Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Dulais Valley Primary Care Centre, Swansea Bay University Health Board

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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 Dulais Valley Primary Care Centre, Swansea Bay University Health Board on 3 April 2024.

Our team for the inspection comprised of one HIW senior healthcare inspector and three clinical peer reviewers. The inspection was led by a senior 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. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 48 questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
The responses received in the patient survey suggested that patients were satisfied with the level of care and treatment they received, with all patients saying that the service was ‘very good’ or ‘good’.

Information was displayed on how patients could look after themselves and how they could engage with health promotion initiatives. This included signposting to services that supported mental health. There were quick response (QR) posters, encouraging patients to view information through their smart phones.

Dignity and privacy of patients was also important to the practice. The waiting room was spacious and the treatment areas were all situated on the ground floor.

There were clearly a number of good processes within the practice to enhance patient experience. However, there were some issues that needed to be addressed.

This is what we recommend the service can improve:

- Display the patient information leaflets
- Documenting the policy for did not attend (DNAs) at both the practice and for hospital appointments.

This is what the service did well:

- Patient responses in the questionnaire were generally positive
- Ensuring patients were treated with dignity and respect
- Having access to third party services for patients.

Delivery of Safe and Effective Care

Overall summary:
Infection prevention and control (IPC) arrangements were generally good. The practice was spacious and free from clutter.

Refrigerated medicines were appropriately stored to ensure adherence with cold chain requirements.

Safeguarding procedures were generally good and staff were aware of the procedure to follow should a child not attend for their appointment.

The clinical records were good and supported the delivery of safe and effective care.

There were some areas that required improvement, including the need for an IPC audit and a need for a formal policy to identify the children at risk.

This is what we recommend the service can improve:

- Carry out an IPC audit
- Implement a formal child at risk policy
- Introduce weekly checks of emergency drugs and equipment.

This is what the service did well:

- Patient records were clear and easy to navigate
- Safeguarding procedures were generally good
- Supplying a number of other services to the patient population.

Quality of Management and Leadership

Overall summary:
Management and leadership at the practice appeared to be robust. We saw that staff had clear reporting lines with a dedicated and enthusiastic practice management and senior team.

Staff responses to the questionnaire were generally positive. Staff agreed that care of patients was the practice top priority and that overall, they were content with the efforts of this practice to keep staff and patients safe.

We identified issues with a lack of in date mandatory training in a number of key areas and also the management of the disclosure barring service (DBS) requirements and regular certification in relation to these checks. These issues were dealt with under HIW's immediate assurance process.

Immediate assurances:

- Poor compliance with mandatory training
- Disclosure barring service (DBS) checks were not in place for all practice staff.

This is what we recommend the service can improve:

- Implement a formal induction checklist for new staff and locums

- Ensure the practice holds up to date records of the recommended occupational vaccination status for all staff
- The policies and procedures shown were not the latest version of the policies and procedures.

This is what the service did well:

- Staff responses to the survey were positive
- Good overall management of the practice
- Staff were aware of the duty of candour.

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

HIW issued a questionnaire to obtain patient views on the care at Dulais Valley Primary Care Centre for the inspection in April 2024. In total, we received 48 responses from patients at this setting.

Responses were positive, all respondents who answered rated the service as 'very good' or 'good'. Some of the comments we received about the service and how it could improve are below:

> *"Always very helpful and try their best to deal with my request. I have experienced no problem getting an appointment or speaking with a doctor or relevant health professional. I am very happy with this practice."*

> *"All staff, go over and beyond their duty of care. They are all exceptional in the care they provide. They are truly exceptional in executing the services they provide. I cannot praise them enough. [Doctor] is quite exceptional though. A rare example of such exceptional care."*

> *"Brilliant service and despite being a very busy practice they are always available and do their utmost to achieve a satisfactory outcome."*

> *"The practice really tries to keep up with changes. Ask my GP is a great addition to the services offered. The GPs always try their utmost to deal with the same day. The triage system seems to be a success in how they assess and allocate patients. I have every confidence in the full range of services and appreciate all that they do."*

Person-centred

Health promotion

We saw that health promotion initiatives such as healthy lifestyle (including smoking cessation) and breastfeeding support, were provided on a quick response (QR) code. There was also comprehensive information on the practice website. Leaflets that had been removed from display due to COVID-19 and on advice from infection prevention and control at the health board had not been put back on display. This meant that patients who could not access the website or QR codes,

could not access information to help promote their health, improve their health and lead a healthy lifestyle.

The practice is to confer with the health board infection prevention and control lead and re-introduce the leaflets back on display if authorised.

There was a waiting room blood pressure monitor at the practice, which enabled patients to 'self-screen' and take their own blood pressure readings.

The practice had access to a cluster physiotherapist following a general practitioner (GP) triage and MIND (a mental health charity). There were social prescribers that connected patients to activities, groups and services in their community, as well as diabetic retinopathy, prediabetes and heart failure clinics. We were told that the practice held an annual flu vaccination programme at the practice and also community vaccination clinics.

Staff we spoke with said that patients who missed three routine appointments were then unable to book an appointment online. Where children did not attend (DNA) an appointment, they would be marked as a DNA initially, then depending on the reason for the appointment, the practice would contact the patient to ascertain the reason for not attending. Where patients DNA a hospital appointment, there would be correspondence from the hospital in the patient notes and these instances would be discussed at the daily 11am meeting, where the General Practitioners (GPs) would decide the course of action. We were told that the number of DNA appointments had reduced since the introduction of text message reminders. There was no formal DNA policy, as the practice did not believe they needed a policy currently. However, there is a need to document the process followed to ensure that staff follow the correct procedure.

The practice must ensure that there is a documented policy, including the process to be followed, for DNAs at both the practice and for hospital appointments.

In total, 95% of patients who answered the questionnaire said that there was health promotion and patient information material on display.

All staff agreed in the questionnaire that the practice offered health promotion advice and information about chronic conditions to patients in a variety of mediums.

Dignified and respectful care
The environment and practices of the organisation supported the rights of patients to be treated with dignity and respect.

Clinical rooms gave patients appropriate levels of privacy, with doors being closed during consultations. There were curtains in the consulting and treatment rooms to draw for patients to undress. The practice building was accessible for wheelchair users and people with mobility difficulties. All consultation and treatment areas were on the ground floor with wide corridors.

The practice offered chaperones in appropriate circumstances, with notices highlighted in red in the consulting and treatment rooms. There was a chaperone policy available.

