Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Lansdowne Surgery, Cardiff and Vale University Health Board

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Lansdowne Surgery, Cardiff and Vale University Health Board on 27 March 2023.

Our team for the inspection comprised of one HIW Healthcare Inspector and three clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 34 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that the service worked hard to provide a caring, professional, and positive experience to patients. Throughout the inspection we witnessed clinical and non-clinical staff speaking to patients and their carers in a kind and helpful manner. We saw that patient dignity and privacy was upheld. This was evidenced by a dedicated confidentiality booth integrated into the reception space that was available for sensitive conversations between patients and the reception team.

The practice had a supply of patient information leaflets and benefitted from a number of wellbeing initiatives run as part of the neighbourhood care network. These included a parkrun with the practice team and a gardening project to combat loneliness and social isolation.

We found arrangements for patients wishing to converse through the medium of Welsh required improvement.

This is what we recommend the service can improve:

- Develop and encourage the Welsh 'Active Offer'
- Provide consent forms and written information in a range of formats (e.g. Easy-Read, large print)
- Implement a 'You said, we did' system to encourage participation in patient feedback and suggestions.

This is what the service did well:

- Provision of a variety of ways to book appointments, including telephone, mobile application and in-person
- Modern, welcoming, and bright practice with parking facilities and level access for patients and their carers as well as a hearing loop system
- Patient confidentiality booth for provision of sensitive or confidential conversations with the reception team
- Access to wellbeing initiatives such as a parkrun and social gardening project.

Delivery of Safe and Effective Care

Overall summary:
Our findings demonstrated a dedicated clinical team who strived to provide their patients with safe and effective care. However, we noted significant

improvements were required in medicines management procedures and infection prevention and control (IPC) practices.

We found patient medical records to be comprehensive with minor improvements required to ensure appropriate Read coding.

We confirmed the correct storage of refrigerated medicines with appropriate data logging and temperature checks. However, the key to the medicine's refrigerator must be available at all times to prevent an unintended breach in the cold chain.

Immediate assurances:
HIW were not assured that the practice had in place suitably robust procedures to ensure safe and effective medicines management and medical device maintenance. During the inspection, HIW found areas of concern relating to ineffective and inappropriate medicines management at the practice. These included insecure storage of medicines and prescription pads and expired vaccines available for use within medication fridges. Immunisation protocols displayed within clinical rooms were not dated. An otoscope was found within a clinical room that required recalibration having last been inspected and recalibrated in 2016, and a refrigerator used to store patient samples prior to dispatch to the laboratory was leaking and in need of defrosting. A clinical couch had several rips within its fabric which hindered appropriate decontamination.

HIW were not assured that the medical practice had in place appropriately robust procedures to ensure that IPC was always maintained. We found clinical privacy curtains requiring replacement within most clinical rooms and a sink was found to be leaking onto sterile surgical operations packs. Furthermore, posters were not laminated and did not allow for cleaning. We were not assured that the practice had in place a suitably robust system to ensure that expired items, including sterile items were removed from use in a prompt manner. Due to difficulties with recruitment, at the time of inspection, the practice did not have a lead IPC nurse.

Emergency drugs and equipment were stored next to full clinical sharps bins awaiting collection posing a risk of contamination.

Furthermore, we were not provided with a practice resuscitation policy or procedure or an appropriate procedure for treating patients presenting with meningitis and an allergy to penicillin.

This is what we recommend the service can improve:

- Develop, implement, and maintain an appropriate medicines management policy and procedure to include arrangements for the safe and secure storage of medication and prescription pads and materials and replacement and removal of expired materials from clinical rooms

- Implementation of improved infection prevention and control procedures to include formal training for the IPC lead nurse, implementation of audits such as hand hygiene, overall IPC compliance and a healthcare waste audit
- Develop, implement, and maintain a practice resuscitation policy or procedure and have in place an appropriate procedure for treating patients presenting with meningitis and an allergy to penicillin
- Relocation of full sharps bins awaiting collection for disposal, and safe storage of sharps bins in use within clinical rooms.

This is what the service did well:

- Variety of methods for the reordering of repeat prescriptions
- Appropriate care navigation pathways and allocation of services
- Excellent working with the cluster group to implement services to benefit patients such as the 'Grow Well' wellbeing project.

Quality of Management and Leadership

Overall summary:
Overall, we were assured that senior management were committed to ensuring the practice team were supported appropriately within their roles.

Recruitment processes were appropriate and pre-employment checks were completed in a timely manner. Locum staff or those staff new to the practice were provided with a comprehensive induction programme. Appraisals were completed annually, and the practice had a supportive process in place for staff wishing to raise a concern.

We found that cluster working arrangements were good, with excellent engagement and information sharing arrangements to encourage shared learning between practices.

The immunisation status of staff was not suitably recorded and some staff requiring revalidation of hepatitis B status had not completed this at the time of inspection.

Immediate assurances:
HIW were not assured that the management systems and procedures in place were sufficiently robust to ensure adequate governance, of the practice. During our inspection HIW found that mandatory training required significant improvements and greater oversight by the senior management team. This included a lack of suitable training for all clinical staff in basic life support, IPC, safeguarding of children and vulnerable adults and medical emergencies. Furthermore, we found evidence of a failure to effectively audit the practice and its clinical practices.

We were not assured that the practice had a suitable number of trained fire wardens in place and no designated first aider.

This is what we recommend the service can improve:

- Implementation of a mandatory training programme and oversight of the same in line with General Medical Council guidelines
- Implementation of an audit schedule and programme
- Addition of a suitable number of trained fire wardens and designated first aiders
- Develop, implement, and maintain a robust policy and procedure for the checking and confirmation of the immunisation status of staff.

This is what the service did well:

- Committed and supportive practice management team
- Comprehensive staff files
- Excellent collaborative working with the GP cluster group for shared learning and information sharing.

