Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Iechyd Teifi Health, Newcastle Emlyn

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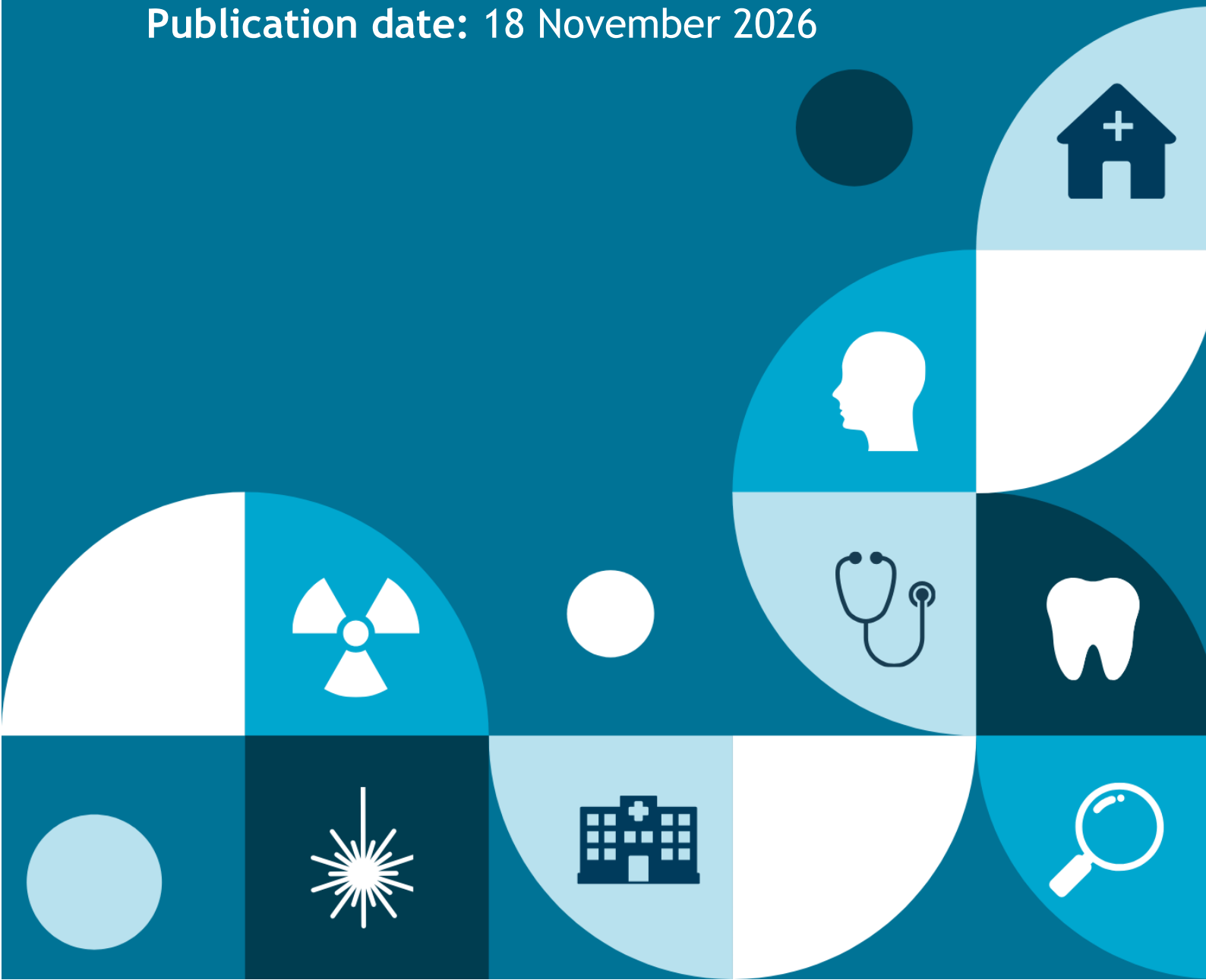

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

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 12

Quality of Patient Experience 12

Delivery of Safe and Effective Care 18

Quality of Management and Leadership 25

4. Next steps 29

Appendix A – Summary of concerns resolved during the inspection .. 30

Appendix B – Immediate improvement plan 31

Appendix C – Improvement plan 32



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 Iechyd Teifi Health, Newcastle Emlyn on 18 August 2026.

Our team for the inspection comprised of two HIW healthcare inspectors and two clinical peer reviewers.

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 six questionnaires were completed by patients or their carers and four were completed by staff.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patients received a high standard of care and reported very positive experiences across all aspects of the service. Feedback obtained from six patient questionnaires was unanimously positive, with all respondents rating the service as very good. Patients described the clinic as professional, accessible and providing timely appointments and thorough care. One patient commented that it was the "best thing ever happened to the area."

The service promoted healthier lifestyles through a wide range of health promotion information available within the clinic and on the website, covering topics such as smoking cessation, healthy eating, mental health, weight management and preventative health screening. Clinicians provided personalised advice and signposted patients to relevant support services when required.

Inspectors found that privacy, dignity and confidentiality were consistently maintained. Staff interacted with patients respectfully and professionally, confidential information was handled appropriately and facilities supported privacy during consultations and examinations. Robust arrangements were in place for the use of trained chaperones.