The chaperoning was normally carried out by medical and nursing staff. Whilst administrative staff had not carried out any chaperoning of patients previously, four members of administrative staff had expressed an interest in formal training, that was being arranged. We were told that the practice followed the General Medical Council guidance that stated that a practice should record verbal consent for intimate examination and requests for chaperones in patients' notes.

All staff who responded in the questionnaire stated that patients were offered chaperones when appropriate. Additionally, 73% of patients said they were offered a chaperone (for intimate examinations or procedures).

The reception area gave patients appropriate levels of privacy. There was a room where patients could speak to receptionists in confidence, with a notice displayed in the reception about the use of the consultation room for private conversations. Additionally, we were told that the receptionist did not make outgoing calls, but would take any overflow incoming calls, again for patient privacy. We noted that there were signs in reception and boxes marked on the floor to encourage patients to remain a respectful distance behind a patient speaking at the reception desk. However, only 42% of patients said in the questionnaire that they were able to talk to reception staff without being overheard.

All patients who answered the question felt they were treated with dignity and respect and said that measures were taken to protect their privacy. All but one of the patients who answered felt the GP explained things well and answered their questions, felt involved in decisions about their healthcare, felt listened to and said they were offered healthy lifestyle advice. Some comments we received about patient care are below:

> *“I have been with the practice for 20 years. They have always provided an extremely high level of care for me and my family. Every member of staff has gone above and beyond what I would expect of them. I cannot praise them highly enough.”*

"Very pleasant staff, helpful and kind. The GPs I have dealt with at this practice have all been lovely. The facilities are always warm and comfortable.... Keep doing what you're doing!!"

"Long term side effects of medications not always explained or taken into sufficient consideration."

All staff said that measures were taken to protect patient confidentiality and patient privacy and dignity.

Timely

Timely care
There were processes in place to ensure patients could access care via the appropriate channel in a timely way, with the most appropriate person. Patients were informed of the different options available to them in terms of accessing appropriate advice from a health care professional through the website, practice leaflet, telephone messages, signs in the waiting room. In addition, there were QR codes and askmyGP, a workflow management for practices, and for GPs, which allowed patients to describe their problem in their own words.

Patients who were digitally excluded could telephone the practice or visit the practice in person. The access policy was displayed on a poster in the practice waiting room and on the practice website.

The practice would also signpost the patient to health board services as well as third sector services. There was a list of these services available for call handlers and how to refer.

Receptionists had a clear pathway of care navigation. Training was through shadowing and mentoring in house. Additionally, staff had completed a care navigation course. There were opportunities for non-clinical triaging staff to speak with clinical staff if they were unsure about the best options for a patient through the duty doctor and the askmyGP service.

Arrangements were in place for people with communication difficulties, including people whose first language was not English, with a translation line available.

We also noted that during the tour of the setting at 9:30 am only 29 telephone calls had been received, we were told that this low number was due to the patients being educated about the triage system and other options available to them as well as patients calling for appointments later in the day.

The process for deciding which patients were seen face to face and those that were not, was described. We were told that over 90% of demand was resolved at this point and face to face appointments would be offered if the patient insisted on this.

We were told that there were always appointments available on the day, allocated by the duty doctor in response to requests received by use of askmyGP, as well as by telephone or in person at the practice. Children who required an urgent appointment would be flagged as a higher priority at the pre-triage stage.

Patients' percentage answers, where applicable, to the relevant question included:

- My appointment was on time - 88%
- My identity was checked – 89%
- My medical details were checked, such as allergies and long-term conditions, before medication was prescribed – 92%
- I was given enough time to explain my health needs – 98%.

All patients said they were satisfied with the opening hours of this practice and were able to contact the GP practice when they need to. All bar one patient said they were content with the type of appointment they were offered. Patients commented:

> *"Considering the problems caused by the junior doctors strike the Surgery has really been proactive in helping."*
>
> *"Online chat, a doctor has offered a test on a part of our body that has been removed after surgery!"*

Regarding whether patients with an ongoing medical condition could access the support they needed, 75% said it was 'easy' or 'very easy', but 8% said it was not easy with 17% saying not applicable. Additionally, 46% of patients said that the appointment was in person at the practice, 50% by telephone or textphone and 4% a virtual appointment.

Most patients who answered were able to get a same-day appointment when they need to see a GP urgently and said they could get routine appointments when they need them. Most patients also said they were offered the option to choose the

type of appointment they preferred. Some comments we received about accessing the practice were:

> *"I have never had any issue with this GP practice, as a health care professional myself I only ever contact the practice for myself and family when I feel is absolutely necessary that a GP is required, am always contacted within a timely manner, and treated by professional staff with respect. I have seen complaints online/social media regarding the surgery and the complaints are usually when the service is being used inappropriately and patients having unrealistic expectations of the current NHS."*
>
> *"Always responsive to requests and talk to you the same day and see you if appropriate. A very friendly practice where you feel valued."*
>
> *"My care during this short period I have needed to use the surgery has been very good. My only negative has been the difficulties I have had with the reception area, I appreciate that they are busy but it has been difficult trying to explain my personal situation and my needs with regards to appointments which I have been asked to make by the doctor."*
>
> *"Haven't spoken to the doctor, don't need an online message, haven't got an appointment! Not happy at all!"*
>
> *"I feel the askmyGP service they offer is amazing. And I think this should be rolled out across the country."*

Almost all patients knew how to access out of hours services if they needed medical advice or an appointment that could not wait until the practice opening hours.

Regarding the environment, patient answers were:

- The building was easily accessible – 100%
- There are enough seats in the waiting area – 100%
- There are toilet and hand washing facilities that suit my needs 95%
- The practice was 'child-friendly' – 64% (but 27% said they did not know or was not applicable.

All staff in the questionnaire stated that patients or their advocates were informed and involved in decisions about their care, were satisfied with the quality of care and support given to patient and overall and were content with the efforts of the practice to keep staff and patients safe. All but one respondent felt that care of patients was the practice's top priority and most said that they would be happy with the standard of care provided for themselves, friends and family.

Equitable

Communication and language
The practice provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to their individual needs to enable them to make informed decisions about their care. However, there was not a hearing loop at the practice to assist patients with hearing difficulties.

The practice needs to make a hearing loop available for patients with hearing difficulties.

Large print letters were available to patients on request and letters were mainly sent out in English. The practice had started to send out text messages to patients about certain clinics and would also do this for winter flu clinics in the future.

