Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Preseli Practice Newport, Hywel Dda 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 Preseli Practice Newport, Hywel Dda University Health Board on 30 July 2024.

Our team for the inspection comprised of three HIW healthcare inspectors and three clinical peer reviewers. The inspection was led by a HIW senior healthcare inspector.

During the inspection we invited patients or their relatives/ 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 62 questionnaires were completed by patients or their carer's and nine were completed by staff. The 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.

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 findings from our patient questionnaires were positive. Almost all patients felt they were treated with dignity and respect and all rated the service as 'good' or 'very good.' During our inspection we witnessed staff speaking to patients and their carers in a polite and positive manner.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The patient waiting room was clean and spacious, with a separate room available for private discussions.

The practice should improve the health promotion information available and ensure that all carers are offered a carers assessment.

This is what we recommend the service can improve:

- Have a better range of health promotion information available for patients
- Ensure that all patients registered as carers are offered an assessment of their needs
- Document the process for care navigation.

This is what the service did well:

- Good patient access
- Waiting area pleasant and airy with bilingual signage
- Ensured that patients felt they were treated with dignity and respect with good service.

Delivery of Safe and Effective Care

Overall summary:
Our findings demonstrated a dedicated and enthusiastic clinical team who worked hard to provide patients with safe and effective care, in a clean and tidy environment, which was free from clutter.

Patients felt the building was accessible and child friendly, and there were enough seats in the waiting area. Almost all said the toilet facilities were suitable for their needs.

The patient medical notes were of a good quality with safe and effective management of acute and chronic illness. There was a clear narrative with

evidence of patient centred decision making and judicious use of medical and psychosocial interventions.

Improvement was needed to strengthen local safeguarding processes by implementing a local safeguarding policy which would support staff alongside the Wales Safeguarding Procedures.

Improvements were needed with the completion of cleaning schedules and appropriate equipment, such as a selection of mops and buckets available to clean different environments in the practice to minimise the risk of cross contamination.

This is what we recommend the service can improve:

- Implement a local safeguarding policy
- Introduce cleaning schedules and ensure sufficient availability of mops and buckets to prevent cross contamination
- Signage and use of sharps bins to ensure they are used correctly and not overfilled.

This is what the service did well:

- Good compliance with emergency equipment checks and appropriate emergency drugs boxes in use
- Good quality patient medical notes
- Regular weekly clinical meetings which were well recorded.

Quality of Management and Leadership

Overall summary:
The quality of management and leadership was satisfactory, with clear reporting lines and a dedicated and committed practice management and senior team.

Responses from staff who completed the questionnaire were generally positive. All staff felt that the care of patients was this practice's top priority and overall, they were content with the efforts of the practice to keep staff and patients safe.

We issued an immediate assurance in relation to the lack of a valid hepatitis B register. Staff have since taken action to resolve this issue. Improvement was also needed with the version control of policies and procedures and not all the required policies and procedures were in place. Compliance with all mandatory training was also needed.

Immediate assurances:

- The inspection team were not provided with evidence that the practice could assure itself regarding the hepatitis B immunity status of clinical staff,

to protect themselves, those they are close to and work with, and people attending the practice for clinical consultations or care.

This is what we recommend the service can improve:

- Compliance with mandatory training
- Ensure policies and procedures are version controlled, list an author, an implementation date and review dates.

This is what the service did well:

- Good collaboration between the practice and the local GP cluster
- Duty of candour training completed by staff
- Well managed complaints process with few complaints.

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 Preseli Practice for the inspection that took place in July 2024. In total, we received 62 responses from patients at this setting. Responses were overall 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 included the following:

> *"Fantastic service as usual. Very polite and respectful. Have been brilliant with my ongoing conditions."*

> *"Preseli Practice is an excellent practice. My needs are always listened to. I have no problem getting an appointment when needed. The staff are very friendly, efficient and professional. We are also very fortunate to have a lovely, modern surgery which is very accessible and very well maintained."*

