

General Practice Inspection Report (Announced)

Strathmore Medical Practice, Betsi
Cadwalader University Health Board.

Inspection date: 30 June 2026

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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.



Contents

1. What we did	5
2. Summary of inspection	6
3. What we found	9
Quality of Patient Experience	9
Delivery of Safe and Effective Care	12
Quality of Management and Leadership	16
4. Next steps	20
Appendix A – Summary of concerns resolved during the inspection ..	21
Appendix B – Immediate improvement plan	22
Appendix C – Improvement plan	23



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 Strathmore Medical Practice, Betsi Cadwalader University Health Board on 30 June 2026.

Our team for the inspection comprised of one HIW healthcare inspector, one GP peer reviewer, one practice nurse 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. A total of three questionnaires were completed by patients or their carers and seven were completed by staff. Feedback and some of the comments we received appear throughout the report.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, we found arrangements were in place to support a positive patient experience. Patients had access to a range of health promotion information and were supported to make informed choices about their health and wellbeing. We found patients were treated with dignity and respect, and that the practice had processes to support timely access to care, including appropriate signposting, triage arrangements and support for patients with urgent needs.

Communication arrangements supported patients' individual needs, including Welsh language provision. The premises were generally accessible with good parking and wheelchair access.

Although conversations at the reception desk could be overheard, the practice had taken steps to reduce the associated privacy risk. There was also a separate consultation reception room for private conversations.

There was a pharmacy co-located within the surgery, which provided patients with easy access to collect prescriptions following their consultation.

This is what the service did well:

- Appointments with a range of healthcare professionals were available to support access and best meet patient needs
- The practice was physically accessible and pharmacy services were available on-site to support ease of access and to provide additional capacity for treating common ailments.

Delivery of Safe and Effective Care

Overall summary:

The practice had established processes for supporting and managing safe and effective care. We found good examples of patient correspondence, reviewing and learning from significant events, maintaining emergency equipment, and ensuring medicines, medical devices and clinical equipment were stored, checked and used appropriately.

Patient records were detailed, contemporaneous and supported continuity of care. They showed clear evidence of clinical assessment, decision-making, consent, safety-netting and follow-up arrangements. Staff demonstrated a sound understanding of their responsibilities, and we saw evidence that care was delivered in a person-centred and holistic way, taking account of patients' individual needs and circumstances.

We found that although significant work was underway with the maintenance of the building there were shortfalls in the future planning of major structure repairs which would require the support of the health board to enable the practice to safely deliver care to their patients.

Reception staff were undertaking care signposting and symptom-screening activities, including the identification of sepsis and other potential red flag symptoms. However, the practice was unable to provide assurance that all staff had received appropriate training for these responsibilities.

The health board had recently made significant changes to their safeguarding policy and escalation structure and whilst the practice had implemented what they were able to at the time of inspection there was still additional information required to support the new safeguarding policy.

This is what we recommend the service can improve:

- Maintenance of the building structure, including continued monitoring and vigilance
- Completion and oversight of cleaning schedules
- Review and implementation of the revised safeguarding policy

This is what the service did well:

- Good quality clinical record keeping and overall care delivered to patients
- Reviewing and learning from significant events
- Use of dedicated emergency phone line for care homes and ambulance staff to support timely care.

Quality of Management and Leadership

Overall summary:

Effective arrangements were in place to support good governance, leadership and accountability. Staff were clear about their roles, responsibilities and reporting lines, and understood the importance of working within their scope of practice. The practice had systems in place to share information with staff, maintain policies and procedures, and support staff engagement through regular team, clinical and multidisciplinary meetings.

We found good practice in the open-door approach adopted by management, which enabled staff to raise concerns, share ideas and contribute to service improvement.

Workforce arrangements were generally well managed, with appropriate induction processes, recent appraisals and development reviews, oversight of mandatory training, and suitable recruitment procedures were in place. Staff described a positive working environment, felt involved in decisions affecting their work, and reported having access to the resources, equipment and information technology needed to carry out their roles.

The practice had clear arrangements to encourage and respond to patient feedback, manage complaints in line with NHS Wales guidance, and support compliance with the Duty of Candour. We also found appropriate arrangements for information governance, including a current policy, published patient information and staff training. Learning and improvement were supported through regular staff meetings, clinical audits and the review of data across key clinical areas.