There were a couple of members of staff who spoke Welsh but they did not wear a 'iaith gwaith' badge, or other visual prompts to indicate they spoke Welsh. There were two patients who stated they spoke Welsh in the patient questionnaire.

We viewed a sample of five patient results and five outpatient letters. Information from secondary care electronic letters were triaged by trained summarisers. Those requesting action were printed and passed to GPs or the prescription clerk, others were summarised and filed. Paper letters were passed to doctors, before scanning and filing in Docman, the document management systems.

Incoming mail would be divided between the GPs based on the patient's address. Where one GP was absent the mail would be shared amongst the other GPs. The advance nurse practitioner would have their mail re-distributed to a GP. The incoming mail would be prepared for the 11am daily meeting, where the GPs would read and select the relevant action.

A summary of the relevant information from incoming mail would be recorded in the patients' medical notes, so that all clinical staff were aware of any new diagnosis or changes to a patient's condition. The patient would then be contacted as necessary through askmyGP or the patient would be contacted by the practice.

Where an incoming result or report of investigation required a follow-up, the patient would be contacted on three consecutive days and if no response the practice would write to the patient. The practice would normally only be informed of patients who had been admitted to hospital by the discharge letter.

Regarding carer support less than half of those who stated in the questionnaire that they cared for someone with disabilities, long-term care needs or a terminal illness had been offered an assessment of their needs as a carer. Fewer said the practice had given them details of organisations or support networks that could provide information and support.

Staff were also asked in a questionnaire about how the practice identified and supported carers. All staff stated that a register of carers was not maintained and only one said that they had a 'carers champion' at the practice. Very few stated that the practice offered an assessment of carers needs but most said they signposted carers to support organisations.

The practice must maintain a register of carers, ensure that all carers are offered an assessment of their needs as a carer and make all staff aware of the carers lead.

Rights and equality
The organisation's culture and processes supported an approach that recognised the diversity and rights of individuals. There was an equality and diversity policy dated January 2022. However, staff had not received equality and diversity training, but had attended a treat me fairly / duty of candour course.

There were examples where reasonable adjustments had been put in place so that individuals with particular protected characteristics could access and use services on an equal basis. These included disabled parking outside the practice with level access to the practice main entrance.

Regarding whether patients could access the right healthcare at the right time, regardless of any protected characteristics, 90% agreed. However, two patients said that they had faced discrimination when accessing or using this health service.

The practice must consider the issues raised by patients in the questionnaire regarding discrimination.

We were also told by the practice that there were cross border issues relating to patients living in Coelbren, a small village within the geographical area of Powys Teaching Health Board, who were patients of the practice, which was in the

geographical area of Swansea Bay University Health Board. The practice development plan also referred to the practice engaging with both Swansea Bay Health Board and Powys Health Board to overcome cross-border issues with special reference to the village of Coelbren. The examples provided suggested this was an issue of serious health inequality for patients living in Coelbren.

The practice must continue to engage with the health boards concerned and further escalate the issue as necessary, to prevent patients in Coelbren from receiving a lower standard of care than the remainder of the practice due to their geographical location in a different health board.

Delivery of Safe and Effective Care

Safe

Risk management
There were processes in place to protect the health, safety and wellbeing of all who used the service. The consulting and treatment rooms were all similar and well organised. The practice (including the clinical rooms) was clean, tidy and free of clutter. The practice was in a good state of repair and staff were pleasant and welcoming. Sharps containers were securely fixed and not overfilled.

Whilst the practice was currently using a locum to cover the diabetes service that the practice was running, we were told that the practice did not routinely employ locums to cover any medical staff absence.

There was a dedicated member of staff responsible for receiving patient safety alerts as well as handling and disseminating this information. The safety alerts would be directed to appropriate clinicians upon receipt. Significant events would be reviewed and discussed by the practice after the event or at the weekly clinical meeting.

Staff were aware of the location of the emergency equipment, in the nurses treatment room, and how to access it.

Requests for house calls were treated the same as all other requests for consultations, i.e. entered onto askmyGP, passed to the duty doctor for triage and acted upon accordingly, usually with a visit the same day, if this was felt appropriate. There was good use of askmyGP to send photos or email photos and attachments to provide a diagnosis which were attached to clinical records.

Infection, prevention and control (IPC) and decontamination
The environment, policies and procedures, staff training and governance arrangements upheld standards of IPC and protected patients, staff and visitors using the service. The practice was visibly clean, tidy and clutter free. Equipment was stored and organised appropriately. There were hand hygiene facilities available for staff, patients and visitors with appropriate sinks, soap and alcohol gel. There were appropriate signs regarding hand washing and other infection control issues around the practice.

There was a cleaning contract in place. Cleaning schedules had not been routinely kept previously but had been kept for the last four weeks. We were told that the carpets were deep cleaned every six months.

There was not a blood borne virus policy at the practice.

The practice must ensure that a blood borne virus policy is written and adopted by the practice.

The infection control policy had been reviewed and was up to date. There was an appointed IPC lead in the practice who was identified in the policy as the main lead. All practice staff knew to speak to the nursing team regarding any issues, including IPC.

Whilst the practice nurse had completed a clinical waste audit in February 2024, they were not sure of when the last IPC audit had been completed and there was no evidence of a recent audit that could be located. The policy also detailed general guidance on requesting support from the local health board IPC lead to undertake an external audit, that had also not taken place.

The practice must ensure that an IPC audit is conducted.

There were appropriate waste management procedures, waste was collected every two weeks and was stored in a dedicated location until collection. However, clinical waste bags were not labelled with the date and point of origin.

The practice must ensure that clinical waste bags are labelled with the date and point of origin.

There was an ongoing vaccination programme in place and this was recorded by practice management.

Whilst the clinical and nursing staff we spoke with were aware of the needlestick injuries procedure, this was not displayed in clinical rooms, to ensure there is a quick guide available to follow in the event of an injury.

The practice must ensure that signage is displayed in treatment rooms on the immediate actions to follow in the event of a needlestick injury.

We asked a series of questions of patients relating to IPC in the questionnaire. All the patients who answered thought the practice was clean. Almost all patients who said it was applicable to them, said there were signs at the setting explaining to patients what to do if they were contagious and that hand sanitizers were available. All bar one patient agreed that healthcare staff washed their hands before and after treating them.