Effective consent processes ensured patients received clear information regarding treatment options, risks, benefits and costs before making decisions about their care. Consent was appropriately documented and patient capacity was assessed when necessary.

The clinic demonstrated a strong commitment to effective communication and the Welsh language. All staff were bilingual and routinely offered services in Welsh, ensuring compliance with the Active Offer. Patients confirmed they felt comfortable using Welsh and that healthcare information was available in their preferred language.

Care was individualised, evidence-based and delivered by appropriately qualified staff. Clear pathways existed for follow-up care, referrals, mental health support and management of test results. Patients confirmed they received appropriate aftercare

advice and guidance regarding potential complications.

The service also demonstrated a positive approach to equality, diversity and inclusion through accessible facilities, reasonable adjustments and staff training. Patient feedback was actively sought and had informed service improvements. However, further work was required to ensure information about feedback was consistently included within the patients' guide and other patient information resources.

This is what we recommend the service can improve:

- Providing information about patients' feedback results within the patients' guide and made readily available to patients
- Implementing a more structured patient survey process to strengthen citizen engagement and service improvement.

This is what the service did well:

- Consistently positive patient feedback, with all respondents rating the service as very good and praising the professionalism, accessibility and quality of care
- Arrangements to protect patients' privacy and confidentiality
- A patient-centred approach to communication, with all staff able to provide services bilingually and patients routinely offered the opportunity to communicate in Welsh throughout their care
- Care and treatment were tailored to patients' needs and delivered within an inclusive environment.

Delivery of Safe and Effective Care

Overall summary:

The service provided safe and effective care within a well-maintained, secure and appropriately governed environment. Premises were clean, fit for purpose, free from hazards and supported by robust security, fire safety and health and safety arrangements. Comprehensive risk assessments, emergency planning processes and clear staff responsibilities contributed to the safe operation of the service.

Strong infection prevention and control (IPC) arrangements were evident throughout the clinic. The service had an identified IPC lead, comprehensive policies, regular audits, staff training and effective waste management systems. Clinical areas were visibly clean, reusable equipment was appropriately decontaminated and all patients who responded to the questionnaire agreed that the environment was clean and that IPC measures were being followed.

Medicines management arrangements were generally positive. Secure storage, effective cold-chain management, documented monitoring processes and good standards of medicines administration records were observed. Emergency medicines and equipment were available and regularly checked. However, improvements were required in relation to emergency preparedness, including weekly checking of emergency medicines, availability of oxygen cylinders, provision of paediatric AED pads and improved signage for emergency equipment.

Effective safeguarding arrangements were in place, supported by clear leadership, policies aligned with Wales Safeguarding Procedures, staff awareness and accessible guidance. Medical devices and equipment were appropriately maintained, calibrated and serviced, ensuring they remained safe and suitable for patient care.

Clinical care was delivered in line with evidence-based practice, supported by recognised guidance, clinical updates, staff appraisal processes and professional revalidation arrangements. Quality assurance systems were established and included audits, risk assessments, feedback mechanisms and community health initiatives. However, the service had identified opportunities to further strengthen clinical audit activity and outcome monitoring across the full range of treatments provided.

Patient information and records were managed securely using electronic systems. A

review of patient records demonstrated high standards of documentation, including evidence of consent, risk assessment, clinical decision-making and person-centred care. Minor improvements were identified regarding record coding and the completeness of demographic information to support future quality improvement activity.

This is what we recommend the service can improve:

- Emergency medicines equipment and checks to be in line with best practice
- Complete a comprehensive programme of clinical audit and quality assurance
- Provide relevant staff with appropriate training in medical record coding and ensure this coding is regularly audited.

This is what the service did well:

- Comprehensive IPC systems supported by a clean, well-maintained clinical environment.
- Patient records were clear, accurate, contemporaneous and person-centred
- Ensured the premises were safe, secure and well maintained, supported by comprehensive risk assessments and clear emergency planning processes
- Delivering care in accordance with recognised clinical guidance and supported by effective governance arrangements.

Quality of Management and Leadership

Overall summary:

There was a positive culture, strong leadership and effective governance arrangements that supported the delivery of safe, high-quality care. Feedback received from the four staff members who responded to the HIW questionnaire was entirely positive, with staff describing the practice as a relaxed, happy and enjoyable place to work. Although the number of responses was too low to identify consistent themes, the feedback reflected a supportive and welcoming workplace culture.

Governance arrangements were comprehensive and well established. The service operated in accordance with its statement of purpose, which was current and compliant with legislative requirements. Clear accountability and reporting structures were in place, and policies were reviewed regularly through a structured process. Staff were informed of policy updates and formally acknowledged changes. Leaders were visible, approachable and promoted an open-door culture, contributing to strong teamwork and effective communication across the practice.

A positive approach to managing complaints, incidents, and learning was in place. Although no formal complaints had been received, robust procedures were in place to investigate concerns fairly and promptly. Patient feedback was actively encouraged and had contributed to improvements in practice processes. The organisation showed a clear understanding of its responsibilities under the Duty of Candour, with evidence of openness and transparency when responding to a data breach.

Recruitment processes were good and included comprehensive pre-employment checks to ensure staff suitability. Personnel records reviewed during the inspection evidenced compliance with recruitment requirements and staff were appropriately qualified, experienced and supported through induction and appraisal arrangements.