This is what we recommend the service can improve:

- Ensure updated DBS governance is strengthened in a timely manner

This is what the service did well:

- Good range of clinical audits and quality improvement activities Staff demonstrated a sound understanding of their roles, responsibilities and appeared committed to providing a quality service.

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 Strathmore Medical Practice prior to the inspection that took place in June 2026. In total, we received three responses. Responses were overall positive, with all respondents who answered rating the service as 'very good' or 'good.' Due to the low response rate, questionnaire feedback has not been included throughout the report.

Person-Centred

Health promotion

Patients were able to access a range of information to support their health and wellbeing and to help them maintain a healthy lifestyle. We spoke to patients during our inspection and all agreed that they felt well supported and advised.

We saw health promotion information on topics such as smoking cessation and healthy eating. Information boards in both waiting areas also displayed a variety of public health campaigns, including those relating to vaccinations.

Further information was available on the practice website, including advice on pregnancy, alcohol, healthy eating, travel, exercise and mental health support.

Staff told us they provided a shared immunisation service with Betsi Cadwaladr University Health Board for eligible patients. Patients were invited by email, letter or telephone, depending on their preferred communication method or individual needs.

Dignified and respectful care

The environment supported patients' right to be treated with dignity and respect. Clinical rooms provided appropriate levels of privacy and had lockable doors.

Disposable privacy curtains were available in examination rooms. Telephone conversations with patients took place in a room adjacent to the reception area and could not be overheard.

Patients told us they were able to speak to reception staff in private when needed. However, during our inspection we noted that conversations at the reception desk could sometimes be overheard. Staff were aware of confidentiality requirements and responded appropriately when privacy issues arose.

The practice offered male and female chaperones as appropriate, supported by a chaperone policy.

Timely

Timely care

Patients who responded to our questionnaire, and those we spoke with during the inspection, told us they were offered a choice of appointment type, including face-to-face, telephone or virtual appointments.

The practice had processes in place to support patients to access care through an appropriate route, in a timely way, and from the most suitable healthcare professional.

Staff described the arrangements in place to help patients access services. We found that different ways for appointments to be accessed were available and the practice access policy was available on the practice website. Most appointments were arranged by telephone.

Trained reception staff used an agreed list of conditions to support appropriate signposting to other service providers who would be better placed to meet their needs.

Patients assessed as less urgent were booked for an initial telephone assessment. They were then managed by telephone or offered a face-to-face appointment, as appropriate. Staff told us that children and vulnerable patients were always seen face-to-face.

A separate telephone line, referred to as the emergency line, was available for care homes, district nurses and paramedics. This was designed to reduce delays in accessing the right treatment, and we saw this process in use during our inspection.

Staff also described the arrangements for patients who required urgent mental health support. The practice had a dedicated mental health practitioner who attended the surgery at least once a week, and usually twice a week. Where a patient was in crisis and needed an urgent mental health assessment, staff told us they would be assessed by the duty doctor, who could contact NHS 111 Wales, option 2, the mental health support line, if required.

Staff said this service could also be accessed directly by patients who required urgent support, or by people seeking advice on behalf of someone else. Children with mental health concerns would be referred urgently to Child and Adolescent Mental Health Services (CAMHS), and could also contact NHS 111 Wales, option 2.

Equitable

Communicating and language

The practice provided information to patients and communicated with them in a clear and accessible way, using language appropriate to individual needs. This supported patients to make informed decisions about their care.

All patients who completed our questionnaire and those we spoke to on the day of the inspection said staff gave them enough time during their appointment. Patients also said the GP explained matters clearly, listened to them, and treated them with dignity and respect.

A hearing loop was available at the main reception desk. We also saw signage and information displayed in both Welsh and English.

Staff told us that reception staff would inform patients if appointments were running late. This was reflected in the patient survey feedback.

Staff told us there were several Welsh-speaking staff at the practice, and several others were learning Welsh. Staff we spoke with were aware of the Active Offer. We also noted that signage on each surgery door indicated whether the practitioner spoke Welsh. This was a good example of proactive measures taken by the practice to promote use of the Welsh language.

Rights and equality

Respondents told us the premises were accessible, with sufficient seating and appropriate toilet facilities. They also described the practice as child-friendly and said health promotion information was displayed.