> *"Incredibly friendly receptionists, helpful and insightful GPs willing to help and follow up where needed. I'm very fortunate to be registered at such a great GP practice. The only issue I have is sometimes routine appointments have long wait times which results in more urgent appointments needed to be booked. Though I have worked at various GP surgeries myself so I know this issue isn't isolated to this Surgery and is a UK wide epidemic."*

> *"As a [patient] with complicated health problems I have never been treated so well by any practice in my life. It is an amazing practice and all the staff are so friendly and helpful. If they can, they will! It concerns me, however that the shortage of doctors, closing surgeries and the ever expansion of building with no extra resources will, sadly but inevitably, put an ever-increasing pressure on all the staff. This increasing stress will make it difficult to retain staff and will become a doom loop of unsustainability."*

> *"Excellent building, practice manager. Some Drs seem inexperienced, poor judgement. Others are great. Never know who is a regular member of [the] team and who is locum. Have never seen the same Dr twice!"*

"With the amount of training for new doctors that goes on here, it is sometimes difficult to see the same doctor twice running. I feel that continuity is very important and I will always ask to see one of the permanent staff."

Person-centred

Health promotion
Senior staff at the practice spoke about the practice's patients health questionnaire, which included questions about patients' health status and if they required any support. Whilst there was a nursing assistant in post who was a lifestyle advocate to support patients, there was nothing advertised about this service. The practice intended to start a process to signpost patients with these initiatives in due course.

We found some local health board initiatives which had been implemented at the practice, which included self-referral to physiotherapy and musculoskeletal services. Staff also told us about the 'Elemental' system in use, which helped healthcare professionals to signpost patients to non-medical support services, which could improve their wellbeing. There was also a direct link to the local community hub which offered advice and support with social needs.

We were told that several health promotion leaflets had been removed from waiting areas during the COVID-19 pandemic. However, these had not been re-introduced since then. Health promotion information should be made readily available to patients, about the services they can access, particularly relating to smoking cessation, healthy eating and healthy lifestyle.

That being said, responses in our patient questionnaire suggested there was health promotion and patient information material on display, and 79% said they were offered healthy lifestyle advice. Additionally, respondents to our staff questionnaire said the practice offered health promotion advice and information about chronic conditions to patients in a variety of mediums.

The practice must ensure that more health information is available at the practice to ensure that patients are aware of the options available to improve their healthy lifestyle choices.

There were healthcare professionals co-located at the practice, such as health visitors and midwives. The practice also employed an advanced paramedic practitioner, which was a positive initiative given the practice's rural location and the distance and travel time to a general hospital.

Staff told us they would be offering the winter vaccination and a campaign would be started following our inspection. This would be promoted on social media, the practice website and by text messaging. For those patients without digital access, the campaign would be promoted at the practice and staff would also telephone eligible patients.

Nine respondents to the patient questionnaire said they cared for someone with disabilities, long-term care needs or terminal illness. Only two of those said they had been offered an assessment of their needs as a carer and four said the practice had given them details of organisations or support networks that could provide information and support. However, our questionnaire asked staff how the practice identifies and supports carers. All respondents felt that the practice maintained a register of carers, offered them an assessment of their needs and signpost carers to support organisations. All but one member of staff said that the practice had a carer's champion.

The practice must ensure that all patients registered as carers are offered an assessment of their needs as a carer and are signposted to carer support services.

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

The clinical rooms provided appropriate levels of privacy, with lockable doors. There were also disposable privacy curtains within the examination rooms. The external windows had appropriate frosted glass and / or curtains to maintain privacy.

All staff said that measures were taken to protect patient confidentiality. For example, ensuring patient information was not overlooked or overheard and they felt that measures were taken to protect patient privacy and dignity. A room was also available to maintain discreet conversations between patients and staff next to the reception area. Whilst some telephone conversation could be overheard in reception, we were told that no patient identifiable information would be discussed. However, only 61% of patients said that they were able to talk to reception staff without being overheard.

The practice must ensure that all patients conversations, including telephone conversations, are private to ensure the privacy of all patient issues.

The practice offered both male and female chaperones in all appropriate circumstances, and there was a chaperone policy in place. However, whilst there

was a sign in reception saying that chaperones were available on request, there was not a notice in each clinical room. The chaperones were provided with online training through e-learning Wales. Most patients said they were offered a chaperone for intimate examinations or procedures. All respondents to our staff questionnaire said that patients were offered chaperones when appropriate.