In all, eight patients said they had an invasive procedure at the practice, they all agreed that:

- Staff wore gloves during the procedure
- The syringe, needle or scalpel used was individually packaged or sanitised
- Antibacterial wipes were used to clean my skin before the procedure.

Staff were also asked questions in the questionnaire about IPC and the practice scored well across infection prevention and control areas, all respondents stated that the organisation implemented an effective infection control policy and agreed that:

- There was an effective cleaning schedule in place
- Appropriate personal protective equipment was supplied and used
- The environment allowed for effective infection control.

Medicines management
The practice ensured the safe prescribing of medication. Prescription pads were securely stored at night including being removed from printers at night. GPs would use manual prescriptions for home visits.

Repeat prescriptions could be ordered at the reception desk, through various online systems as well as reorder forms at the practice or chemist. The repeat medication could not be requested by phone to prevent the risks of errors. The practice would then make the relevant checks to ensure that the medications were due. All medications no longer being taken would be flagged to the prescribing team at the practice and removed from the repeat prescribing list.

Dedicated clinical refrigerators were in place that maintained temperature within the recommended ranges. These were annually inspected by a contractor. The fridge would be checked every morning, by nursing staff or the healthcare assistant. The practice also had data loggers to constantly monitor and record fridge temperatures. In the event of the fridge failing, or if the cold chain was interrupted staff were aware of the protocol to follow. The practice also had a spare fridge available for winter season stock and as contingency for fridge failure.

The vaccines were stored correctly and according to guidelines in refrigerators of the right size to meet storage needs, there was sufficient space around the vaccine

packages for air to circulate. The practice also had vaccine cooler bags for transporting stock for house bound patient visits.

Safeguarding of children and adults
The policies, procedures and culture at the practice ensured that patients and staff were able to report safeguarding concerns. Safeguarding issues were appropriately investigated and action taken where necessary to protect the welfare of vulnerable children and adults.

The practice had a safeguarding meeting for children every eight weeks, staff had access to the GPs and health visitors if they had any concerns. The practice will also look to start safeguarding meetings every eight weeks for vulnerable adults.

Staff were aware of who the safeguarding lead was at the practice. Staff had access to safeguarding guidelines and relevant safeguarding board contact phone numbers. The All-Wales Safeguarding Procedures were installed on individual desktops.

Senior staff described the system for identifying adults at risk, this involved raising concerns about those patients where the social circumstances had changed and may impact on their care.

We were not assured that there was a system in place to ensure children on the child protection register (together with their parents / carers and siblings) could be identified from their family records. Whilst there was a pop-up box that could be used to record and highlight children at risk, this was not always used. There was also not a formal process for removing the marker when it was considered the child was no longer at risk. Although these were all discussed at the eight weekly safeguarding meetings.

The practice is to introduce a formal policy to identify the children at risk on the patient records. This should involve creating a flag on the record and removing this when the patient was no longer on the register or no longer a looked after child. The policy should also include flagging other family members records without breaching confidentiality.

All but one member of staff stated they were up to date with adult and child safeguarding training and all but two staff stated they knew how to report safeguarding concerns and knew the safeguarding lead for the practice.

Management of medical devices and equipment
The service had processes in place to ensure all equipment was used in a safe way. The checks of various items of equipment were allocated to various members of

staff and the checks were recorded. There were in date contracts for maintaining equipment and for emergency repairs and replacements.

The practice nurse checked the emergency drugs monthly, the practice was told that the check had to be made on a weekly basis.

The practice is to ensure that the emergency drugs and emergency equipment are checked on a weekly basis and a record of the check documented.

We noted one item in the emergency drugs held on site which had expired four days previously, hydrocortisone, replacement stock was on order. The practice was instructed to destroy the out-of-date drugs. This was dealt with as a concern identified and escalated during our inspection. The out-of-date stock was immediately removed and this is included in Appendix A.

There was an automatic external defibrillator (AED) available with age appropriate and in date pads, as well as being charged with in date batteries. All staff were aware of the location of the AED.

Effective

Effective care

There were suitable arrangements in place to report patient safety incidents and significant events. The practice made use of the Datix system for reporting incidents. We were told that there was a system in place to inform staff of changes to guidelines and examples of best practice, this included new National Institute for Health and Care Excellence (NICE) guidance.

There was a process in place to ensure that referrals were made appropriately.

Where patients choose to ring the practice for emergency care rather than 999, all administrative and reception staff involved had a proforma with the appropriate questions to ask. Where they identified a clinical emergency, they would advise the patient to call 999 and document the call and advice as well as notifying the on-call GP. Where the patient refused to call 999, the on-call GP would always call them back to discuss this.

Examples were provided by the practice where they had to provide emergency care for patients at the practice, this included a patient who collapsed with sepsis and where a patient had to be given cardio-pulmonary resuscitation and a defibrillator was used.

There was a robust process for ordering tests and relaying results to patients. The tests were ordered and reported via an online system. Urgent results would be actioned on the same day or next day.

Where patients had contacted the practice in crisis, the practice would attempt to contact the local crisis team, but we were told this could be extremely difficult. Patients would be initially assessed over phone by the on-call GP and given a same day appointment if needed. We were told of an example from the previous week where a patient with no previous diagnosis or history of mental illness presented at the practice in crisis. The crisis team could only offer a four-hour assessment.

The practice is made aware of the crisis team intervention when they received a discharge summary, or if notified by a family member.

Patient records
The patient medical records of ten patients were reviewed and we noted that an effective records management system was in place. Records were securely stored to prevent unauthorised access.

Records reviewed were clear, legible and of good quality. From the records, it was clear who was entering the notes of each contact, the date each contact was made and the type, such as a surgery consultation or a telephone consultation. Records were completed contemporaneously and showed evidence of valid consent being obtained, where appropriate. There was an in-date consent policy which was version controlled.

The records reflected the care or treatment provided and the relevant findings. Patients' known allergies and adverse reactions to medications were highlighted.

Every set of records checked had an issue with the language required not being recorded despite a warning message. However, all bar one member of staff agreed that there were alerts on patient records that made them aware of any patient communication difficulties.

The practice must ensure that language preferences are recorded on patient records.

Efficient

Efficient
Services were arranged to provide efficient movement through care and treatment pathways Care navigation staff would inform patients on referral routes where patients could self-refer to services.

Senior staff described the alternative processes in place to avoid inappropriate hospital admission. This included an acute clinical team, a hospital at home service and a virtual ward service for patients in the Swansea Bay University Health Board area.