Workforce planning and training arrangements ensured adequate staffing levels and safe service delivery. Staff worked within their scope of practice, received supervision and appraisal and had completed mandatory and role-specific training. However, there was a need for ongoing annual declarations of staff fitness to practise and relevant staff had not yet completed medicines management training.

This is what we recommend the service can improve:

- Ensure relevant staff complete medicines management training and maintain competency in this area
- Display complaints information more prominently within the practice to improve patient awareness of how concerns can be raised.

This is what the service did well:

- Strong leadership and governance arrangements, with clear accountability, policy management and visible, approachable leaders
- Positive workplace culture, evidenced by supportive teamwork, staff morale and positive staff feedback
- Effective complaints and incident management, promoting openness, learning, service improvement and compliance with the Duty of Candour
- Safe recruitment and workforce management, including structured inductions, appraisals and appropriate staffing levels.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at the clinic for the inspection in July 2026. In total, we received six responses from patients at this clinic. All patients agreed that the service they received was 'very good'. Patients commented that:

> *"A really special service offering quick, thorough appointments without having to wait weeks to see a doctor. Very happy."*
>
> *"Only praise. This place offers a very high standard of service provided by totally professional staff."*
>
> *"The service I have received has always been extremely professional."*

A patient we spoke with said:

> *"Best thing ever happened to the area, I am lucky, I can afford the treatment here."*

Health promotion, protection and improvement

Patients were supported to live healthier lives through the provision of a range of health promotion resources. Information on smoking cessation, healthy eating, alcohol awareness, blood pressure management, mental health and wellbeing was available within the reception area and on the practice website. Additional information was provided on the practice website relating to the benefits of allergy testing, health and wellbeing medicals and weight loss management. Information was also provided by a monitor in the reception area.

During consultations, particularly weight management appointments, we were told that clinicians offered personalised advice and signposted patients to relevant resources. Evidence was seen of proactive health monitoring, screening and early identification of concerns. Where specialist lifestyle support was required, patients were referred to appropriate private services.

Dignity and respect

Evidence observed during the inspection indicated that patients' privacy, dignity and confidentiality were consistently respected. Staff interacted with patients in a professional, respectful and sensitive manner and were discreet when discussing patient information. No confidential conversations were observed being conducted in areas where they could be overheard. Background music in the reception area further helped to maintain confidentiality and reduce the risk of conversations being heard by others. Telephone calls at reception were managed appropriately, with staff only receiving personal information and not disclosing confidential details.

Clinical rooms provided appropriate levels of privacy, with consultation and treatment room doors kept closed during appointments. Privacy curtains were available in examination rooms and external windows were suitably screened to prevent overlooking.

The service had a comprehensive chaperone policy in place, which stated all patients were routinely offered a chaperone where appropriate. The policy required chaperones to have completed suitable training and relatives or friends would not be considered impartial chaperones, in line with professional guidance.

In the patient questionnaire all respondents strongly agreed staff treated them with dignity and respect and protected their privacy. Patients said staff explained what they were doing, they were involved in decisions about their healthcare, listened and answered questions.

Patient information and consent

Appropriate arrangements were in place to ensure patients received the information they needed to make informed decisions about their care and treatment. We were told that consent processes were tailored to the type of consultation or intervention, with implied, verbal, or written consent obtained and documented as appropriate. Written consent forms were provided in advance where required and discussed with patients before treatment. Evidence demonstrated that patient capacity was assessed when necessary.

Patient consent was recorded within clinical records, with signed consent forms scanned and retained in patient notes. Information regarding language and

communication preferences was obtained prior to the first consultation. The service had a written consent policy in place, supported by consent information displayed in consultation rooms and specific consent forms for higher-risk procedures.

Systems were in place to confirm changes to patients' medical history or conditions at each consultation, with updates routinely sought by reception and clinical staff, documented in records. Information was shared with other healthcare professionals, including GPs, where appropriate and with patient consent. Where consent to share information was withheld, this was respected and documented, although treatment options could be reviewed where non-disclosure created clinical risks.

All patients who received treatment confirmed consent was obtained before new treatment and they received sufficient information about treatment options, risks and benefits.

Communicating effectively

There was a patient-centred approach to communication and information sharing to ensure patients received clear, accurate and accessible information to support informed decision-making about their care and treatment. All staff were able to communicate in both Welsh and English, enabling the needs of Welsh-speaking patients to be met effectively. Patients were routinely greeted and supported in Welsh, reflecting the service's commitment to bilingual communication. We were told that translation arrangements could be made available as required.

A Provision of Information to Patients Policy was in place and outlined the information provided before, during and after treatment. We were told that patients received explanations of proposed treatments, expected benefits, potential risks, alternative options, aftercare requirements and associated costs, with opportunities to ask questions before giving consent. Treatment options, post-treatment advice and fees were communicated by clinicians and were also available on their website.

Patients could access appointments through telephone, face-to-face, or online booking systems, helping to accommodate those without digital access. Information on providing feedback was available through comment boxes and online reviews.

All patients in the questionnaire said that costs were explained before the treatment. In

total five of the six respondents said their preferred language was Welsh. They all stated:

- They were actively offered the opportunity to speak Welsh throughout your patient journey
- They felt comfortable using the Welsh language within the clinic environment
- Healthcare information was available in Welsh.