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

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice. Patient comments included the following:

> *"All the staff are very professional and approachable there is nothing they can do to improve"*
> *"Always take time to reassure and assess myself and my kids. Friendly and calm. Such a lovely doctors surgery."*

We asked what could be done to improve the service. Comments included the following:

> *"Make getting an appointment easier. More support for women's health, and referrals needed slow to be made which has meant I'm waiting a long time for an gynaecology appointment"*

Staying Healthy

Health Promotion

On the day of our visit, we saw that the medical practice had an abundance of written health promotion information and advice available for patients. The waiting room had a supply of posters and information boards that promoted a healthy lifestyle and there were leaflets with information for patients to take away.

We were informed by senior staff that, due to staffing issues, they no longer offered a smoking cessation clinic at the practice and instead patients would be signposted to the national "Stop Smoking Wales" service.

The medical practice had a physiotherapy service available to patients for self-referral and a wellbeing initiative managed by the GP cluster group. There is a

community gardening project called the “Grow Well Project”, run across three sites within the cluster group throughout the week. This project aimed to encourage wellbeing and to combat loneliness and social isolation. Further initiatives were advertised on the medical practice website and included a weekly parkrun with the GP practice team.

Senior staff informed us that the practice used the mental health liaison service provided by the health board for patients requiring further mental health support, advice and guidance.

Dignified care

Communication and Language
We observed a friendly and helpful reception team who greeted patients in a professional and welcoming manner.

Patients requiring confidential conversations were encouraged to use a purpose-built confidentiality booth that formed part of the main reception area. This enabled patients and reception staff to speak privately on a 1:1 basis. The booth also contained a patient accessible blood pressure machine.

Consultation and treatment rooms were located away from the main waiting room area. Doors to consulting rooms were always kept closed when in use and curtains were present around examination couches to preserve patient dignity.

We were informed by senior staff that both male and female chaperones were available, and we were provided with evidence of a policy that covered their use. Chaperone availability was advertised to patients via notices displayed within the waiting room area. Staff providing this service were usually members of the reception team and occasionally members of the administration or management team. We were told that staff had undertaken in-house training to provide this service competently and confidently.

Patient Information
We saw that the practice had an informative website available to patients with digital access. This provided details of the staff team, opening hours and the arrangements for accessing out of hours help and advice. A link on the website also provided guidance for ordering repeat prescriptions as well as how to access the range of services available at the practice.

Limited information, available upon request, was available to patients through the medium of Welsh. Bilingual signage was found to be minimal. The practice did not have any Welsh speaking members of staff at the time of our visit. **We recommend**

that the practice improves availability of Welsh language documents and information leaflets in line with the Welsh 'Active offer'.

Information on the NHS complaints process, Putting Things Right, was displayed within the waiting area. However, this information was located within an alcove area of the waiting room and not immediately noticeable to patients. Also, the information displayed was a printout from the NHS website, the text size was small and would not be accessible to those patients with a visual impairment. Patients with digital access could find information on how to provide feedback to the practice via the practice website.
We would recommend that the practice considers accessibility of the Putting Things Right procedure displayed within the practice.

Timely care

Timely Care

Lansdowne Surgery was open between the hours of 8am to 6:30pm, Monday to Friday. Patients were able to access the surgery via telephone, in-person and by using a dedicated online platform (E-consult). The E-consult platform would also conduct a risk assessment and direct patients to other suitable services if appropriate.

Many of the patients who completed our questionnaire indicated that they were able to get a same-day appointment when they needed to see a GP urgently, however for patients requesting routine appointments, many answering our questionnaire indicated that they could not get routine appointments when needed. Most respondents answered that they were offered a choice of appointment type.

Some comments received were:

> *"I have no problems accessing services at the practice."*

> *"[I would like to improve] The ability to book appointments via phone without being made to feel it's an inconvenience – always told to do via online and it is tiresome with many questions that are not applicable or relating to reason. It helps to speak to a real person."*

Patients telephoning the practice to request an appointment would first be screened by a member of the reception team. We were told that receptionists had undertaken Care Navigation training via an online training module provided by Health Education and Improvement Wales (HEIW). This allowed for patients to be

signposted to other appropriate services if necessary. A policy was in place to further support the reception team in undertaking this role and reception staff were able to seek advice from the duty doctor if unsure.

If an appointment was required, patients would then be triaged by the duty doctor. Patients requiring an urgent appointment would be offered an appointment the same day. Senior staff informed us that the daily triage list was not capped.

Patients requiring mental health support were triaged in the same way. Patients presenting in crisis or needing emergency mental health support were advised to contact 111. Patients requiring less urgent intervention were offered support and advice via a self-bookable mental health nursing service. This was offered via the cluster based primary care liaison.

Secondary mental health care referrals to the Community Mental Health Team (CMHT) were managed by the Welsh Clinical Communications Gateway system (WCCG). If a delay was likely, advice would be given, and interim care provided by the practice. Alternative mental health support services available via the practice included an independent living support service for social needs.

Patients that sought mental health crisis intervention out of hours would be followed up as appropriate by the practice. Notification to the practice of out of hours crisis intervention was made via an assessment form that would be sent to the practice. These patients would be discussed at daily morning meetings to ensure all staff were aware of the increased care needs for these patients.

We spoke with senior staff to understand the adjustments available to assist vulnerable patients or those with carers to access appointments. We were told that reasonable adjustments would be made when possible and were provided with several examples of this. These included offering preferred appointment times as well as access to translation services. Face to face appointments were offered when appropriate.

When assessing the needs of unpaid carers, of the patients that responded to our questionnaire, none stated that they were offered a carer needs assessment or provided with details of organisations or support networks that could provide information and advice. **We recommend that the practice ensures that carers are aware of their right to request a carer needs assessment and that information is readily provided of the organisations that can offer support, guidance, and advice**.

We were told that the surgery offered domiciliary visits to patients unable to attend the surgery and that these would be the responsibility of the duty doctor. The surgery had responsibility for providing care to local care homes.

Individual care

Individualised Care
Lansdowne surgery was located within a purpose-built building which also contained the hub for the GP cluster.

Senior staff informed us that the surgery had been offering the winter flu vaccine. This was managed primarily by the GPs at the practice with some support from the practice nurse when available. Vaccination clinics were available at weekends to accommodate patients who may not have been able to attend at any other time. Uptake of the vaccine was actively encouraged and included reminders sent via letter, text messages and in practice posters. Where appropriate, GPs would also recommend the vaccine during consultations.