Accessible parking was available at the practice. Entry through the main entrance was straightforward, with a permanent ramp and handrail in place. Key facilities, including the reception desk, waiting area, patient restroom and consultation rooms, were located on the ground floor.

Some clinics were held on the first floor. These consultation rooms could be accessed by lift or staircase.

Delivery of Safe and Effective Care

Safe

Risk management

The practice is a traditional building. We saw evidence that some structural repair work had previously been undertaken, but other appeared fit for purpose.

Access to the main entrance was supported by a permanent concrete ramp with a handrail. A small set of steps was also available for patients who were able to use them.

Internally, we noted some concerns about the condition of the building. Numerous cracks were visible in several clinical rooms, walls and ceilings. There were also damp issues on the ground floor, including in one clinical area where treatment was taking place during our inspection.

We saw evidence of ongoing communication with the building owners. A detailed professional structural report had also been issued within the previous 12 months. All relevant parties acknowledged that further work was required, but the building had been assessed as structurally safe.

The practice had a current Business Continuity Plan. This clearly outlined the procedures to follow in the event of major health emergencies and long-term GP absences.

The practice must ensure that:

The condition of the building structure, including any visible structural changes, is routinely monitored and recorded.

Timely liaison takes place with the building owner and the Health Board about any required maintenance or repairs.

Appropriate action is taken to maintain a safe environment for patients, staff and visitors.

We found effective processes in place for receiving, distributing and managing patient correspondence and documents. Information from secondary care, including discharge information and test results, was recorded and acted on appropriately.

A clear workflow was in place for clinicians to review incoming correspondence, supported by an up-to-date policy. Administration staff had received training to process documents, and an audit trail we reviewed showed these were being managed appropriately.

Staff communicated internally using the task function within the electronic patient

record system. Outstanding actions were monitored by the practice manager for assurance, and any paper documentation received was scanned into the electronic system.

A designated staff member was assigned to receive and distribute patient safety alerts, with the senior partnership team stepping in as needed during their absence.

It was reported that significant events, including those impacting patient safety, were discussed at meetings across all organisational levels. There was a clear understanding that such events would be examined to identify any required changes. Documentation was provided demonstrating discussion, escalation, and learning resulting from these meetings.

Emergency equipment needed in the event of a serious cardiac incident was stored in reception. The kit was well equipped and regularly checked, and all staff were aware of its location. However, we suggested that its location should be clearly indicated on the reception door so that new or locum staff could identify it quickly. Signage showing the location of the oxygen cylinder was already in place.

Infection prevention and control (IPC) and decontamination

Respondents to our questionnaire reported seeing information displayed regarding infectious conditions and stated that hand sanitiser was available within the practice. Respondents generally stated that staff washed their hands before and after providing care or treatment. The few respondents who reported undergoing invasive procedures stated that staff used gloves, sterile equipment and cleaned the skin prior to treatment.

There was an infection control policy in place which was reviewed annually and the Lead Practice Nurse was named as IPC Lead. We saw evidence that all staff had read the policy and its updates as appropriate.

All areas of the practice appeared visibly clean and staff had access to personal protective equipment, such as gloves and disposable plastic aprons to reduce cross infection.

Hand sanitizers were readily available around the practice and hand washing and drying facilities were provided in clinical areas and toilets. We saw evidence that water temperature was monitored and was consistent.

IPC was part of the practice mandatory training programme. We saw that all clinical and non-clinical staff had completed training, at a level appropriate to their role

There was a system in place to manage waste appropriately and safely. Contract documentation was in place for the disposal of hazardous (clinical) and non-hazardous (household) waste. We saw that all waste had been segregated into the designated bags and containers in accordance with the correct method of disposal.

However, cleaning schedules for the building were incomplete and we were made aware that the subcontracted domestic service was required to dispose of clinical waste and sharps to the external depository. However, there was no indication that the individual responsible for the domestic cleaning responsibilities was covered for Hepatitis B and we made recommendations to support the individual undertaking the task.

The practice must ensure that all members of the team who are patient facing or handle clinical waste must be covered for Hepatitis B or that a risk assessment is in place to support the individual. Whilst status is being established we suggested that the nursing staff disposed of the daily clinical waste and sharps

In addition, floor cleaning mops were inappropriately stored, and the storage room was overstocked and cluttered which could pose as a health and safety risk.