All members of staff were Welsh speakers but there was nothing to identify them as Welsh speakers, However, all patients were greeted in Welsh, to indicate that the practice complied with the 'Active Offer' of Welsh to patients.

Care planning and provision

Effective arrangements were seen to ensure patients received the right care, at the right time, from appropriately qualified staff. Patients had the choice of consultation type determined by patient preference, supported by clinical judgement where a more suitable approach was identified. Patients were encouraged to maintain contact with the service before, during and after treatment through telephone, email, or in-person communication.

Appropriate pathways were described to support patients experiencing mental health concerns or crisis. Staff were able to signpost patients to NHS crisis services, secondary care, commissioned services and third-sector support organisations. Risks were managed through ongoing monitoring, safety-netting and follow-up arrangements where required.

Care and treatment was described as individualised and based on comprehensive assessments of patients' health and wellbeing needs. Treatment plans were developed collaboratively, with patients given additional time to discuss options and participate in shared decision-making. Clinical care was informed by recognised evidence-based guidance.

Patients were provided with clear information about their treatment, medications, aftercare requirements and recovery expectations. Accessible communication methods were available, including written information and a hearing loop for patients with sensory needs. Systems were in place for managing test results, referrals and

follow-up care. Abnormal findings were discussed directly with patients by a clinician, ensuring appropriate explanation, management and onward referral where necessary.

All patients in the questionnaire agreed they received appropriate aftercare instructions and they received clear guidance regarding infection or emergency concerns.

Equality, diversity and human rights

The premises, services and information were accessible, with evidence that the needs of individuals with protected characteristics were considered and accommodated appropriately.

The service demonstrated a positive and inclusive culture that promoted equality, diversity and human rights. Staff completed mandatory equality and diversity training, supported by induction processes, regular reviews, team meetings and appraisals to reinforce awareness and compliance. An up-to-date policy was in place, with clear review arrangements and procedures for reporting discrimination. The policy reflected the organisation's commitment to equal opportunities and compliance with the Equality Act 2010.

The practice had implemented a range of reasonable adjustments to support equitable access to services, including a wheelchair-accessible entrance, disabled parking, an accessible toilet with handrails and a hearing loop. Staff advised that information could be provided in larger print where required. The rights and dignity of transgender patients were respected, with staff recognising and using patients' preferred names throughout their care journey.

All patients in the questionnaire agreed that the building was accessible and that they could access the right healthcare at the right time regardless of any protected characteristics.

Citizen engagement and feedback

This review found that the service actively sought patient feedback through a variety of mechanisms, including online reviews and a comments box available within the practice. Feedback requests were issued periodically to a proportion of patients and the results were displayed within the service and published on the Trustpilot platform.

Staff also considered patient comments as part of the appraisal process to support ongoing learning and service development.

Evidence demonstrated that patient feedback had been used to inform improvements. Examples included the installation of a handrail within the toilet facilities to enhance accessibility, clearer communication of treatment costs and improved information regarding the potential need for additional cryotherapy treatments and associated charges.

Whilst arrangements were in place to gather and review patient feedback, opportunities remain to strengthen this process. Information on how patients could provide feedback or make a complaint was included within the patients' guide and on the service website. Consideration should be given to introducing a structured patient survey process and ensuring that summaries of patient feedback and resulting service improvements are routinely shared with patients. The online service used for feedback had overwhelmingly positive result about the experience of patients at the setting. To strengthen patient feedback arrangements and to comply with relevant regulations, feedback information must be included within the patients' guide and on the website.

The registered manager must ensure that feedback information is included within the patients' guide.

Delivery of Safe and Effective Care

Environment

The premises were safe, secure and fit for purpose. Clinical areas were clean, well maintained, free from clutter and trip hazards and designed to support effective cleaning and infection prevention. Furniture, fixtures, fittings and equipment were in good condition, with no areas requiring maintenance identified during the inspection.

Appropriate security measures were in place to protect the premises from unauthorised access, including CCTV, an alarm system linked to management personal phones, controlled access arrangements and secure storage of staff and clinical areas. Evidence of current Portable Appliance Testing (PAT) was available, providing assurance that electrical equipment was safe to use.

Comprehensive fire safety arrangements were in place and supported by an up-to-date fire safety policy, clearly defined staff responsibilities and there was a current fire risk assessment, with identified actions completed. Fire safety systems were subject to regular monitoring and testing, including weekly fire alarm checks, monthly emergency lighting and extinguisher inspections and six-monthly fire drills with documented debriefs and actions.

Fire exits and escape routes were clearly signposted and free from obstruction, emergency procedures were displayed, fire extinguishers were available and serviced and appropriate maintenance arrangements were in place for fire safety equipment.

Managing risk and health and safety

A range of up-to-date health and safety risk assessments were in place to support the safe operation of the service, including assessments relating to Control of Substances Hazardous to Health (COSHH), infection prevention and control, manual handling, slips, trips and falls. The premises, including clinical rooms had appropriate safety signage displayed throughout. Sharps containers were securely positioned and appropriately managed.