We reviewed the consent policy in place at the surgery. We found this to be compliant and containing all relevant details. The policy was dated, version controlled and with an appropriate date for review. **However, we encourage the surgery to consider the needs of those patients wishing to communicate through the medium of Welsh, or those requiring easy-read versions when accessing this document.**

When considering the accessibility of this surgery we saw that the practice had access to a hearing loop system as well as a telephone translation service. Patients with additional learning needs undergoing minor surgical operations would be supported through the consent process by the practice. A follow up telephone call made the next day would encourage discussion of the consent form and allow a space to answer any questions they may have. Patients requiring adjustments to access the surgery would have this noted on their patient record to ensure these were in place when they accessed the surgery. The practice further benefitted from a patient car park.

Corridors and doorways were wide, allowing wheelchair accessibility and patient areas were located on the ground floor of the building providing stair-free access. However, we found that the main doors to access the building were not automatic and would prove difficult for a patient with accessibility requirements to open if attending the practice alone. **The surgery should therefore consider how to ensure building accessibility in this instance.**

The surgery did not have information readily available to patients in a range of formats such as braille or easy read. We were told that should a patient require written information in an alternative large print format this was available upon request. **The surgery must ensure that information is available in a range of formats, such as braille or easy read for patients with learning difficulties.**

Rights and Equality
Of the patients questioned, almost all answered that they felt they were treated with dignity and respect when attending the practice for an in-person appointment.

During our discussions with senior staff, we were told that the practice had an Equality and Diversity Policy in place. Staff also completed Equality and Diversity training. These helped to ensure that staff and patients were always treated fairly.

The practice had a feedback mechanism in place so that any concerns regarding unfair or inequitable treatment could be escalated to the practice management team. A practice questionnaire was circulated to staff to ensure that concerns were noted and acted upon to continue to drive improvements, if necessary, in the fair treatment of staff.

The practice was proactive in upholding the rights of transgender patients. We found that transgender patients were treated sensitively, with a prompt response to any disclosure. We were told that records would be changed to reflect the use of any new name and pronouns and a new NHS number would be issued to the patient in a timely manner to ensure they were appropriately placed.

People Engagement, Feedback and Learning
The practice had a patient suggestion box available within the patient waiting area. However, we did not see a method for feeding back to patients when suggestions had been implemented. We **recommend that the practice consider a 'You said, we did' noticeboard to display details of improvements made because of patient suggestions**.

The complaints policy and procedure adhered to the NHS Putting Things Right procedure, providing guidance to patients and their carers should they wish to raise a complaint. We noted that the policy had also not been reviewed for some time and required review in October 2022. **The practice needs to review this policy to ensure that the roles and responsibilities referred to within it are up to date.**

We saw evidence of a complaints log held by the practice. This contained details of the complainant, date received and a named individual responsible for

overseeing the complaint and its resolution. Our review of the complaints log demonstrated an endeavour to reach a satisfactory outcome for all parties. We saw that complaints were resolved and closed in a timely manner. A separate folder provided to us held copies of letters of complaint and written responses to each. We were assured that complaints were dealt with in a robust and timely manner and where a resolution could not be reached, escalated appropriately.

Delivery of Safe and Effective Care

Safe Care

Risk Management
We found patient areas to be cluttered with equipment and materials, with many of these items out of date. We found evidence of equipment no longer in use, stored behind an examination couch. **The practice must ensure that unnecessary equipment is removed from clinical areas and stored appropriately when not in use.**

We saw that sharps bins were not always stored appropriately within clinical areas and found these insecurely placed on top of worktops and not securely fixed to walls to prevent tipping or access by children. **The practice must ensure that sharps bins are stored appropriately within clinical areas to prevent tipping and the associated risk of needlestick injuries.**

The Business Continuity Plan adequately covered the business partnership risk including contingencies for long term staff absence and had been updated to appropriately reflect the management of COVID-19 and other significant health emergencies should they arise. This was held online and in hard copy form within the practice and all staff were aware.

We noted that the practice had panic buttons to call for help, situated throughout the practice. Our discussions with staff demonstrated that they were knowledgeable of this system should it be required.

Emergency drugs and equipment was located within the sluice room which had a sign on the door to indicate this. Our discussions with staff demonstrated that all staff were aware of the location of emergency equipment, and new staff would receive an induction which included the location of this equipment and the contents of the emergency drugs trolley.

At the time of our visit, the practice advertised that they offered a minor surgical operations service to patients. However, we noted that the practice did not have atropine readily available to treat bradycardia, when undergoing a surgical procedure. This drug must be available to clinicians when undertaking minor surgical operations. We discussed this with senior staff during the inspection and were told that currently, the practice was not providing minor surgical operations. **Should the practice decide to recommence the minor surgical operations service, we recommend that atropine is available prior to the provision of minor surgical operations.**

We reviewed the fire safety arrangements in place at the practice. We found a suitable number of fire safety action notices placed in strategic locations throughout the practice. Additionally, we saw that fire extinguishers were readily available. These had been recently tested. However, from our discussions with staff, we did not feel confident that all staff were fully aware of the action to take in the event of a fire. There was also some confusion among senior staff as to the responsibility of fire warden. **The practice must ensure that all staff have undertaken suitable fire safety training. In addition, to allow for staff leave, the practice must ensure that they have are a suitable number of trained fire wardens**.

We were told of concerns over ambulance waiting times for patients requiring them. In some instances, due to exceptional waits, medical staff had personally transferred patients to hospital due to their clinical condition.

Senior staff informed us that they worked effectively with their cluster group to improve care for patients. During our visit we saw that the cluster hub was based at the practice and previously the cluster lead had been a GP partner of the practice, prior to their retirement.

Infection, Prevention, Control (IPC) and Decontamination
Of the patients that responded to our questionnaire, all indicated that they felt the practice was 'fairly clean or very clean' and we saw that the practice had maintained some precautions originally employed because of the COVID-19 pandemic. These included a Perspex screen at the reception desk and access to face masks for patients and their carers. Air purifiers were also present in each examination room to protect staff and patients.