The practice must ensure that there is a chaperone availability notice displayed in each consultation and treatment room to advise patients of the service.

All but one respondent in our patient questionnaire felt they were treated with dignity and respect and all felt measures were taken to protect their privacy. Almost all who answered felt the GP explained things well, answered their questions and that they felt involved in decisions about their healthcare. Some comments we received include:

> ***"The care and compassion of the staff at the practice is second to none. I and my family have been patients of the practice for over 40 years and they continually strive to provide the best care to their patients in a clean and comfortable environment."***
>
> ***"This GP practice is excellent. The receptionists are all very polite and very helpful. The doctors are all very good and attentive. The surgery contacts you with information regarding results if necessary. The best GP surgery by far!"***
>
> ***"All staff are kind, friendly and caring."***

Timely

Timely care

There were processes in place to ensure patients could access the appropriate care in a timely way and with the most appropriate person.

The arrangements for patients to access services were described with different access models being used. There was an appointment access policy in place to support this. There was a mixture of on the day and pre-bookable appointments up to five weeks in advance. Triage processes were in place to decide which patients needed face-to-face consultations or other means. Where a patient needed urgent support, we were told that additional appointments would be made available to address these needs. All children would be seen on request, regardless of their condition. Non-clinical staff had access to a clinician to triage appointments.

Following triage, patients were informed and signposted to the most appropriate service to manage their needs. This included accessing GP cluster-based services, such as the cluster pharmacist, physiotherapist and heart failure nurse.

Whilst a clear process was described for care navigation this was not documented. There was a need for a clearly documented care navigation process for staff to follow to ensure consistency in their approach.

The practice must ensure that a process is documented for care navigation.

There was a process in place for patients who required urgent mental health support or were experiencing a crisis. Staff highlighted that access to the community mental health team was good and patients would be triaged for a mental health condition promptly. We were also told that referrals to children and adolescent mental health services could be completed within an hour. There were also other mental health care services available, such as the primary mental health counselling service within the health board.

For more vulnerable groups of people, such as those with more challenging or complex needs, or language barriers, face-to-face appointments were available.

Most respondents to our patient questionnaire felt they could obtain a same-day appointment when they needed to see a GP urgently and they could also arrange routine appointments when necessary. Some patient comments we received about accessing the GP were:

> ***"I have several health conditions and have to seek medical appointments to speak to GP and have blood tests etc. Reception staff are always helpful and if they say they will call you back, they do, they always try to help. Some of the GPs are extremely helpful. I have one particular GP I like to see as she listens and tries to help but explains things well. They often over run and appointments aren't usually on time but I don't mind this as they are clearly helping other patients."***
>
> ***"I think they need to be more flexible on the days you can see a nurse for things. I should be able to book an appointment for my day off even if I have to wait a few weeks. I am prepared to wait to get the day I need."***

Whilst 58% of patients agreed they were offered the option to choose their preferred appointment type, 17% were not sure. Almost all patients said they were content with the type of appointment they were offered. Two patients commented:

"To long a wait and only offered the needed appointment on certain weekdays. So not able to organise for my day off."

"Not had an appointment as yet as I have only just moved there but the services provided so far with prescriptions and registration has been 100% excellent."

Regarding access to the practice, all but one patient said they were satisfied with the opening hours of the practice and most said they could contact the practice when needed. For patients with an ongoing medical condition, 90% said they were easily able to access the regular support they needed. Similarly, 90% of patients said they knew how to access out of hours services if they needed medical advice or consultation if it could not wait until the practice was open.

When considering their experience of appointments, responses to our survey found that 77% of patients said their appointment was on time. 87% said their identity was checked, such as date of birth and address. Also, 90% said their allergy status and ongoing medical conditions were checked prior to the GP prescribing new medications, 96% felt they had enough time to explain their health needs and 95% felt they were listened to.

All staff agreed that patients were able to access the services this GP practice provided in a timely way.