Suitable arrangements were in place to respond to emergencies, supported by a Business Continuity Plan that included key contact information, access arrangements for patient records and processes for managing appointments during service

disruption. Opportunities were identified to further strengthen contingency planning for power outages, electrical failures and water ingress. Staff demonstrated an understanding of their roles and responsibilities during emergencies, supported by regular fire drills and training. A suitable first aid kit was available and an appropriately trained first aider was always available on duty.

Infection prevention and control (IPC) and decontamination

Comprehensive arrangements were in place to uphold IPC standards and protect patients from healthcare-associated infections. The service had a designated IPC Lead and staff demonstrated a clear understanding of their responsibilities in maintaining effective IPC practices. An IPC policy was in place, supported by regular staff training, risk assessments, audits and established governance processes.

Appropriate measures were in place for the safe management and disposal of clinical waste, including sharps, dressings and personal protective equipment. Clinical waste was securely stored prior to collection by an approved waste contractor, with clear procedures for segregation, storage, transportation and disposal. Sharps containers were appropriately located and managed and safer sharps devices were used where possible.

The clinical environment was visibly clean, uncluttered and maintained in a good state of repair, enabling effective cleaning and decontamination. Shared equipment and reusable medical devices were cleaned after each use, stored appropriately and decontaminated in accordance with local procedures. Suitable hand hygiene facilities, personal protective equipment (PPE), foot-operated waste bins, cleaning schedules and blood-borne virus arrangements were in place throughout.

Staff had completed appropriate IPC training and all relevant clinical staff had received Hepatitis B immunisation. Policies and protocols were available to support staff in managing needlestick and sharps injuries, with evidence demonstrating staff awareness of these procedures. Regular hand hygiene, IPC, medicines management and clinical audits were undertaken, with records available from 2024 to 2026, demonstrating ongoing monitoring and improvement.

Patients were further protected through infection risk assessments, access to facilities that enabled the segregation of patients when required, routine environmental cleaning and effective incident reporting processes. Staff reported having access to the

equipment, resources and support necessary to maintain high standards of infection prevention and control.

All patients, in their questionnaire agreed the setting was very clean and that IPC measures were being followed.

Medicines management

A review of a random sample of ten patient medication records and medicines management arrangements found that robust systems were in place to support the safe ordering, storage, prescribing, administration, monitoring and disposal of medicines. Medication administration records reviewed were consistently completed to a good standard, with patient identifiers, allergy information, prescribed medicines and administration details clearly documented and signed appropriately.

Effective medicines governance arrangements were evident. Vaccines and other cold-chain products were stored within dedicated clinical refrigerators maintained between the recommended temperatures, with fridge temperatures monitored and recorded twice daily. Staff followed an up-to-date Cold Chain Policy and appropriate procedures were in place to respond to temperature excursions. Medicines were stored securely, monitored appropriately and all medicines reviewed during the inspection were within their expiry dates.

Clear accountability for medicines management was established, with day-to-day responsibilities delegated to the practice nurse and overall oversight provided by the clinical director. Systems were in place for reporting adverse drug reactions through the Yellow Card scheme and for the safe disposal of expired medicines and sharps.

Emergency medicines and equipment, including an automated external defibrillator (AED), were available, in date and subject to regular documented checks. Although there were not paediatric pads available. Staff had received basic life support training and were aware of emergency response procedures. However, emergency medicines were being checked monthly rather than weekly and did not include a list of all emergency drugs held and expiry dates. In addition, no oxygen cylinder was available on site and the practice manager had been asked to review this arrangement. Until the relevant oxygen cylinders are in place the setting had drafted a risk assessment. Consideration should also be given to improving signage identifying the location of emergency equipment and medicines.

The registered manager must ensure:

- **Emergency medicines include a list of individual medications with dates and are checked weekly**
- **Oxygen cylinders are available for use as required and staff receive the appropriate training in their use**
- **AED pads are available for all ages**
- **Appropriate signage must be displayed to identify the location of emergency equipment and medicines.**

Safeguarding children and safeguarding vulnerable adults

Systems, leadership and guidance were in place to ensure safeguarding concerns were managed effectively. The safeguarding policy aligned with relevant legislation, national guidance and Wales Safeguarding Procedures. The safeguarding policy provided clear direction on recognising, reporting and escalating concerns, including procedures relating to children who were not brought to appointments, repeated cancellations and potential indicators of neglect or abuse.

Clear safeguarding leadership arrangements were in place, with the responsible individual acting as safeguarding lead and the registered manager as the deputy. Staff were aware of reporting processes and understood the action required if safeguarding concerns were identified. A safeguarding guide was available on the staff notice board, the registered managers' office and reception.

Children were permitted on the premises and the environment was observed to be safe, with no hazardous items accessible to them. Staff had access to safeguarding and whistleblowing policies and procedures to support the reporting of concerns. Concerns identified by staff would be escalated promptly to the safeguarding lead, who would act in accordance with established policies, training and local safeguarding procedures.

Medical devices, equipment and diagnostic systems

There were suitable processes in place to ensure equipment was used safely and effectively. Single-use equipment was utilised wherever possible and a designated individual was responsible for overseeing equipment and device safety checks.

Records of inspections and checks were maintained and available for review. Equipment observed during the inspection was in good condition, appropriately stored and suitable for the needs of patients.