The practice manager attended local community council meetings and access to services would, on occasion, be discussed there. There was a small utilisation of the urgent primary care centres (UPCC) by the practice on a weekly rather than a daily basis, to assist in managing demand when there was a shortfall at the practice.

Services available at the practice location included physiotherapy, MIND, heart failure, diabetic retinopathy screening, prediabetes team, social prescribers for local groups, counselling services and bereavement. District nurses were based at the practice, a community midwife visited one day a week, health visitors ran a joint clinic at the practice one day a week. It was noted that the podiatry service stopped attending the practice after COVID-19 and this would be well used if it returned. The practice should continue in its efforts to re-introduce the podiatry service.

District nurse students also attended practice nurse clinics, which was noted as a good practice.

Staff we spoke with said that there was no longer the availability of the monthly protected time that was in place pre COVID-19. The health board required the practice to stay open whilst training was undertaken but this was not practical, which was impacting on the delivery of training. This was an issue promoted by the actions and expectations of the health board rather than the practice. Monthly protected time was also not available to nursing staff for administration duties such as referrals. They would use the time at the end of a session or sometimes carry over the work to the next day, which we were told was not adversely impacting on patient care.

We saw evidence of spirometry clinics and coagulation clinics being run by the nursing staff which were positive to note.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain patient views on the care at Dulais Valley Primary Care Centre for the inspection in April 2024. In total, we received 13 responses from staff at this setting. All staff said they would recommend this practice as a good place to work. All but two respondents felt that they could make suggestions to improve GP services at this setting although fewer felt they were involved in any decision-making surrounding changes that may affect their work.

Leadership

Governance and leadership

There were operational systems and processes in place to support effective governance, leadership and accountability to ensure sustainable delivery of safe and effective care. Staff and managers were clear about their roles, responsibilities and reporting lines. Regular team meetings were held, these included weekly clinical meetings, weekly clinical and nursing meeting. Administrative staff would hold informal meetings at the practice hub. Practice meetings involved the clinical, nursing and practice management staff. Any information relevant for administrative staff would then be passed onto them, mainly verbally. We noted minutes of these regular meetings on file.

Any changes to the practice policies and procedures would also be communicated verbally mainly but staff could also be informed by email.

Staff were aware of the designated leads for specific practice areas.

Non-medical staff, such as care navigators worked within a recognised scope of practice and had written documentation to follow on various issues. Triage call handlers sat with a GP to grade issues this meant they received on the job training.

As a result of checks of staff records it was noted that disclosure barring service (DBS) checks were not in place for all practice staff. We were not assured that the systems and procedures in place were sufficiently robust to ensure adequate governance of the practice relating to the DBS checks. During our inspection we were told that the practice was in the process of ensuring that there were DBS checks on file for the clinicians and that none of the administrative staff had been subject to a DBS check.

These issues were dealt with by our immediate assurance process and are included in Appendix B.

Staff were asked a series of questions in the questionnaire about their health and wellbeing at work. Many respondents felt that the practice took positive action on health and wellbeing and that they could achieve a good work-life balance from their current working pattern. Whilst all staff said that in general, their job was not detrimental to their health, 79% said they were aware of the occupational health and wellbeing support available.

Workforce

Skilled and enabled workforce
There was a staff handbook which was shown to all staff and they were given training on patient medical records and signed a confidentially agreement. They also all signed up for eLearning accounts and had on the job training. Registrars were given a clinical staff book that had how to guides as well as staff training. However, we were told there was not a formal induction checklist for new staff and locums.

The practice must introduce an induction checklist for new staff and locums and also keep the evidence of the induction completed.

There were arrangements for CPD training for clinical staff and time was allocated as part of the protected learning time sessions (PLTS). Training needs for clinical staff were identified as part of their appraisals and revalidation. However, the practice development plan stated that, due to financial constraints, the practice was unable to provide PLTS at the practice level.

During the inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory training. The information showed that staff were not up to date with face-to-face basic life support (BLS) training, fire safety training, IPC training and safeguarding training.

These issues were dealt with by our immediate assurance process and are included in Appendix B.

Until recently there had not been a monitoring and reporting process in place for mandatory training.

Whilst staff were not up to date with the annual Immunisation and vaccination update training, this was due to be completed by the end of April 2024.

The records checked, showed that relevant staff had received the original Hepatitis (Hep) B vaccinations with dates, but there were no details of antibody level checks, or boosters.

The practice must ensure that all clinical staff have completed the recommended Hepatitis B vaccination schedule and that records of these are maintained on file.

Staff we spoke with said that the responsibilities for management, administration, accountability and reporting structures within the team were clearly defined and understood by team members. There was evidence of relevant job descriptions with roles and responsibilities for the workforce.

The practice was currently in a state of escalation currently called level two, due to the long-term absence of key staff and maternity leave. Senior staff we spoke with said that retention of staff was an issue. The practice was a training practice which helped with staffing of the workload, but this also took time and staff investment.

We were told that there had recently been a Royal College of General Practitioners review of the practice to look at long term sustainability of the practice, with future plans being discussed. The practice business development plan stated that the practice was currently reviewing the management team, utilising a review of their succession plan. The practice had reviewed the job descriptions of staff and introduced cross-functional team-working, with staff learning new skills, meaning that they could provide in-house cover for colleagues during both planned and unplanned absences.

Staff we spoke with raised concern about staff numbers and demands of patients, but there were financial constraints restricting the ability to employ any additional staff. We were told the main challenges and pressures being faced by the practice were staff absences. This was being addressed by administrative staff working additional hours to cover maternity leave and absences.

Regarding staff professional development, 77% of staff said they had an appraisal in the last 12 months. Many respondents felt they had appropriate training to undertake their role, 62%, with the remaining 38% said it was partially appropriate. The two comments we received on training are shown below:

"Ongoing, joined practice last month."

"Any course related to coding and keeping updated with clinical practice."

All staff respondents in the questionnaire felt there was an appropriate skill mix at the setting and that they had the materials, supplies and equipment needed to do their job. However, only half felt there was enough staff employed at the centre to allow them to do their job properly.

All staff said they were able to access ICT systems provide good care and support for patients and that patients were able to access the services this practice provided in a timely way. However, less, 77 %, said they were able to meet all the conflicting demands on their time at work.