We saw that Personal Protective Equipment (PPE) was readily available within clinical areas and were assured that the practice had in place suitable precautions to see patients presenting with respiratory transmitted infections without risk to other patients. Senior staff informed us that staff had been trained in the correct method of donning and doffing PPE during the pandemic and this was confirmed by observations of staff wearing the correct PPE when treating patients throughout our visit.

However, our observations of IPC and decontamination procedures at the medical practice found several areas requiring significant improvement.

Assessment of the practice environment found poor adherence to the cleaning of clinical areas. We saw evidence of dust and clutter in some areas and equipment and materials stored haphazardly on the work surfaces within clinical rooms and

sluice room. Patient hand sanitisers located throughout the practice were often found to be empty by the inspection team. Posters and information displayed on noticeboards both within the patient waiting area and clinical rooms, had not been suitably laminated to allow for them to be effectively cleaned.

Clinical curtains used to preserve patient privacy and dignity did not all adhere to IPC guidelines. Although some were of the approved disposable paper design, many were not dated. The curtains had been in place for over three years and required replacement. Other privacy curtains were made of a think fabric and did not contain dates for replacement.

Observations of the clinical rooms found multiple items left haphazardly on trolleys and on worktops exposed to the air. These included cervical cytology brushes used to collect cells during cervical smear tests, cotton wool balls and swabs as well as disposable aprons.

Sterile items used in the direct treatment of patients at the surgery, including sutures, biopsy punches and histology pots, sterile gloves, urine sample collection pots, oxygen tubing, lubricating jelly and swabs and minor surgical operation kits were found within clinical examination and treatment rooms to be expired and their sterility could not be assured.

Reusable items such as otoscopes were found to be dusty, and desks and walls were cluttered with paper and appeared disorganised, hindering effective cleaning processes.

Within the sluice, we found a lack of appropriate zoning between clean and contaminated items. Notably, full sharps bins that were awaiting collection were stored stacked against the emergency drugs trolley.

We were told by senior staff that the practice IPC lead was the recently appointed practice nurse. However, we were not provided with evidence of appropriate training undertaken by this member of staff on the day of our visit to provide us with assurance that they were able to competently carry out this role. Furthermore, no evidence was offered of a recently completed IPC audit or hand hygiene audit.

These matters were dealt with under the HIW immediate assurance process, whereby we wrote to the practice requesting immediate improvement. We have since received satisfactory assurance of improvement in these areas.

The practice used a contract cleaning company to carry out non-clinical cleaning and we saw evidence of a contract in place for the removal of clinical waste from

the practice however we were not provided with a recent waste management audit.

Sinks within clinical areas were fitted with elbow operated taps and clinical rooms were observed to have suitable 'cap and cove' flooring to allow for cleaning. Worktops were of a wipeable material and chairs within the practice were also cleanable. **As sinks were seen to have overflows and plugs, we would recommend that the practice considers adapting these in line with IPC guidelines.**

Medicines Management

We were told that patients could request a repeat prescription in a variety of different ways, including in person, via a mobile telephone application or email to the practice or by using the service provided by the local pharmacies.

Repeat prescription requests would be undertaken by a trained staff member via a rota system. The prescription would be written and then passed to a clinician to check and sign where it would then be stored securely prior to patient collection or passed directly onto the patients preferred pharmacy. To prevent overuse of medication by patients, two prescription clerks would carry out checks on repeated prescription requests. Patients would also be required to undergo medication reviews as necessary. We were provided with evidence of a practice policies that outlined these processes. At the time of our visit, these policies were under review.

We were assured that clinical staff were aware of the yellow card reporting scheme for adverse effects. Once reported, patients medical records would also be updated.

Although not a dispensing practice, the practice did have a limited number of medications on site, this included the winter flu vaccine for adults and children. We were provided with an up-to-date cold chain policy to ensure safe storage and saw that temperatures for the fridge that held the vaccines were checked and recorded on a regular basis via electronic means. We saw that the fridge had a data logger installed to record details of breaches in acceptable temperatures. However, no checklist was provided to us to demonstrate adherence with the cold chain procedure and although the fridge was lockable, no key was present for the duration of our visit. Although a sticker was fixed to the electrical socket for the fridge advising staff not to turn it off, this was not immediately obvious and was partly obscured by the plug.

Our observations of the medicines management procedures demonstrated poor adherence to medicines management policies and procedures with many medications stored insecurely and without organisation.

Within the vaccination fridge, we found expired children's flu vaccines. Unlocked cupboards within clinical areas stored labelled patient medications. These included vitamin B12 injections, medications used for the treatment of breast cancer, and contraceptive injections.

Treatment rooms contained undated or out of date immunisation guidance pinned to noticeboards. It was unclear whether this guidance complied with current guidelines and as such could prove confusing for locum or temporary staff.

Furthermore, a blank prescription sheet was found to be stored insecurely within a desk drawer of a clinical room.

As a result of these findings, these matters were dealt with under the HIW immediate assurance process, whereby we wrote to the practice requesting immediate improvement. We have since received satisfactory assurance of improvement in these areas.

Safeguarding of Children and Adults
We conducted a review of the safeguarding polices and procedures in place at the medical practice. We saw that the practice had a designated safeguarding lead who was one of the practice GPs and we were provided with evidence of an up-to-date safeguarding policy that had been regularly reviewed. In addition, it was confirmed that all staff had access to the All-Wales Child Protection Procedures.

Discussions with senior staff gave us assurance that the practice had a robust mechanism in place to ensure children and vulnerable adults were safeguarded effectively. Designated safeguarding meetings chaired by the safeguarding lead and containing others from the wider primary care network such as midwives and health visitors would provide opportunities for discussion of cases that required escalation. Adults and children at risk would also have a clear, designated marker placed within their medical records to ensure that staff were reminded of any increased safeguarding concerns.

