare, to ensure safe, consistent and traceable care.		

Improvement needed		Standard / Regulation	
4.	The service must implement and maintain a complete and accurate patient treatment register that records all laser treatments, including treatment parameters, operator details, clinical assessments and aftercare, to ensure safe, consistent and traceable care.	Regulation 45 (2) of the Independent Health Care (Wales) Regulations 2011	
Service Action:		Responsible officer	Timescale
At the time of the inspection, the laser treatment parameters and treatment date were routinely recorded by the practitioner on the patient's consultation form after each treatment session. The treatment time could also be verified through our electronic booking system. However, I acknowledge that this information was not maintained in a separate laser treatment register as required by the regulations. Following the inspection, I have updated the consultation form to include a dedicated section for recording the date, time, and laser parameters used during each treatment session. In addition, a laser treatment register has now been implemented to ensure full compliance with Regulation 45(2) and to provide complete traceability and continuity of care. With regard to the laser equipment, daily safety checks are carried out before use. As I am the sole practitioner using the laser, I was advised by the manufacturer that routine maintenance consists of daily operational checks, scheduled water replacement, and servicing at the recommended intervals. These procedures are now documented as part of the clinic's equipment maintenance records. As always, patient safety remains the highest priority at FemHaus, and I have taken immediate steps to strengthen our documentation and record-keeping procedures to ensure full compliance with regulatory requirements.		Registered Manager	Completed

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: Alina Skorohoda

Name (print): Alina Skorohoda

Job role: Registered Manager

Date: 28 July 2026

Appendix C – Improvement plan

Service: FemHaus

Date of inspection: 18 June 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.	The SOP and Patient's guide was missing some required information.	The registered manager must ensure both the statement of purpose and the patient's guide includes all information required.	The Independent Health Care (Wales) Regulations 2011 6 (1), 7 (1)	The Statement of Purpose and Patient's Guide have been reviewed and updated to ensure that all information required under The Independent Health Care (Wales) Regulations 2011 is included. The revised documents will be reviewed periodically and whenever there are changes to the service to ensure the information remains accurate, current and clear for patients.	Registered Manager	Completed – August 2026

2.	We did not see evidence of a complaints policy.	The registered manager must implement a complaints policy and procedure which is available for patients should they require it.	The Independent Health Care (Wales) Regulations 2011, Regulation 24	A formal Complaints Policy and Procedure has been implemented. It explains how patients can raise a concern or complaint, how complaints will be acknowledged, investigated and responded to, and how patients can escalate their concerns if they remain dissatisfied. The policy will be readily available to patients and reviewed regularly to ensure it remains current and effective.	Registered Manager	Completed – August 2026
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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: Alina Skorohoda

Name (print): Alina Skorohoda

Job role: Registered Manager

Date: August 2026