The practice must ensure that the cleaning contractor follows guidance for cleaning schedules, and storage of products for use within the practice

We found that some toilet facilities lacked basic requirements. Not all units had general waste disposal bins or waste disposal for nappies. Sanitary waste bins were in each unit however not easily identified as were wall mounted and some without a lining.

The practice must ensure that each toilet facility houses a disposal unit for general waste, nappies and that sanitary bins are identified.

Medicines management

The practice had policies and procedures in place for the storage and administration of medicines. We also saw documented evidence of clear links between medicines, repeat prescribing and patient diagnoses.

We reviewed the Patient Group Directives in use at the practice. All were in date and had been appropriately signed and authorised.

Emergency medicines were stored in a tamper-evident container. The medicines refrigerator temperature was monitored electronically on a regular basis, and records were maintained as required. Other medicines and associated equipment were stored securely by the practice.

Portable oxygen cylinders were available, ready for use and appropriately stored in a cylinder holder. All staff had received training on oxygen therapy, including safe delivery and administration, in line with Betsi Cadwaladr University Health Board policy through British Oxygen Company (BOC) online training.

Safeguarding of children and adults

The practice was in the process of updating its safeguarding policy, in response to changes being made by the health board.

We saw evidence that the practice had access to the updated safeguarding flow matrix, including revised contact details and escalation routes. There were also policies and procedures in place to promote and protect the welfare and safety of children and adults who were vulnerable or at risk.

The practice had discussed and identified a named safeguarding lead. We also saw planning for upcoming safeguarding meetings to support oversight of safeguarding arrangements within the practice.

The proposed meetings included discussion of children on the child protection register and processes for escalating concerns when children did not attend appointments.

We saw that staff had undertaken safeguarding training at a level appropriate to their roles.

The practice must ensure that the policy endorsed by the health board is bespoke to their practice, is regularly reviewed and supports the named clinician for safeguarding within the practice

Management of medical devices and equipment

Portable electrical appliances were safety tested on a regular basis.

Disposable, single-use clinical equipment was used where appropriate. Annual checks and calibration of medical equipment were up to date, and the practice had arrangements in place to respond promptly to equipment breakdowns or servicing needs.

Effective

Effective care

From our discussions with staff and examination of patient records, we found that patients were receiving safe and clinically effective care. Patient records were found to contain of a good standard of clinical narrative and follow up, when needed. We saw evidence of holistic- person centred approach to the provision of care.

A range of written policies and procedures were available to support the operation of the practice. These were reviewed and updated as required.

We noted that reception staff were undertaking care signposting and symptom-screening activities, including the identification of sepsis and other potential red flag symptoms. However, the practice was unable to provide assurance that all staff had received appropriate training for these responsibilities.

The practice must ensure that all clinical staff undertake Sepsis training as part of their mandatory training and that non-clinical staff who may speak to patients on

the telephone and face to face are aware of signs and symptoms of Sepsis.

Patient records

Record entries were contemporaneous, clear, legible and of good quality. They included a clear narrative of the patient presentation and clinical assessment, the rationale for decisions made, and the advice provided. Actions taken were appropriately documented, including investigations requested, referrals made, medicines prescribed and any required safety-netting. Follow-up arrangements were recorded where relevant. The records also confirmed that clinicians consistently documented when patients gave verbal consent for examinations or treatments.

Overall, the level of detail within the records was of a high standard. This supported continuity of care by enabling other clinicians to readily understand each patient's history, clinical management and any agreed next steps.

A robust information governance framework was in place. Staff demonstrated a clear understanding of their responsibilities for accurate and secure record keeping.

Efficient

Efficient

Arrangements were in place to support the efficient delivery of safe and effective care. We identified good practice in the management of both acute and long-term conditions, with clear clinical narratives and evidence of person-centred decision-making.

Staff described appropriate arrangements for reporting significant events and sharing organisational learning. This supported reflection, improvement and a consistent approach to patient safety.

Clinical staff confirmed that robust processes were in place for receiving and sharing new evidence-based practice, including updated or newly issued NICE guidance. This helped ensure clinical practice remained current and aligned with recognised guidance.

Quality of Management and Leadership

Staff Feedback

Staff feedback was received from seven members of staff. Due to the small number of responses, findings should be interpreted with caution; however, they provide helpful insight into staff experience.