Our review of mandatory safeguarding training at the practice, however, found that multiple staff at the practice, including some GPs, had not undertaken recent safeguarding training. **To ensure that staff are up to date on guidance for the safeguarding of children and vulnerable adults, we recommend that the practice ensure that all staff undertake regular safeguarding training in line with the most recent guidance.**

Management of Medical Devices and Equipment
On the day of our visit, we found that most of the medical devices and equipment were in a good state of repair and had been well maintained. However, we noticed that some medical devices and equipment that required recalibration did not appear to have undergone this. **We recommend that the practice develops and maintains a log to ensure that medical devices and equipment are maintained in line with manufacturers and clinical guidelines to include recalibration checks.**

We saw that single use equipment was available in some clinical rooms and for patients undergoing minor surgical operations at the practice. However, some clinical rooms were still using multiple use equipment. **To prevent confusion and to adhere to IPC guidelines, we recommend that the practice ensure that single use equipment is available for clinicians whenever possible.**

The sluice contained a drinks fridge that was used to store patient samples prior to transfer to the laboratory. This fridge was observed to be poorly maintained with no checks on the temperature. This was evidenced by a build-up of ice towards the back of the fridge that required defrosting and a leak of an unknown substance on the bottom. Wet paper towels were present on the bottom of the fridge in a bid to stem the leak. We saw that this fridge was storing disposable cold packs as well as ice blocks usually frozen in a freezer. On the day of our visit, we saw that this fridge was being used to store a patient sample.

Assessment of one clinical room found a leak under the sink which had directly discharged onto sterile surgical operations packs and had contaminated them. In addition, we found that some equipment within this room was in a poor state of repair. This included an examination couch used by the visiting physiotherapist that was ripped in multiple places and was therefore unable to be appropriately cleaned.

We reviewed the emergency equipment and found that the automated external defibrillator (AED) was charged and the batteries in date. We saw evidence of a checklist demonstrating that emergency drugs and equipment would be checked on a weekly basis in line with Resuscitation Council (UK) guidelines.

However, we found that both the adult and child oxygen masks present with the emergency equipment had expired and required replacement.

As a result of these findings, these matters were dealt with under the HIW immediate assurance process, whereby we wrote to the practice requesting

immediate improvement. We have since received satisfactory assurance of improvement in these areas.

Effective care

Effective Care

Our discussions with senior medical staff at the practice demonstrated genuine dedication and care towards patients. The practice ensured staff were kept up to date with best practice, national and professional guidance, and new ways of working by engaging with the cluster group. Regularly held meetings would ensure that alerts and changes to clinical guidelines were appropriately disseminated. These would then be emailed to staff.

The practice manager informed us of the arrangements for ensuring patient safety alerts were received and acted upon in a prompt and timely manner. The practice manager was responsible for receiving patient safety alerts and a system was in place to ensure that should they be on leave; these would be received by another senior member of staff. Once received, patient safety alerts would be distributed electronically to the clinical team. We were told that discussions would take place on a weekly basis during regular meetings. The GP partners would further review alerts received. However, despite a comprehensive induction, we saw that patient safety alerts did not appear to form part of locum induction packs. **We recommend therefore that a suitable system was implemented to ensure that temporary or locum staff were fully sighted on patient safety alerts.**

Significant patient safety events were appropriately logged via the NHS Datix system, reviewed, and discussed and a spreadsheet was available for us to review on the day of our visit that demonstrated good record keeping in this regard. **However, we recommend that a log was kept detailing the minutes of meetings held to discuss significant patient safety events.**

Staff confirmed that referral requests would be made by the referring clinician. These would then be managed by the Welsh Clinical Communications Gateway (WCCG). Locum staff unable to access the WCCG, were asked to request a referral within the patients medical records. This would then be acted upon by a member of the practice administration team. Patients referred for urgent suspected cancer were acted upon in a prompt and timely manner by the practice. Rates of referral were discussed with the cluster group.

Information Governance and Digital Technology

We spoke to senior staff who confirmed arrangements for data security at the practice. We were told that the practice had a data protection officer who was appropriately trained. This was a service provided by Digital Health Wales.

The practice had a clear process in place for the handling of personal and sensitive data. The practice privacy policy was available for patients to view within the practice and on the practice website.

Patient Records
We reviewed a sample of 10 electronic patient medical records. We saw that medical records were secured against unauthorised access.

We noted that where the patient had a particular language preference or requirement, this was noted within the medical records.

Record keeping was found to be mostly good throughout our assessment of the medical records and were clear and easy to understand. However, we noted that not all diagnoses were appropriately Read coded and clinical examinations undertaken were not always recorded. Furthermore, some risk factors that should have been Read coded, were instead recorded under a section entitled 'lifestyle' with others entered in a free text consultation box.

We noted that the medical records system used by the practice featured an audit tool. However, we were not provided with an audit of medical records on the day of our visit. **We recommend that the practice undertake an audit of patient medical records to ensure they are appropriately Read coded and highlight areas that may require improvement.**

Quality of Management and Leadership

Governance and Leadership
At the time of our inspection, Lansdowne Surgery was owned and operated by three GP partners. The practice was part of the Cardiff Southwest GP cluster group. Staff reported this to be beneficial and worthwhile.

The practice employed a number of clinical and non-clinical staff, including oneGP retainer, four salaried GPs as well as one part time practice nurse and one healthcare assistant. The practice was well supported by a team of administrative staff.

The practice had in place a dedicated and enthusiastic practice manager who was supported by a deputy practice manager. Together with the GP partners, the practice appeared to have a clear pathway to ensure it remained sustainable. We were told that positive discussions with a nearby GP practice to merge were going well and would soon be finalised.

Information sharing was a priority, and this was achieved in a variety of ways. Staff would be emailed where appropriate. The practice also benefitted from a computer software system that held all documentation and assisted with recording staff leave and rotas. New policies would be visible to staff and would be highlighted until read.

We were told that regular team meetings would be held to encourage communication between all staff. These would take place weekly and would be minuted. Further to this, the practice utilised a messaging system built into the practice software to communicate with each other throughout the working day.

Clinical oversight was provided by one of the GP partners who also had joint responsibility for management of compliance with the Quality Assurance and Improvement Framework (QAIF) with the practice manager.

Skilled and Enabled Workforce
We spoke to staff across a range of professions working at the practice. This demonstrated that staff were knowledgeable of their roles and responsibilities and committed to providing a quality service to patients.

Senior staff expressed that they had found it difficult to recruit to vacant nursing posts at the practice. At the time of inspection, the practice had in post one part time practice nurse with a second scheduled to start shortly after.