Service and maintenance arrangements were supported through formal contracts. Documentation demonstrated that equipment had been installed, calibrated and serviced in accordance with manufacturers' recommendations. Clear procedures were in place for reporting faults, maintaining fault records and arranging prompt repair or replacement through approved contractors, helping to ensure continuity and safety of service provision.

Safe and clinically effective care

We found that patients were provided with safe and effective care supported by evidence-based clinical practice. National and local guidance, including the National Institute for Health and Care Excellence (NICE), the British National Formulary (BNF) and Eolas, an online healthcare application, resources, informed clinical decision-making and treatment delivery. New and revised clinical guidelines were reviewed by the relevant healthcare professional and communicated to staff through email or locally stored information systems.

National and local safety alerts were received through established NHS channels, with relevant updates incorporated into policies and shared with staff. Staff development was supported through annual appraisals, which identified learning and development needs. Medical practitioners also participated in annual appraisal and revalidation processes, providing assurance that professional knowledge, skills and competencies were maintained.

Nursing staff we spoke with said they had appropriate time to deal with their patients and that they were informed of diabetes and immunisation updates.

Participating in quality improvement activities

Several mechanisms were in place to monitor and improve the quality and effectiveness of care. Quality assurance activities included IPC audits, risk assessments, patient feedback and community health promotion initiatives such as blood pressure monitoring events and health screening programmes. Evidence was seen of audit activity relating to diabetes care, which had identified opportunities for improvement and supported service development.

The service recognised the value of further developing its clinical audit programme and outcome monitoring processes. While data was collected on some aspects of care, there was limited analysis of clinical outcomes and complications across the range of treatments provided. The practice acknowledged this as an area for future development to strengthen assurance regarding the effectiveness and quality of services.

The registered manager must ensure clinical audit including audit and quality assurance of work carried out, injections, procedures to establish discernible benefit, medical records and weight loss audits.

An annual return as required by the Independent Health Care (Wales) Regulations 2011 had been completed. This covered the governance, patient experience, clinical quality, safeguarding, infection prevention and control, medicines management, risk management, information governance and continuous improvement. Learning from audits, incidents, complaints and patient feedback was used to inform service improvements. Staff were also aware of the requirements for notifying Healthcare Inspectorate Wales (HIW) of notifiable events, although no such notifications had been required to date.

Information management and communications technology

Patient information and records were managed in a safe and secure manner. The service primarily maintained electronic records, with any paper registration documents transferred to electronic systems and subsequently destroyed. Access to patient information was controlled through individual user logins and password-protected systems.

Remote consultations were offered where appropriate and were based on patient preference alongside clinical judgement. Intimate consultations were not conducted remotely. We were told that consultations were undertaken in a secure clinical environment, with patients responsible for ensuring privacy at their location. No consultations were recorded. Where images were obtained, they were securely uploaded to the clinical system and deleted from local devices in accordance with the practice's data protection arrangements.

An up-to-date Data Protection Policy was in place, providing guidance on preventing

unauthorised access, unlawful processing and the loss or destruction of personal information. Clear responsibility for data protection had been assigned, with named leads overseeing compliance and policy review.

Records management

A review of 20 patient records found that record keeping was of a high standard and provided clear evidence of safe, effective and person-centred care. Records were consistently clear, accurate, legible, contemporaneous and well organised, enabling care and treatment decisions to be easily understood and followed. Documentation included relevant clinical findings, treatments provided, investigations undertaken, medicines prescribed, decisions made, agreed actions and the identity of the clinician making each entry.

Evidence demonstrated that informed consent was routinely obtained and appropriately documented, including assessments of mental capacity where required. Records showed that patients received comprehensive information about their condition, treatment options and management plans, with shared decision-making clearly reflected throughout. Chaperone offers were also documented where appropriate.

Patient needs and risks were appropriately assessed, with records demonstrating that individual circumstances were considered when planning and delivering care. Relevant medical history, medication details, allergies and adverse reactions were routinely recorded and medicines management documentation was thorough.

The service utilised a commercial electronic records system, which provided secure and accessible record management. A minor area for improvement was identified regarding the completeness of patient demographic information, as some records did not consistently record sex, gender, or title. Improving data completeness would support future audits, service evaluation and quality improvement activity. The medical record coding could be further improved through additional training and checking that staff coding are aware of the correct actions to take and through auditing the coding.

The registered manager must ensure staff receive the appropriate training for coding medical records and that the medical coding is audited on a regular basis.

All patients in the questionnaire agreed their medical history was checked.

Quality of Management and Leadership

Staff Feedback

HIW issued an online questionnaire to obtain staff views on services carried out by the setting and their experience of working there. We received four responses from staff, which were all positive. Due to the low number of responses we were unable to draw any conclusions or themes from these replies. Staff comments included:

> *"It's a relaxed and happy place to work."*
>
> *"A lovely place to work in."*

Governance and accountability framework

There was a positive, welcoming and supportive culture within the service. Staff demonstrated strong teamwork and professionalism, spoke positively about working within the practice and described a supportive environment under effective leadership and management arrangements.

The service was well led and managed, with appropriate governance arrangements in place to support safe and effective care. The statement of purpose was available, up to date, dated appropriately and contained all information required by legislation. Services were being delivered in accordance with the statement of purpose.