Leadership

Governance and leadership

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

The practice had arrangements for sharing information with staff, including updates to policies and procedures. Policies and procedures were stored on the shared drive, and staff were informed of changes through dedicated team meetings. A comprehensive suite of policies and procedures was in place, with appropriate version control.

Management confirmed that an open-door approach was in place, enabling staff to raise concerns, share ideas and contribute to practice improvements. Staff told us they felt involved in decisions affecting their work and were able to suggest improvements.

Clinical meetings, including multidisciplinary team meetings, were formally recorded and held at regular intervals.

Workforce

Skilled and enabled workforce

We spoke with staff across a range of roles. They demonstrated a sound understanding of their responsibilities and were committed to providing a quality service to patients.

Most staff told us they had received training appropriate to their roles, and most had received an appraisal or development review within the previous 12 months. We also saw that an induction programme was in place for new starters.

Appropriate recruitment policies and procedures were in place. The practice manager described suitable pre-employment checks for new staff before they joined the practice, including references and Disclosure and Barring Service (DBS) checks appropriate to each role. However, we noted some gaps in the recording of DBS checks. The practice manager was able to demonstrate that gaps were actively being

addressed.

Management maintained effective oversight of mandatory training compliance. This helped ensure staff continued to demonstrate the competence needed to carry out their duties safely and appropriately.

Staff, overall, described a positive work-life balance. Staff generally felt they had sufficient resources to undertake their roles, including appropriate equipment to carry out their roles.

Culture

People engagement, feedback and learning

The practice had arrangements in place to encourage and respond to patient feedback. Information displayed in the waiting area explained how patients could share their views, and we saw evidence that feedback was routinely used to support learning and service improvement.

Patients we spoke with told us they regularly saw practice management in the patient waiting areas and felt able to speak with them when needed.

The practice had a complaints policy aligned with NHS Wales Listening to People guidance. The policy clearly identified the practice manager as the person responsible for managing complaints.

Arrangements were in place to support compliance with the Duty of Candour. A Duty of Candour policy was available, and the records we reviewed showed that staff had completed relevant training. Staff we spoke with demonstrated an appropriate understanding of the subject.

Staff said appropriate measures were in place to protect patient confidentiality, privacy and dignity, and that chaperones were offered when required. Most staff reported no experience of discrimination and felt the practice supported equality, diversity and inclusion.

Information

Information governance and digital technology

The practice demonstrated a clear understanding of its responsibilities for processing information safely and securely. A current information governance policy was in place to support this.

The practice's process for handling patient data was available for review and was also

published on the practice website.

Training records confirmed that staff had completed information governance training, supporting their understanding of safe and appropriate data handling.

Learning, improvement and research

Quality improvement activities

Learning was shared across the practice through regular group staff meetings, supporting service improvement and shared understanding across the team. The practice was part of a GP cluster group. Although the cluster had been without a leader for some time, this had not prevented the practice from continuing its own development work.

We saw evidence of regular clinical audits across several topics, with staff from across the practice involved in quality improvement work. The practice also shared and reviewed data from a range of clinical areas, including infection control and immunisation activity, to support learning and improvement.

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: Strathmore Medical Practice

Date of inspection: 30 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	No immediate concerns were identified on this inspection		
Improvement needed		Standard / Regulation	
1.			
Service Action:		Responsible officer	Timescale

Appendix C – Improvement plan

Service: Strathmore Medical Practice

Date of inspection: 30 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 building in some areas showed signs of significant structural issues.	The practice must ensure that the condition of the building structure, including any visible structural changes, is routinely monitored and recorded. Timely liaison takes place with the building owner and the Health Board about any required maintenance or repairs and appropriate action is taken to maintain a safe environment for patients, staff and visitors.	Health and Care Quality Standards (2023): Safe Care – risk management and maintaining a safe environment.	While lease negotiations are ongoing, the practice is undertaking basic remedial and maintenance works to mitigate any immediate risks and maintain a safe environment for patients, staff and visitors. Structural issues relating to the fabric of the building have been reported. The practice will continue to monitor & record any visible deterioration, liaise regularly with the landlord and the Health Board, and escalate concerns where required until a permanent resolution is agreed and completed.	Practice Manager Partners	Ongoing monitoring, with the landlord until works are completed.