We reviewed the staff personal files. These were kept securely with the practice manager. All staff had in place a valid job description that accurately described their role and we saw evidence of annual appraisals and DBS checks where required. Appraisals and clinical peer review for clinical staff were carried out by the GP partners.

Clinical staff were provided with the opportunity to discuss training needs and suggestions of how to access support and learning during annual appraisals. In addition to this, weekly clinical meetings were held to encourage shared learning among the clinical team. This was further detailed on the clinical meeting log. We were informed that clinical staff are provided with protected learning time by the local health board should this be required
We found that staff were working within their clinical competence and aligned with their scope of practice relative to their qualifications, current skills, knowledge, and experience. Clinical staff offering private only treatments were doing so with the correct indemnity in place. However, on the day of our visit, there did not appear to be sufficient workforce plan in place to always ensure staff capacity and skill mix. This was instead reported to be reviewed on demand and following discussion with GP partners. Senior staff reported that this was likely to be undertaken in line with the planned merger due to go ahead imminently. **We would encourage the practice to put in place a suitable workforce plan to ensure adequate staff skill mix until such time as the planned merger goes ahead.**

A review of staff immunisations and vaccination records found this to require renewal and updating. Practice records concerning the immunisation status of staff against Hepatitis B was not up to date. **The practice should ensure that staff records are reviewed on a regular basis to ensure appropriate action is taken to prevent a healthcare acquired infection of this type.**

A review of staff mandatory training found this to be incomplete with many staff requiring updates in areas such as Basic Life Support and medical emergencies (including anaphylaxis) and training in IPC. Further to this, staff training in Equality and Diversity was not up to date and several clinical and non-clinical staff at the practice had not undertaken recent training in the safeguarding of children and vulnerable adults. We did not find evidence of fire safety training. **Due to the serious nature of our findings, this issue was dealt with under HIW's immediate assurance process, whereby we write to the practice to request immediate improvement. We have since received satisfactory evidence and assurance of improvement in this area.**

Staff new to their role or the practice were provided with a comprehensive induction training package. This included a review process to ensure that staff were aware of their role and responsibilities.

The practice did not currently offer a provision to provide training in Welsh. However, senior staff informed us that ability to speak Welsh did inform recruitment processes among equally placed staff, although were not part of the overall application process.

From our conversations with staff throughout the inspection, we felt confident that should they feel the need to raise a concern, they would be supported in doing so. We were provided with the practice Whistleblowing policy and saw that this was available to all staff for guidance.

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 summaries 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
Multiple expired sterile items were found within clinical rooms	Clinician's could inadvertently use expired equipment. As sterility can not be confirmed beyond expiry date, using expired equipment could pose a risk of patient harm.	Discussion with senior staff. Follow-up with immediate assurance process due to the number of items found.	Items were removed in part during the inspection. This was completed following issue of the immediate assurance.

Appendix B – Immediate improvement plan

Service: Lansdowne Surgery, Sanitorium Road, Cardiff CF11 8DG

Date of inspection: 27 March 2023

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
Finding HIW were not assured that the practice had in place suitably robust procedures to ensure safe and effective medicines management. During the inspection, HIW found areas of concern relating to ineffective and inappropriate medicines management at the practice. These included: • Storage of medicines within unlocked cupboards and drawers. These included medications including contraceptive injection medications, prescribed to named patients as well as multiple boxes of vitamin B12 injections (Hydroxocobalamin 1mg/ml). • An unlocked medication fridge located within an unlocked room.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Expired children's influenza vaccine kept within the medication fridge • Blank prescription sheets stored within an unlocked drawer • Medications stored within lockable cupboards with their keys left in situ In addition, our observations of the clinical rooms found that displayed vaccine protocols for childhood immunisations were some three years out of date. Others were not dated and it was not apparent whether the advice contained within it was in line with the most recent guidance. This could provide confusion for locum staff or new starters as it may no longer be adhering to the most recent guidelines.				
Improvement needed The practice is required to: • Ensure all expired medications are disposed of immediately and in an appropriate manner • Implement and maintain a robust medicines management procedure to ensure that all medication held at the practice is done so in a safe, secure and effective manner that prevents access to and removal by unauthorised persons	**2.6 Medicines Management**	All out of date medicines have been disposed of in the appropriate manner. All medicines are stored in a lockable cupboard which will be locked when the room is not in use. We have put a sign on each of these cupboards to remind staff these are to be locked after use. A medicines and medical gases storage protocol has been implemented	Robert Parton	Immediately

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Ensure medication fridges and cupboards are not routinely left unlocked and the keys removed and held securely other than when access is required • Ensure only the most recent immunisations guidance is displayed within clinical rooms.		Keys will be removed from fridges and cupboards when not in use. Keys will be kept in an agreed secure place. New practice nurse to display latest guidance and review all posters to ensure they are the latest versions. The practice immunisation guidance policy and immunisation poster has been updated.	Kat Davies	1 week

Finding

HIW were not assured that the practice had in place a suitably robust system to ensure that expired items including sterile items, were removed from use in a prompt and timely manner.

During the inspection HIW found many expired items present within clinical consulting rooms that had not been removed from use, some of which had expired, in 2006. Expired items included (but was not limited to):