Clear lines of accountability, reporting and responsibility were in place. The registered manager oversaw the review of policies and procedures, which were reviewed periodically and updated immediately when required. Staff were informed of new and revised policies and acknowledged receipt through a formal sign-off process. A master policy index was maintained to monitor review dates and ownership.

Processes were in place to act on safety notices from Welsh Government and the Medicines and Healthcare products Regulatory Agency (MHRA), with information cascaded to relevant staff. The HIW registration certificates was prominently displayed, registration requirements were being met and appropriate employer and public liability insurance was in place. Staff and managers demonstrated a clear understanding of their roles, responsibilities and reporting lines, while leaders were visible, approachable and maintained an open-door policy.

Dealing with concerns and managing incidents

There was a positive culture of openness, learning and continuous improvement. Appropriate and effective processes were in place for managing complaints, concerns and patient feedback. Information regarding the complaint's procedure was included within the patients' guide, available online and could be provided in alternative formats, including Welsh and large print, to meet individual communication needs. However, consideration must be given to displaying complaints information more prominently within the service.

The registered manager must ensure that complaints information is displayed more prominently in the setting.

A clear and up-to-date complaints policy was in place, outlining timescales for acknowledgement, investigation, review and escalation. The registered manager was responsible for handling complaints and ensuring concerns were investigated openly, fairly and in a timely manner. Learning from complaints, concerns and significant events was shared with staff through meetings and incorporated into service improvements where appropriate.

Although the service had not received any formal complaints, evidence demonstrated that concerns would be responded to promptly and that feedback had informed changes to working practices, including processes relating to blood test requests. Patient suggestions were actively encouraged and displayed within the practice.

The service demonstrated an understanding of its responsibilities under the Duty of Candour. An up-to-date Duty of Candour policy was available and evidence was seen of an open and transparent response following a data breach, including disclosure to the patient and an apology. Staff were also aware of procedures for notifying HIW of relevant incidents.

Workforce recruitment and employment practices

The service demonstrated a safe and effective recruitment process that supported the health, safety and welfare of patients. There were appropriate recruitment processes in place to support the safe employment of suitably qualified and competent staff. An up-to-date recruitment policy outlined procedures for recruitment, selection and retention, including comprehensive pre-employment checks. These included

verification of identity, right to work, professional registration, qualifications, employment references, health screening and Disclosure and Barring Service (DBS) checks.

The registered manager was responsible for verifying and monitoring professional registration to ensure healthcare professionals remained appropriately registered with their regulatory bodies. Systems were also in place at recruitment to confirm that staff possessed the necessary qualifications, skills, training and experience to undertake their roles safely and effectively.

Whilst no concerns were identified regarding staff suitability, there needed to be periodic checks or annual declarations to provide ongoing assurance that staff remain fit and suitable to work. During the inspection, a draft form was devised which we were told would be used annually by staff to self-certify their suitability to work at the setting. This was dealt with at Appendix A.

A review of two staff personnel files found that appropriate recruitment documentation and pre-employment checks were in place, providing assurance that the service had implemented safe recruitment processes to protect patients' health, safety and welfare.

Induction records were available for both staff members and appraisal arrangements were in place, with annual appraisals either recently completed or scheduled. The records demonstrated that staff were suitably qualified, experienced and supported to undertake their roles.

No concerns were identified regarding staff suitability and the overall standard of recruitment and personnel records reviewed was satisfactory, demonstrating compliance with key recruitment requirements and providing assurance that appropriate safeguards were in place.

Workforce planning, training and organisational development

Staffing arrangements were in place to ensure patients received safe and effective care from suitably qualified and competent staff. Roles, responsibilities, accountability arrangements and reporting structures were clearly defined and understood by staff, with comprehensive job descriptions available for all roles.

Staff worked within their individual scope of practice, supported by relevant qualifications, experience, ongoing professional development and regular appraisal processes. Workload allocation was appropriate to each staff member's competence and level of autonomy, with suitable clinical supervision and regular team meetings providing additional oversight and support. Prescribing clinicians worked within agreed prescribing competencies and scope of practice.

The service maintained sufficient staffing levels to meet patient demand, with appropriate clinical cover available each day. Appointment availability was managed to ensure patients were only booked when a suitably qualified clinician was available. Structured induction arrangements were in place for new staff, supported by a formal induction checklist covering key aspects of the role and working environment.

Staff were encouraged to undertake continuing professional development and additional training relevant to their responsibilities. Mandatory training compliance was monitored and staff were supported through regular appraisals, supervision and team meetings. Clear processes were in place for raising concerns, with staff aware of reporting lines, whistleblowing procedures and their ability to raise issues with HIW if required.

A review of two staff records found clear evidence that all mandatory and role-specific training requirements had been completed and maintained. Staff had undertaken mandatory training in all relevant areas apart from medicines management. Additional training relevant to individual roles had also been completed. The records demonstrated that staff were generally appropriately qualified, experienced and competent to carry out their duties safely and effectively

The registered manager must ensure that relevant staff are trained in medicines management.