Equitable

Communication and language

We found that staff communicated clearly in a language and manner appropriate to patient needs. They also provided information in a way that enabled patients to make informed decisions about their care.

Patients were usually informed about the services offered at the practice through the website and by a text messaging service for example when patients were due an influenza (flu) vaccination or a medication review. Where patients were known not to have a mobile phone, letters would be sent to individuals and communication through telephone calls. There was also a comprehensive, bilingual, patient information leaflet service available in the practice. We were told that the practice was also considering developing a quarterly newsletter for patients.

We also found that information could be provided in larger font where necessary, and in ‘easy read’ on request, which had been produced by the learning disability team at the health board.

For specific programmes such as the flu vaccine, posters were displayed in the local pharmacy, on the local town notice board and in the community hub. We were told that the Pembrokeshire Association of Voluntary Services (PAVS) also attended the flu clinics to give information to patient about their service and food packages where necessary. Where applicable, patients would be provided with transport through PAVS and Age Cymru for the flu clinics.

All staff in the questionnaire said that there were alerts on patient records that made staff aware of any communication difficulties. There were seven patients who said their preferred language was Welsh, with five saying that they were actively offered the opportunity to speak Welsh throughout the patient journey at least sometimes.

In all five of the nine staff who answered the question said they were a Welsh speaker, but they did not always wear a ‘iaith gwaith’ badge or lanyard. Four of the five Welsh speakers said that patients were asked to state their preferred language. They said that they used Welsh language in everyday conversations at least ‘sometimes’ and three said they were given the opportunity to train in Welsh.

There were good processes for the flow of patient letters and patient documents circulated around the practice. Information from secondary care was recorded and acted upon appropriately, such as inpatient hospital discharge letters, outpatient letters and patient results. This was done using a document management system with clear workflow to clinicians of incoming correspondence. This was supported by a current workflow policy.

Discharge details were clearly recorded in patient records so that staff accessing the records could understand the discharge plan or longer-term needs, post discharge. We also found good examples of follow up consultations with patients, to discuss the correspondence received. There was a clear narrative recorded of patient discussions.

The practice recorded telephone calls for training purposes and patients were informed of this in the telephone message service. Patient information for requesting a home visit were also added to the message and these were recorded in the home visit appointment book.

Relevant information from incoming mail would be recorded in the patients' medical summary, to ensure all clinical staff were aware of any new diagnosis or changes to a patient's condition. Administrative staff would complete the relevant Read coding, a coded thesaurus of clinical terms, and the letter draft was sent to the relevant GP for accuracy and approval.

Any out of hours GP consultation information was received by the practice, via a secure link, and was provided to the relevant duty GP for review. Where relevant, the GP would contact the patient. There was also a system in place to alert the out-of-hours GP services or duty doctor of patients receiving end of life care and for alerting the practice team if a patient had died.

Rights and equality
The practice's culture and its processes supported the equality and diversity of individuals. Equality and diversity were promoted through practice policies and staff training. Staff had also received learning disability training. Staff treated everyone equally and fairly.

There was a slight slope outside up to the practice. However, all but one patient said that the building was easily accessible and almost all patients thought that the practice was 'child-friendly'.

There was level access in the practice and all consulting and treatment rooms were on the ground floor along with a disabled access toilet. There was no lift to the upper floor. However, most administrative staff were located on the ground floor. There was also an accessible section of the reception desk at the entrance to the practice. There were raised chairs and chairs with arms in the reception area, to help patients with mobility difficulties.

Staff said they were aware of the patients that required additional needs, such as those needing a quieter area of reception for sensitive needs, or who may need additional privacy for some conditions, such as autism or attention deficit hyperactivity disorder. The practice also offered some patients with appointments later in the day when the environment was quieter and less patients in the building. For patients who may need isolation from others, staff were aware of locating them as appropriate to a separate waiting room.

Senior staff stated that work-based risk assessments had been carried out for some staff and subsequently opportunities to work from home were provided where necessary.

The practice was proactive in upholding the rights of transgender patients. We were told transgender patients were treated with sensitivity and it was confirmed

that their preferred names and pronouns would always be used. There had also been changes to the new patient questionnaire with different pronouns and how patients wanted to be addressed were included.