- Sterile sutures
- Biopsy punches and histology pots
- Sterile gloves

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Urine sample collection packs • Oxygen tubing • Lubricating jelly • Swabs • Urinalysis strips • Minor surgical operations packs • Needles Failure to remove expired sterile items may mean that they are unintentionally used by a clinician and cause patient harm. Furthermore, we found evidence that a mini refrigerator used to store samples provided by patients for analysis, was not working efficiently and was poorly maintained. We saw that this fridge contained a build up of ice and required de-frosting in order for it to work efficiently. In addition, we found a damp paper towel was being used to soak up a leakage inside the fridge. This was also stained. Lastly, we noted that ice packs were being stored within this fridge. Failure to maintain the fridge could lead to contamination or degrading of the samples held within it. This could impact on patient care. Our review of the diagnostic equipment at the surgery found some items to require recalibration with previous recalibration checks undertaken in 2016. Further observations found stickers advising that fridges should not be unplugged from the electrical supply were not clear and in fact covered by the electrical plugs of the equipment.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Improvement needed The practice is required to: • Ensure all expired items are removed from the clinical rooms and disposed of in an appropriate manner • Develop, implement and maintain a robust system for the management of sterile materials • Develop, implement and maintain a robust system for the management of recalibration checks on medical devices and equipment • Ensure all clinical fridges are appropriately maintained and cleaned and kept within the necessary temperature ranges. Fridges that are not working as such should be removed from use.	**2.9 Medical Devices, Equipment and Diagnostic Systems**	All items have been checked for expiry dates and any out of date items have been destroyed in the appropriate manner. Sterile materials will be checked as part of the monthly audit. We have recently had recalibration services at the practice. We will review all items to ensure nothing has been missed. The spirometry machine was not recalibrated due to it being out of use with no sign of this being reinstated. All clinical fridges are appropriately maintained. They all have data loggers and alert us if the temperature goes out of range. The mini fridge is not a clinical fridge and is used to store late produced urine	Robert Parton Amanda Berry Paula Hooper Robert Parton Kat Davies Robert Parton	Immediately Within 1 month Within 2 weeks Within 2 weeks

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Ensure items requiring constant electrical supply are appropriately marked as such to prevent unintended interruption to the electrical supply		samples overnight for the following days collection. The mini fridge will be cleaned and defrosted.		

Finding

HIW were not assured that the medical practice had in place appropriately robust procedures to ensure that infection prevention and control was always maintained at the medical practice.

During our observations of the practice, we found that clinical curtains used to provide privacy within clinical rooms, had not been changed for some years, with some requiring changing in 2019. Other clinical rooms did not contain disposable curtains and were instead still made of a cotton material.

We noticed within one clinical room, a sink had leaked and contaminated sterile minor surgical operation packs that had been stored underneath it within a cupboard.

Posters and information displayed on noticeboards had not been suitably laminated to allow for them to be cleaned in line with the most up to date IPC guidance and an examination couch within a clinical room was found to be ripped in several places.

We found that the emergency drugs and equipment were stored in a room that was used also used by the medical practice as a sluice room. Full clinical sharps bins were stored next to the emergency drugs which may pose a risk of contamination.

Furthermore, we were not provided with evidence of audits of IPC and hand hygiene undertaken at the medical practice or evidence of appropriate training for the lead IPC lead at the medical practice.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Improvement needed The practice is required to: • Provide the lead IPC nurse with an appropriate training programme • Undertaken annual IPC audits • Undertake regular hand hygiene audits of staff. • Replace all non-disposable clinical curtains with a suitable alternative • Replace all expired curtains within clinical rooms • Ensure that the sink within the physiotherapists room is repaired and no longer contaminates the contents of the cupboard beneath it • Ensure that sterile and clinical equipment is not stored beneath a sink	**2.4 Infection Prevention and Control (IPC) and Decontamination**	We now have a permanent practice nurse who has undertaken ILS IPC training. She will be the lead on IPC within the practice. The new practice nurse will undertake an annual IPC audit and to be carried out annually thereafter. The new practice nurse will undertake a hand hygiene audit and to be carried out regularly thereafter. New curtains have been purchased to replace any that have expired or are still material. A schedule will be kept with an alert set up to notify us when they are due to expire.	Kat Davies Robert Parton	Within 1 month Within 1 month 2 weeks

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Remove all paper posters and notices and replace with laminated versions where possible • Repair the examination couch within the physiotherapists room • Ensure that the emergency drugs and equipment are not stored in a way that means they could be contaminated.		The sink has been repaired. All contents have been removed from underneath it. A sign placed on the door to warn staff not to store any materials underneath the sink. The new practice nurse has removed any paper posters or signs that can be removed and we will seek laminated versions where possible. We are looking into the cost of repairing or replacing the ripped couch. The used clinical waste bins have been moved away from the emergency trolley.	Kat Davies Robert Parton	Immediately 1 month
Finding				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW were not assured that the practice had in place suitable training for all clinical staff in basic life support. Furthermore, we were not provided with a practice resuscitation policy or procedure. Checks on the emergency drugs and equipment were found to be carried out weekly and not daily as required by the Resuscitation Council (UK). For patients presenting with meningitis and requiring in practice emergency treatment there was not a procedure in place to appropriately treat patients allergic to penicillin. We were informed by senior staff that the practice had only one trained fire warden in place and did not have a designated first aider. This could put patients, staff and visitors at risk in the event of a fire should this member of staff be on leave.				
<u>Improvement needed</u> The practice is required to: • Ensure that all staff have appropriate training in basic life support and medical emergencies appropriate to their role. • Have a resuscitation procedure is in place that is practice specific. • Have in place a procedure to treat patients presenting with symptoms of meningitis that are allergic to penicillin.	**2.1 Managing Risk and Promoting Health and Safety**	The elearning link has been sent to all staff to complete. There is a medical emergency practice policy in which resuscitation is included. The medical emergency practice policy will be updated to include alternative treatment for patients who are allergic to penicillin. We have also implemented a Policy for	Amanda Berry Amanda Berry Dr C Bryant and Dr K Pardy	Within 2 months 1 month

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Ensure all staff are aware of their responsibilities under these procedures. • Have a second appropriately trained fire warden in place and have in place a designated first aider.		allergies intolerances and sensitivities which includes this information. A member of staff has been assigned as the secondary fire warden. We will look at what the training requirements are and courses available. A member of staff has been assigned as the practice first aider. We will look at what the training requirements are and courses available.		1 month depending on course availability.
Quality of management and leadership				
Finding				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW were not assured that the management systems and procedures in place were sufficiently robust to ensure adequate governance, of the practice. During our inspection HIW found evidence of the following issues that require immediate improvement to ensure the practice operates safely and effectively: • Lack of mandatory training and oversight of this by senior staff • Failure to effectively audit the practice and its clinical practices.				
Improvement needed The practice is required to: • Develop, implement and maintain a mandatory training schedule to ensure staff are up-to-date with the requirements • Develop and implement a full audit schedule	**7.1 Workforce**	Mandatory training has been implemented as part of the new staff inductions. Existing staff will complete all mandatory training modules required. An audit schedule is in place on the practice intranet with a system for renewal dates. We have also implemented a staff development policy which includes mandatory training schedules	Amanda Berry	Immediately Within 2 months depending on staff levels. 1 month