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
Whilst no concerns were identified regarding staff suitability, there was not a periodic check or annual declaration in place to provide ongoing assurance that staff remained fit and suitable to work at the setting.	Staff employed at the setting may not be fit and suitable to work at the setting due to their potential DBS status.	The practice manager was informed and a draft form was devised which we were told would be used annually for staff to self-certify that they remained fit and suitable to work at the premises.	The practice manager produced a draft form and agreed to ensure that staff completed an annual declaration to provide ongoing assurance that staff remained fit and suitable to work at the setting.

Appendix B – Immediate improvement plan

Service: **Iechyd Teifi Health, Newcastle Emlyn**

Date of inspection: **18 August 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			
Improvement needed		**Standard / Regulation**	
1.	No immediate non-compliance issues,		
Service Action:		**Responsible officer**	**Timescale**

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role: **Date:**

Appendix C –Improvement plan

Service: **Iechyd Teifi Health, Newcastle Emlyn**

Date of inspection: **18 August 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.	To strengthen patient feedback arrangements and to comply with relevant regulations, feedback information must be included within the patients' guide and on the website.	The registered manager must ensure that feedback information is included within the patients' guide.	National Minimum Standards - Citizen engagement and feedback. Independent Health Care (Wales) Regulations 2011, Regulation 7 (e).	The patient guide has been reviewed and updated to include clear information on how patients can provide feedback, including compliments, comments, concerns and complaints. Information regarding how patients can provide feedback has	Practice Manager	Completed October 2026

				also been added to the website. Arrangements will be reviewed periodically to ensure the information remains accurate and accessible to patients.		
2.	There were not paediatric pads available for the AED. Emergency medicines were being checked monthly rather than weekly and did not include a list of all emergency drugs held and expiry dates. In addition, no oxygen cylinder was available on site and the practice manager had been asked to review this arrangement. Consideration should also be given to improving signage identifying the location of emergency equipment and medicines.	The registered manager must ensure: • Emergency medicines include a list of individual medications with dates and are checked weekly • Oxygen cylinders are available for use as required and staff receive the appropriate training in their use • AED pads are available for all ages • Appropriate signage must be displayed to identify the location of emergency equipment and medicines.	National Minimum Standards - Medicines management. Independent Health Care (Wales) Regulations 2011, Regulation 15.	Arrangements for emergency medicines and equipment have been reviewed and strengthened. *A comprehensive emergency medicines checklist has been introduced , detailing each individual medicine held, quantity and expiry date. Emergency medicines and equipment are now checked and documented **weekly.**	Practice Manager	October 2026

				***Paediatric AED pads have been obtained** and are available for use when required. *An **oxygen cylinder has been obtained** and is available on site, together with the appropriate equipment. Staff will receive appropriate training in the safe use of oxygen and emergency equipment. *Clear **signage identifying the location of emergency medicines** and equipment has been displayed appropriately.		
3.	While data was collected on some aspects of care,	The registered manager must ensure clinical	National Minimum Standards -	Future clinical audits/analysis will be	GP	To be completed within 12 months

	there was limited analysis of clinical outcomes and complications across the range of treatments provided. The practice acknowledged this as an area for future development to strengthen assurance regarding the effectiveness and quality of services.	audit including audit and quality assurance of work carried out, injections, procedures to establish discernible benefit, medical records and weight loss audits.	Participating in quality improvement activities. Independent Health Care (Wales) Regulations 2011, Regulation 9 (o).	designed and distributed with enhanced processes for obtaining active feedback on outcomes /complications and patient satisfaction.		Agree audit programme - End of Oct 26 Complete first audit of anti-wrinkle injections/procedures by the End of Dec 26 Annual audit cycle complete by End of Sep 27
4.	The medical record coding could be further improved through additional training and checking that staff coding are aware of the correct actions to take and through auditing the coding.	The registered manager must ensure staff receive the appropriate training for coding medical records and that the medical coding is audited on a regular basis.	National Minimum Standards - Records management. Independent Health Care (Wales) Regulations 2011, Regulation 23.	All relevant staff involved in entering or coding information within patient medical records will undertake appropriate training to ensure coding is accurate, consistent and applied correctly. A medical record coding audit will be introduced to provide ongoing assurance.	Practice Manager	Training to be completed by 31st December 2026 with ongoing monitoring thereafter.

				A sample of patient records will be reviewed at regular intervals to assess the consistency of coding.		
5.	Consideration must be given to displaying complaints information more prominently within the service.	The registered manager must ensure that complaints information is displayed more prominently in the setting.	National Minimum Standards - Dealing with concerns and managing incidents. Independent Health Care (Wales) Regulations 2011, Regulation 24.	Complaints information has been reviewed and is now displayed prominently within the clinic.	Practice Manager	October 2026
6.	A review of two staff records found staff had undertaken mandatory training in all relevant areas apart from medicines management.	The registered manager must ensure that relevant staff are trained in medicines management.	National Minimum Standards - Workforce planning, training and organisational development. Independent Health Care (Wales) Regulations 2011, Regulation 20, 2 (a).	The staff training matrix has been reviewed and medicines management training has been identified as mandatory for all relevant staff. Staff will soon be enrolled on	Practice Manager	Training to be completed by 31st October 2026 with ongoing monitoring thereafter.

				appropriate medicines management training and will complete this within the agreed timescale. Completion certificates will be retained and recorded on the clinic's mandatory training matrix.		

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: Rhian James

Name (print): Rhian James

Job role: Practice Manager **Date: 5th October 2026**