Most respondents in our patients questionnaire felt they could access the right healthcare at the right time. The two comments we received on equality were:

> ***"There is a good level of understanding to general problems, but perhaps there could be more instruction in specific areas?"***

> ***"Not a solid yes. Routines are not easy to book."***

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, including within clinical rooms. The practice was clean and tidy, free of clutter and in a good state of repair.

During the tour of the practice, we noted a single mop was in use in the house keeping cupboard. This meant that the same mop was used to clean all the clinical areas, waiting room and kitchen. This posed a risk of cross-infection from area to area. We raised this with the practice manager during our inspection, they resolved this issue during the inspection and ordered several colour coded mops and buckets to ensure each area was cleaned appropriately to minimize the risk of cross contamination. Further details can be found in Appendix A.

We were told that there was a low demand for home visits, these were limited to housebound and palliative care patients. However, there was not a home visit policy, nor a lone working policy. The practice needed to draft a lone working and home visiting policy to ensure the safety of staff and to ensure there is consistency in allowing home visits.

The practice must ensure that a home visit and lone working policy is written and made known to all staff.

There was a current Business Continuity Plan (BCP) in place which staff could access online and there was a hardcopy available behind reception. Whilst there was not considered to be a risk with the current partners, the practice should include reference to this to note that the risk had been considered in the BCP. The practice had a policy in place to deal with a significant health emergency such as a cardiac arrest or anaphylaxis. Whilst there was a COVID-19 policy in place, this should now be re-drafted to be a pandemic policy.

The practice had a clear process for patient safety alerts, where relevant managers disseminate the alerts to staff. Safety alerts were also covered in the staff induction process. Patient safety alerts and patient safety incidents would also be shared and discussed in the clinical meetings, which was evidenced in the minutes we reviewed. These meetings also provided learning from significant events and any other pertinent topics. The meeting minutes were also disseminated to those not in attendance.

We asked senior staff whether there were any outstanding estates issues. We were informed of issues with renewing the lease of the premises which had been ongoing for almost two years. It was, therefore, difficult for the practice staff to carry out any significant changes to the fabric of the building.

All respondents to our patient questionnaire, said there were enough seats in the waiting area and the toilet and hand washing facilities suited their needs.

Infection, prevention and control (IPC) and decontamination
The environment, policies and procedures, staff training and governance arrangements needed improvement to uphold standards of IPC and protect patients, staff and visitors using the service. However, in our questionnaire most the patients felt the setting was 'very clean' or 'clean'. Additionally, all staff were positive in their comments about the cleanliness of the practice.

The practice had a current IPC policy and a blood borne virus policy. There was also a process in place for any needlestick injuries. Nursing staff we spoke with were aware that policies and procedures were accessible on the shared drive. The nursing team appeared to work well together, with all relevant nursing policies easy to find.

There was an appointed IPC lead in the practice. We saw evidence that the last infection control audit had been undertaken in the last three months. The practice had taken steps, to reduce the risks of healthcare associated infections, which had previously been in use during the pandemic. This included a clinical room that could be used for segregation if required.

Some areas of the practice did however need improvement to maintain robust IPC, these included:

- Sharps bins were overfilled and visibly contained inappropriate items, such as swabs and hand towels

- There was no signage displayed to include what should be put into sharps bins and sharps disposal measures will need to be addressed

- There were no female hygiene bins within the downstairs toilets for appropriate disposal

- Appropriate hand hygiene facilities and personal protective equipment was available, there was no appropriate handwashing instructions displayed above the sinks in clinical rooms

- Disposable privacy curtains in clinical rooms were not dated as required, to highlight when they had been installed, to determine the replacement date (usually six monthly, unless contaminated sooner)

- There was an absence of information for the Control of Substances Hazardous to Health (COSHH), including no policy or data sheets for the materials used

- No cleaning schedules were available for review during the inspection.