Service Representative:

Name (print):	**Amanda Berry**
Role:	**Practice Manager**
Date:	**04.04.2023**

Appendix C - Improvement plan

Service: **Lansdowne Surgery, Sanitorium Road, Cardiff CF11 8DG**

Date of inspection: **27 March 2023**

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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The practice must ensure that patients individual needs are met when accessing the practice. This includes: • patients wishing to communicate through the medium of Welsh are enabled to do so in line with the Welsh 'Active Offer' • access to written information in a range of formats (e.g. Easy-Read or large print)	3.1 Safe and Clinically Effective Care	• As part of the patient registration process we ask for preferred language. This is flagged in the patient record. The practice does not currently employ any Welsh speakers. We have access to Language line which is offered to patients if they require to converse in the language of Welsh. Information will be provided where possible in English and Welsh. The practice is seeking services to assist with	Amanda Berry and Robert Parton	The information displayed around the practice is currently being reviewed. This will be an ongoing process to provide information bilingually. Initial review of forms/information 1 month and then ongoing.

• accessibility to the building for patients with mobility access requirements.		translation for general patient notices. • The practice will provide forms and leaflets where possible in a range of formats The practice will look into the cost of automatic doors and the affordability of this. The practice currently provides a buzzer system to alert staff who will assist. A sign will be put up to instruct patients with mobility access requirements to use the intercom system for assistance.		The sign will be put up immediately.
The practice must ensure: • accessibility of the Putting Things Right procedure displayed within the practice • The practice Complaints policy and procedure is reviewed to ensure that the roles and responsibilities referred to within it are up to date. The complaints	6.3 Listening and Learning from Feedback	• The Putting Things Right poster will be moved to a different location within the waiting area so it is more visible to patients. • The practice Complaints policy has been reviewed. The complaints procedure poster will be moved to a different location within the waiting area so it is more visible to patients. The Complaints leaflet will be moved	Amanda Berry and Robert Parton	Immediately Immediately

procedure must be displayed in a publicly accessible area in a way that is accessible to all in a range of formats. • carers are appropriately supported. This must include access to Carers Rights assessments. • Patient feedback is encouraged, and evidence of improvements made as a result is available (e.g. 'You Said, We Did' noticeboard)		to a different location within the waiting area so it is more visible to patients. • The practice has a Carers Champion which is displayed within the waiting area. The practice will promote this. As part of the registration process patients are asked if they are a carer or have a carer. This is flagged in the patient records. • The practice provides Feedback forms in the waiting area and on the practice website. The practice will introduce a 'You Said We Did' notice board within the waiting area and displayed on the practice website.		Ongoing 3 months
The practice must ensure that: • unnecessary equipment is removed from clinical areas and stored appropriately when not in use	2.9 Medical Devices, Equipment and Diagnostic Systems	• unnecessary equipment has been removed from clinical areas	Robert Parton	Already actioned

• a log is developed and maintained to ensure medical devices and equipment are maintained in line with manufacturers and clinical guidelines to include recalibration checks.		• the practice will develop a log to ensure medical devices and equipment are maintained	Robert Parton	2 months
The practice must ensure that: • sharps bins are stored appropriately within clinical areas to prevent tipping and the associated risk of needlestick injuries. • a supply of atropine is available within the emergency drugs kit if it recommences the minor surgical operations service. • All staff have undertaken fire safety training that is renewed annually • There are a suitable number of trained fire wardens at	2.1 Managing Risk and Promoting Health and Safety	• Sharp bins to be moved to a more appropriate area • Practice will ensure a supply of atropine is available if the minor surgery service resumes • The practice will provide timescale for all practice staff to undertake the mandatory fire safety training.	Robert Parton Robert Parton	3 months Ongoing

the practice to allow for staff leave • At all times there are a suitable number of trained first aiders		• The practice will look for additional staff to undertake fire warden training The practice will look for first aid course for practice staff.		
The practice must: • consider how to adapt sinks in clinical areas to remove overflows and plugs. • ensure that single use equipment is available for clinicians whenever possible	2.4 Infection Prevention and Control (IPC) and Decontamination	• A review of the sinks and removal of the overflow plugs. • The practice will review the available equipment and an auditing process for restocking will be introduced.	Robert Parton Robert Parton	3 months Ongoing
The practice must ensure that staff complete training on the safeguarding of children and vulnerable adults	2.7 Safeguarding Children and Safeguarding Adults at Risk	• This is part of the induction process for new staff to be completed within 3 months of starting. The existing staff will be allocated time to complete the mandatory training.	Amanda Berry	2 months

The practice must: • develop and implement a suitable system to ensure that temporary or locum staff are fully sighted on patient safety alerts. • develop and maintain a log detailing the minutes of meetings held to discuss significant patient safety events • develop a suitable workforce plan to ensure adequate staff skill mix until such time as the planned merger goes ahead • develop and maintain a log of staff immunisation status and act upon this in a timely manner	7.1 Workforce	• The practice has reviewed the process for patient safety alerts and updated this process. The alerts are disseminated via email to appropriate staff groups. The alerts are now printed and kept in a folder in the practice meeting room. This will be relayed to any temporary or locum staff. • The practice already has in place a process for recording minutes of the weekly practice meetings, which include patient safety alerts on the agenda. These minutes are available on Teams to all practice staff. • The practice has a staff immunisation log available on the practice intranet system. This will be reviewed and updated.	Amanda Berry Robert Parton Robert Parton	Already actioned Already actioned 1 month

The practice must undertake an audit of patient medical records to ensure they are appropriately Read coded and highlight areas that may require improvement.	3.3 Quality Improvement, Research and Innovation	• The practice as part of QI projects is reviewing the coding of patient records. This is discussed and recorded in the weekly practice meetings to ensure all staff are coding the records correctly.	Christopher Bryant	Ongoing

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): Amanda Berry

Job role: Practice Manager

Date: 22 June 23