All staff also said that they had not faced discrimination at work within the last 12 months. All bar one member of staff who answered the questionnaire said that they had fair and equal access to workplace opportunities and that the workplace was supportive of equality, diversity and inclusion

Culture

People engagement, feedback and learning
Staff we spoke with said that senior staff in the practice were visible and approachable. Staff understood and knew the overall vision and values of the practice. The mission statement was on display in staff areas. Staff said they were encouraged to speak up when they had new ideas or concerns. They were proud and happy to work for the practice and enjoyed the wide variety of work.

There was a focus on the wellbeing and needs of staff with outside events arranged for Christmas, birthdays and special occasions which were arranged informally. Staff could access occupational health referrals to the health board.

During the inspection we asked to see various policies and procedures and were shown a number of these that would benefit from version control, listing who was responsible for reviewing the procedure, when the procedure was reviewed and when it was due review. Also, a number of procedures and policies were overdue a review. The practice policies and procedures were stored on the shared drive. However, we subsequently discovered that the policies and procedures shown were not the latest version of the policies and procedures. Old policies must be archived and clearly separated from the current policies.

The practice must ensure that the:

- **Latest policies and procedures are clearly marked so that there can be no doubt which is an in-date policy or procedure and which is an out-of-date policy or procedure**

- **Policies must be version controlled, listing who was responsible for reviewing the procedure, when the procedure was reviewed and when it was due review.**

There was an in date complaints policy that included reference to a first response in two days but the policy did not reference Putting Things Right the process for raising concerns or complaints in NHS Wales. There was nothing on the policy about the number of days the practice would take to investigate and resolve the complaint, although the letter sent to the complainant referred to 30 days on the letter. The policy also referenced NHS England instead of Putting Things Right. In addition, the NHS Wales concerns process Putting Things Right must also be displayed in the practice.

The practice must ensure that the:

- **Policy is updated to include reference to the length of the investigation**
- **Reference to NHS England is deleted**
- **Reference to the NHS Wales process, Putting Things Right is included in the policy**
- **Poster on the Putting Things Right process is displayed in the practice.**

We were told that the patient information screen would display information on how the practice had learned and improved based on feedback received. However, the screen was not working during the inspection. The screen would also include information on telephone opening times, GP performance, a slide show of videos and performance of other initiatives. We were told that if the practice were running a diabetes clinic, then the screen would have mostly diabetic news.

Staff felt they would be supported if it became necessary to raise concerns about a colleague's health or if their conduct or performance gives cause for concern.

The practice used the All-Wales duty of candour policy. Staff we spoke with were able to describe the duty of candour. Most administrative staff had attended treating people fairly and duty of candour training.

The responses by staff, relating to the duty of candour in the questionnaire were as follows:

- I know and understand the duty of candour 100%

- I understand my role in meeting the duty of candour standards 100%

- My organisation encourages us to raise concerns when something has gone wrong and to share this with the patient 92%.

Regarding incidents, concerns and safeguarding, all staff agreed that that the organisation encouraged them to report errors, near misses or incidents and that the organisation took action to ensure that they did not reoccur. All bar one member staff agreed that feedback was given in response to reported errors, near misses or incidents and that staff involved were treated fairly. Staff we spoke with felt able to raise any concerns.

Information

Information governance and digital technology
There were systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of data and information. This included phone answering times, number of prescriptions issued, referrals and did not attend for an appointment.

The practice used Digital Health and Care Wales to provide the services of the data protection officer. There was a privacy notice on the website for handling data. This was displayed in the waiting area and on the practice website.

There were comprehensive, in date and version controlled, policies relating to information governance. The practice ran a data integrity audit on the software within vision to ensure that the Read codes, a standardised system within healthcare records for codifying medical data, could be checked against the prescription issued.

Effective arrangements were in place to ensure that data or notifications were submitted to external bodies as required and there were clear performance measures, which were reported and monitored. These included the regular review of immunisation targets and flu targets.

Learning, improvement and research

Quality improvement activities
There was a programme of reviews to monitor quality, these included GP hot reviews, clinical meetings, medicines management audits and childhood immunisation uptake. Learning was shared across the practice to make improvements, at practice meetings.

Whole-systems approach

Partnership working and development
The practice was a member of the Upper Valleys GP Collaborative. The practice development plan stated that the practice was working within the collaborative regarding the intermediate medium-term plan, quality information framework projects, allocation of personal medical services monies and any items of common interest.

We were told that the GPs at the practice met with other clinicians to reflect on the delivery of service.

The practice also hosted a virtual ward, typically house bound patients, which allowed patients to receive the care they needed at home safely and conveniently, rather than being in hospital.

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
We noted one item in the emergency drugs held on site which had expired four days previously, Hydrocortisone, replacement stock was on order.	Out-of-date medicines can pose risks due to changes in their chemical composition over time.	The practice was instructed to destroy the out-of-date drugs.	The practice destroyed the out-of-date drugs.

Appendix B – Immediate improvement plan

Service: Dulais Valley Primary Care Centre

Date of inspection: 3 April 2024

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.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During our inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory training. The information showed that staff were not up to date with: • Face-to-face basic life support (BLS) training, with the last training having taken place	The practice is required to: • Maintain a mandatory training schedule to ensure staff are up to date with the requirements and identify when staff were due training • Ensure that all staff had appropriate training in basic life support and medical emergencies, IPC, fire safety and safeguarding	Health and Care Quality Standards – Safe Health and Care Quality Standards – Workforce	**Face to Face BLS Training** - Practice has secured BLS training for all clinical staff via SBUHB – a combination of venues at NPTH and Morriston Hospital Upon completion of the training these will be recorded on a training schedule which will include the due dates. **Fire Safety Training** - Following a meeting on Monday 8th April with the SBUHB Building Manager and the Landlord's Health and Safety Officer the recommendations are agreed to	Practice Manager	17 May 2024 24 May 2024

	prior to COVID-19. Staff had undertaken the online eLearning. We were told that the practice was negotiating with St John Ambulance Cymru to arrange the training. • Fire safety training • Infection prevention and control (IPC) training (apart from the practice nurse and advanced nurse practitioner) • The safeguarding training, the training undertaken was not the required online eLearning for Safeguarding Adults and the majority of staff had not completed	training appropriate to their role • Provide HIW with evidence to support the training undertaken by staff • Ensure that training records are updated to include any training carried out as part of revalidation of clinical staff.		train all clinical and admin staff with the revised fire and evacuation plan which is due for completion by 17th May 2024 Lyn Jenkins is to provide evidence of all actions required by each member of staff and to incorporate the actions required by other users of the Practice in the form of a formal induction and agreement process. In this process a new fire evacuation plan will be drawn up. Practice Manager will provide all details in the form of a report. **IPC** - Staff have been rota'd to carry out all the necessary IPC training no later than the 17th April 2024 the appropriate level and certified copies of this training will be supplied. The training will be included in the training schedule. **Safeguarding Training** - Staff have been rota'd to carry out all the necessary IPC training no later than the 17 April 2024 the appropriate level and certified copies of this		24 May 2024 24 May 2024