The practice must ensure that IPC is improved by carrying out the following actions:

- **Staff are informed on the correct contents of sharps bins and their disposal when required. Additionally, posters may support staff knowledge on waste segregation**

- **Female hygiene bins must be placed in all toilets at the practice**

- **Hand washing instructions must be appropriately displayed above hand washing sinks**

- **Privacy curtains must be dated to ensure they are replaced in a timely manner**

- **A COSHH policy must be implemented and COSHH data sheets must be available for staff information**

- **Cleaning schedules must be completed and maintained on file.**

All respondents to our patient questionnaire said there were notices displayed explaining the procedure if patients attending were contagious. In addition, all but one patient who responded said that hand sanitisers were available and that healthcare staff washed their hands before and after treating them.

In total 29 respondents in our patient survey said they had received an invasive procedure, this included blood tests, injections and minor procedures. All patients said that the equipment used was individually packaged or sanitised and that antibacterial wipes were used to clean their skin before the procedure. Additionally, all but one patient said that staff wore gloves during the procedure.

Regarding the practice's approach to IPC, all staff agreed that:

- The organisation had a current and effective infection control policy
- There was an effective cleaning schedule in place
- Appropriate PPE was supplied and used
- The environment allowed for effective infection control.

However, as highlighted earlier, we were not provided with evidence of cleaning schedules during the inspection, neither was the practice compliant with IPC in all instances.

Medicines management
The practice had processes in place to ensure the safe prescribing of medication. The process for patients to request repeat medication was clear. Patients could request medication via various methods including my health online, repeat prescription slip, pharmacy repeat request and physical requests at the practice. Requests for repeat medication were not accepted over the telephone.

All administrative staff had undertaken in-house training on safe medication management and to prepare a re-authorisation of certain medication for sign off by a GP. Requests for controlled drugs (CDs) would be passed directly to the GP. Prescription clerks had received in-house training. Staff members said they felt supported to undertake this role, with regular reviews being carried out.

Prescription pads were securely stored in a locked filing cabinet. There was a process in place to dispose of prescription pads when a GP left the practice.

Where prescriptions for CDs were raised and given to patients or their nominated representative, there was no requirement to sign for these prescriptions. To further ensure the audit trail of prescription for controlled drugs these should be signed for by whoever collects the prescription.

The practice must ensure that all prescriptions for controlled drugs are signed for, on collection of the prescription.

Patient medication review audits were undertaken and medications no longer being taken by a patient were removed from the repeat prescription list. There was also a policy in place to support this.

There was also a medication cold chain policy in place for medications that required refrigeration. There were dedicated clinical refrigerators in place for refrigerated medicines, such as vaccines. The fridge displayed temperatures and

they were alarmed for out-of-range temperatures. Daily checks were completed, and data were downloaded monthly. Nursing staff were aware of the upper and lower temperature and what to do in the event of a breach to the cold chain and who to report the issue to, along with raising a DATIX.

We found that the vaccine refrigerators were overfilled including storing items on the bottom of the fridge. This could impede the flow of air and maintain appropriate temperatures. The practice should consider vaccine storage within both medical refrigerators to allow for appropriate air flow.

The practice must ensure that the medical refrigerators are not overfilled with vaccines and medication, and consideration should be given to storing vaccines within both medical refrigerators.

Nurse staff were responsible for the checking of all drugs, this included CDs. There were regular checks of CDs carried out and the CDs were kept in a locked cupboard. The CDs were logged and dated in and out as well as being checked by two registered clinical staff.

There were appropriate systems in place to replace expired drugs, syringes and needles. Any concerns about adverse reactions to drugs would be reported using the yellow card documentation.

Safeguarding of children and adults
We considered the safeguarding procedures in place at the practice. Whilst the practice appropriately followed the Wales Safeguarding Procedures, there was no local safeguarding policy in place to direct staff where and how to locally raise any safeguarding concerns. However, there were flowcharts noted throughout the practice for staff reference, these included contact details of local safeguarding teams.

Any child who was subject to the child protection register would be coded in the practice records. This allowed the clinicians to identify children who were subject to the child protection register. Where there may be a safeguarding concern for a child and they were not located on the protection register, then the clinicians would follow the local procedure to raise their safeguarding concern. However, there was not an annual formal audit to check the register was accurate.