2.	Sepsis training had not been completed by all clinical and non-clinical staff.	The practice manager must ensure that all clinical staff undertake Sepsis training as part of their mandatory training and that non clinical staff who may speak to patients on the telephone and face to face are aware of signs and symptoms of Sepsis.	Health and Care Quality Standards (2023) safe and Effective care; Timely; Person Centred.	All nursing staff and non-clinical staff have completed Sepsis awareness training, and evidence of completion is available for review if required. GP's have been instructed to complete any outstanding Sepsis training updates and maintain compliance with mandatory training requirements. Training records will continue to be monitored through the practice training matrix to ensure ongoing compliance.	Practice Manager	Nurses and non-clinical staff completed. GP updates to be completed within 2 months allowing for annual leave and monitored thereafter.
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3.	Limited cleaning schedules, inappropriate storage of mops and overstocking of disposable products above head height unsecured.	The practice manager must ensure that the cleaning contractor follows guidance for cleaning schedules, and storage of products for use within the practice.	Health and Care Quality Standards (2023) safe and Effective Care; Person Centred; equitable; Effective.	The cleaning contractor has been instructed to follow appropriate cleaning schedules and infection prevention and control guidance. Cleaning schedules have been reviewed and are now maintained within the practice. Mop storage arrangements have been addressed, and excess stock previously stored above head height has been reorganised and secured to reduce the risk of injury. Regular audits will be undertaken to ensure ongoing compliance with cleaning and storage requirements	Practice Manager Lead Nurse	Completed and subject to ongoing monthly monitoring.
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4.	Hepatitis B immunisation status was not confirmed for some clinical and non-clinical staff who handle clinical waste.	The practice manager must ensure that all members of the team who are patient facing or handle clinical waste must be covered for Hepatitis B or that a risk assessment is in place to support the individual. Whilst status is being established, we suggested that the nursing staff disposed of the daily clinical waste and sharps	Health and Care Quality Standards (2023) safe and Effective care; Timely; Person Centred.	A review of Hepatitis B immunisation status has been undertaken for all staff who are patient-facing or handle clinical waste. Evidence of immunity/vaccination is being obtained and documented where required. Risk assessments will be completed for any staff member who is unable to provide evidence of Hepatitis B cover. In the interim, the disposal of clinical waste and sharps is being undertaken by the cleaning contractor whose staff are appropriately immunised. Immunisation records will be monitored as part of the practice's staff compliance process.	Practice Manager	Review completed and records being updated within 1 month. Ongoing monitoring thereafter
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5.	Not all public/patient toilet had a general waste bin or a bin suitable for nappy disposal. Sanitary bins although present in each toilet were wall mounted, did not all have a lining and were not easily recognisable as a sanitary waste bin.	The practice manager must ensure that each toilet facility houses a disposal unit for general waste, nappies and that sanitary bins are identified.	Health and Care Quality Standards (2023) safe and Effective Care; Person Centred; equitable; Effective	Appropriate waste disposal facilities have been reviewed in all patient and public toilet areas. General waste bins and suitable nappy disposal bins will be provided where required. Sanitary waste bins have been checked to ensure they are clearly identifiable, appropriately lined, and fit for purpose. Regular environmental audits will be undertaken to ensure facilities remain compliant and adequately stocked.	Practice Manager GL Cleaning Contractors	Within a month and will be monitored monthly
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6.	The Safeguarding policy is incomplete due to the Health Board making structural changes.	The practice manager must ensure that the policy endorsed by the health board is bespoke to their practice, is regularly reviewed and supports the named clinician for safeguarding within the practice	Health and Care Quality Standards (2023) safe and Effective Care; Person Centred; equitable; Effective	The safeguarding policy has been reviewed and was introduced beginning of July after the inspection, updated to reflect the current Health Board and local safeguarding arrangements. The policy is practice-specific, clearly identifying the named safeguarding lead clinician and outlining staff responsibilities and reporting processes. The policy will be reviewed annually, or sooner if guidance or organisational changes occur, to ensure it remains current and effective. Training and awareness of the updated policy has been communicated to all staff.	Practice Manager Safeguarding lead	Completed with annual review from July 2027
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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: Strathmore Medical Practice

Name (print): Alison Stones

Job role: Practice Manager

Date: 14/08/2026