	Safeguarding Children training. The senior partner said that they were up to date with level three safeguarding as part of their role as safeguarding lead. HIW were not assured that staff had the required up-to-date skills to perform effective BLS resuscitation, would know what to do in the event of a fire and did not have sufficient knowledge on IPC and safeguarding. This posed a potential risk to the safety and wellbeing of patients.			training will be supplied. The training will be included in the training schedule. **To maintain Mandatory Training Schedules** - The Deputy Practice Manager will set up and maintain mandatory training schedules which will depict the date of the latest training carried out and the next training due date. She will also diarise reminders with sufficient lead time to ensure that the training is maintained. Provide HIW with evidence to support the training undertaken - All appropriate face to face and e learning training certificates will be included as appendices to the training schedule. All on going appropriate training certificates will be maintained on time and on an event basis.		24 May 2024 24 May 2024

			Actions Completed as of 21/05/2024 – Mandatory training schedule provided which includes face to face BLS training, the practice confirms that all face to face BLS training for the clinical team has been completed, which includes 2 members of the admin team as backup support. Fire Safety Training – all staff have undertaken fire safety basic awareness training on e-learning and have had e-mails from the practice manager stating their role as fire wardens in the event of a fire. The fire plan has been manually updated depicting the additional fire doors and is in the process of being electronically drawn up by the Health Board Building Team in CAD format. Safeguarding – Not yet completed, due to staff pressures, bank holidays and COVID Spring Booster planning, preparation and execution. Revised target date for completion – 30th June 2024. Infection Prevention & Control – 100% of those available for training have completed Level 2 with the remainder to complete on their return to work from long term illness and maternity.			
2.	HIW were not assured that the systems and procedures in place were sufficiently robust to ensure adequate	The practice must ensure that: • Relevant DBS checks are completed for all	Health and Care Quality Standards – Workforce	**Management and Leadership -DBS checks for all staff -** All clinical staff DBS checks have been submitted, the results of which will be added to the training schedule.		Awaiting results from DBS service.

	governance of the practice relating to the Disclosure Barring Service (DBS) checks. During our inspection we were told that the practice was in the process of ensuring that there were DBS checks on file for the clinicians and that none of the administrative staff had been subject to a DBS check.	staff, this should be carried out prior to employment and evidence of this maintained on file • Staff annually confirm that the information on the DBS check remains accurate and that there have not been any changes since this check • Staff are reminded that they must inform the practice management of any issues or convictions that would affect their DBS status.		All Administrative staff have been issued with DBS forms the return date to the Practice has been set as 17th May 2024 with formal submission on the 18th May 2024. Will be submitted by the Deputy Practice Manager to the DBS service on 18th May 2024, then training schedules will be updated when results received. Staff Annually confirm that the information on the DBS certificate remains accurate - As part of the staff annual appraisal system, staff will require to complete a signed annual declaration to this effect. No later than 31st March each year. Staff are reminded that they must inform Practice Management of any issues or convictions that might affect their DBS status - HR Consultants to amend either staff contracts of employment or the staff book which ever they deem		24 May 2024 24 May 2024

				appropriate and the amendments to be notified to all staff. DBS for new staff to be carried out to prior to start date - During the interview process all new applicants will be advised that a DBS check will be required and as a condition of employment this check must be carried out prior to their start date. HR Consultant to either amend contract of employment or staff handbook.		24 May 2024
			Actions completed as of 21/05/2024 All staff have currently carried out DBS applications and we are now awaiting the DBS service to ensure compliance. Staff have been instructed by email that on or before 31st March 2025 they will be required to complete a mandatory self-declaration that there are no issues that need to be brought to our attention that could affect their DBS status.			

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): **Lyn Jenkins**

Job role:	**Practice Manager**
Date:	**10 April 2024 (Updated 21 May 2024)**

Appendix C - Improvement plan

Service: Dulais Valley Primary Care Centre

Date of inspection: 3 April 2024

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.	Patients who could not access the website or QR codes, could not access information to help promote their health, improve their health and lead a healthy lifestyle.	The practice is to confer with the health board infection prevention and control lead and re-introduce the leaflets back on display if authorised.	Health and Care Quality Standards – Health Promotion	1) A notice board has been designated to promote Health & a Healthy Lifestyle; copies of relevant leaflets are displayed (printed on cleanable material) with instructions on how to obtain copies from Reception 2) All clinicians print leaflets for patients if appropriate during consultations 3) Fire Inspector	Reception Supervisor Clinicians	May 31st 2024 May 10th, 2024

				approved items 1 & 2 above, as historically leaflets are deemed a source of fire.	Practice Manager	May 10th 2024
2.	There was no formal DNA policy, as the practice did not believe they needed a policy currently. However, there is a need to document the process followed to ensure that staff follow the correct procedure.	The practice must ensure that there is a documented policy, including the process to be followed, for DNAs at both the practice and for hospital appointments.	Health and Care Quality Standards – Health Promotion	1) Policy formulated will be presented at practice meeting for approval by GP Partners 2) All DNAs are entered on patient records, patients contacted by practice to investigate	Practice Manager	May 31st 2024
3.	There was not a hearing loop at the practice to assist patients with hearing difficulties.	The practice needs to make a hearing loop available for patients with hearing difficulties.	Health and Care Quality Standards – Equitable	Discussions underway with SBUHB Buildings Manager and Landlord underway	Practice Manager	No timescale set, discussions ongoing will as a minimum be included in the next

						round of improvement grant applications
4.	Less than half of those who stated in the questionnaire that they cared for someone with disabilities, long-term care needs or a terminal illness had been offered an assessment of their needs as a carer. Even fewer said the practice had given them details of organisations or support networks that could provide information and support.	The practice must maintain a register of carers, ensure that all carers are offered an assessment of their needs as a carer and make all staff aware of the carers lead.	Health and Care Quality Standards – Equitable	Matter raised with Social Prescribing Support Team, Poster under development. Full reference re: support and contact points specified on the poster. Poster will be displayed at Reception desk.	Practice Manager and Social Prescribing Team (NPTCBC CVS)	Poster Due June 30th 2024

5.	Two patients said that they had faced discrimination when accessing or using this health service.	The practice must consider the issues raised by patients in the questionnaire regarding discrimination.	Health and Care Quality Standards – Rights and Equality	We have no record of any discriminatory concerns. Without details, it is difficult to address specifics. Matter raised at practice meetings.	Practice Manager	Matter raised, positions being monitored. No timescale.
6.	We were told by the practice that there were cross border issues relating to patients living in Coelbren, a small village within the geographical area of Powys Teaching Health Board, who were patients of the practice, which was in the geographical area of Swansea Bay University Health Board. The examples provided suggested	The practice must continue to engage with the health boards concerned and further escalate the issue as necessary, to prevent patients in Coelbren from receiving a lower standard of care than the remainder of the practice due to their geographical location in a different health board.	Health and Care Quality Standards – Rights and Equality	This matter is being dealt with by Powys and SBUHB's chief executives. Practice Manager applying pressure to resolve this matter.	Practice Manager	No date set, out of practice control.

	this was an issue of health inequality for patients living in Coelbren.					
7.	The practice were not sure of when the last IPC audit had been completed and there was no evidence of a recent audit that could be located.	The practice must ensure that an IPC audit is conducted.	Health and Care Quality Standards – IPC	Practice undertakes to carry out audit, on return of infection control lead (head nurse) forecasted return date May 14th, 2024. Due to phased return to work, the audit will be planned for sometime in the summer.	Head Nurse	To be agreed.
8.	There was not a blood borne virus policy at the practice.	The practice must ensure that a blood borne virus policy is written and adopted by the practice.	Health and Care Quality Standards – IPC	Policy formulated and will be adopted once approved in a clinical meeting.	Head Nurse and Senior Partner	June 28th, 2024.
9.	Clinical waste bags were not labelled	The practice must ensure that clinical waste bags	Health and Care Quality Standards – IPC	Procedure changed	HCSW and Practice Nurse	Completed 10th May 2024.

	with the date and point of origin.	are labelled with the date and point of origin.				
10.	Whilst the clinical and nursing staff we spoke with were aware of the needlestick injuries procedure, this was not displayed in clinical rooms, to ensure there is a quick guide available to follow in the event of an injury.	The practice must ensure that signage is displayed in treatment rooms on the immediate actions to follow in the event of a needlestick injury.	Health and Care Quality Standards – IPC	Poster displayed in every clinical room. Issue discussed at Practice clinical meeting	Senior Partner and Practice Manager	10th May 2024.
11.	We were not assured that there was a system in place to ensure children on the child protection register (together with their parents / carers and siblings) could be identified	The practice is to introduce a formal policy to identify the children at risk on the patient records. This should involve creating a flag on the record and removing this when the patient was no longer on the register or	Health and Care Quality Standards – Safeguarding	Children at risk are recorded and coded. The Practice does NOT remove this, it is left on the record to maintain awareness of historical concerns	Child Lead and Health Visitor	Date of last meeting, May 14th, 2024.

	from their family records. Whilst there was a pop-up box that could be used to record and highlight children at risk, this was not always used. There was also not a formal process for removing the marker when it was considered the child was no longer at risk. Although these were all discussed at the eight weekly safeguarding meetings.	no longer a looked after child. The policy should also include flagging other family members records without breaching confidentiality.		Safeguarding meetings held bi-monthly		
12.	The practice nurse checked the emergency drugs monthly, the practice was told that the check had to be	The practice is to ensure that the emergency drugs and emergency equipment are checked on a weekly basis and a record of the check documented.	Health and Care Quality Standards – Medical Devices	Practice Policy changed to weekly and record of checks introduced.	Head Nurse and Practice Nurse	10th May 2024.

	made on a weekly basis.					
13.	Every set of records checked had an issue with the language required not being recorded despite a warning message.	The practice must ensure that language preferences are recorded on patient records.	Health and Care Quality Standards – Patient Records	Practice has commenced recording in 2 ways a) On registration b) Has commissioned "wiggly apps" to add option at patients check in	Practice Manager	June 28th, 2024.
14.	We were told there was not a formal induction checklist for new staff and locums.	The practice must introduce an induction checklist for new staff and locums and also keep the evidence of the induction completed.	Health and Care Quality Standards – Workforce	Locum folder in "G: Drive", formal reference to this folder added to checklist	Assistant Practice Manager	June 28th, 2024.
15.	The records checked, showed that relevant staff had received the original Hepatitis (Hep) B vaccinations with dates, but there were no details of	The practice must ensure that all clinical staff have completed the recommended Hepatitis B vaccination schedule and that records of these are maintained on file.	Health and Care Quality Standards – Workforce	All records re visited and updated	Assistant Practice Manager	Completed May 20th, 2024.

	antibody level checks, or boosters.					
16.	However, we subsequently discovered that the policies and procedures shown were not the latest version of the policies and procedures. Old policies must be archived and clearly separated from the current policies.	The practice must ensure that the: • Latest policies and procedures are clearly marked so that there can be no doubt which is an in-date policy or procedure and which is an out-of-date policy or procedure • Policies must be version controlled, listing who was responsible for reviewing the procedure, when the procedure was reviewed and when it was due review.	Health and Care Quality Standards – Culture	All out of date policies either deleted or marked as SUPERCEEDED/ARCHIVED		Completed May 14th, 2024.

17.	There was a in date complaints policy that included reference to a first response in two days but the policy did not reference Putting Things Right the process for raising concerns or complaints in NHS Wales. There was nothing on the policy about the number of days the practice would take to investigate and resolve the complaint, although the letter sent to the complainant referred to 30 days on the letter. The policy also referenced NHS England instead of Putting Things Right. In addition, the NHS	The practice must ensure that the: • Policy is updated to include reference to the length of the investigation • Reference to NHS England is deleted • Reference to the NHS Wales process, Putting Things Right is included in the policy • Poster on the Putting Things Right process is displayed in the practice.	Health and Care Quality Standards – Culture	Revised Policy introduced with reference to a) "Putting things right". b) Dates amended. c) Removed reference to "England".		Completed May 14th, 2024.

	Wales concerns process Putting Things Right must also be displayed in the practice.					

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): LYN JENKINS

Job role: PRACTICE MANAGER

Date: 20/05/2024