Improvement is required to ensure that the practice's policies and procedures are robust to ensure any safeguarding issues are managed and action taken promptly as required.

The practice must ensure that a:

- **Local practice safeguarding policy is implemented which can be supported by the Wales Safeguarding Procedures**

- **Discussion takes place at the regular clinical team meetings regarding child protection and children looked after**

- **Regular audit is undertaken of the practice's clinical record system to ensure children subject to the child protection register are appropriately flagged on the practice's record system.**

The practice would follow the Wales Safeguarding Procedures for adults at risk of abuse. The practice has a system in place to identify those at risk by flagging them on their clinical record system. Any staff who may be concerned about an adult at risk, would refer them to one of two GP safeguarding leads at the practice. Whilst there were two leads, one was designated lead for child safeguarding and one for adult safeguarding.

For patients who did not attend (DNA) a practice appointment, there was a system in place where a nurse would contact the patient to establish why. Similarly, the clinician would monitor and follow up with parents or guardians for children who were not brought to an appointment. There was also a process in place to monitor and record instances where patients DNA hospital appointments, which included coding the patient record and sending this to a clinician. Whilst there was a child not brought policy, there was not a full DNA policy.

The practice must ensure that a DNA policy is written and made known to all staff.

All staff stated that they were up to date with safeguarding training (adult and child), they knew who the safeguarding lead was for the practice and how to report any safeguarding concerns.

Management of medical devices and equipment
The practice had processes in place to safely maintain equipment. We found all equipment was in a good condition, well maintained with appropriate electrical checks carried out. There were contracts in place for maintenance and calibration as appropriate, and for any emergency repairs and replacement.

There was appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as a cardiac arrest. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. Staff were aware of the location of the equipment which was clearly signposted. This

included the automatic external defibrillator (AED), which was available with age appropriate and in date pads.

There were clear audit processes in place for the regular checking and replacement of all resuscitation equipment, consumables, and relevant emergency drugs, including oxygen. It was noted that emergency drugs were stored in sealed boxes, so that the clinical team could easily recognise the drugs that had been used. The sealed boxes once used or out of date were returned to the pharmacy and were replaced immediately.

We found that staff had completed appropriate training for medical emergencies, and all clinical staff had undertaken appropriate basic life support training. This was delivered in-house by the advanced clinical practitioner (paramedic) who was accredited to give training to staff members.

Effective

Effective care

The practice had processes in place to support safe and effective care. This included a process in place to receive treatment or care within the GP cluster and wider primary care services. We found good examples of acute and chronic illness management, and clear narrative with evidence of patient centred decision making.

Services were arranged to provide efficient movement through care and treatment pathways. Patients could self-refer to physiotherapy services, and there was third sector support and guidance provided. Signage for these services was noted in the reception area. Other processes were in place to avoid inappropriate hospital admission, such as signposting and care navigation undertaken by the administrative team, to ensure appropriate healthcare clinician assessment.

There was collaborative working in the local area, including podiatry and primary mental health services. The administrative team would refer to the Welsh Eye Care Service for patients with issues with their vision. The practice believed that patients thought it was easy to arrange appointments.

The practice also used the Acute Response Team (ART), a team of experienced nurses who provided treatment for patients in the community to prevent hospital admission or to expedite discharge from hospital.

Administrative staff said that the GP's were always accessible for discussion and review of their actions in communicating with patients in crisis and said they felt well supported. In addition, if there were any emergency response situations

where administrative staff were involved in basic life support, they spoke of a debrief and resolution discussion with the GPs following the incident, which staff found to be beneficial.

The practice ensured staff were provided with the opportunity to attend regular webinars and training every Wednesday afternoon. This enabled them to keep up to date with best practice, national and professional guidance, new technologies, and innovative ways of working.

Patient referrals to specialist care were all made through the Welsh Clinical Communications Gateway (WCCG). We noted that GPs would act immediately for any urgent suspected cancer referrals. Referral rates would usually be discussed in GP cluster meetings, although this had not been done recently.

In our staff questionnaire, all but one member of staff felt they were able to meet all the conflicting demands on their time at work and had adequate materials, supplies and equipment to do their work. They also felt there were enough staff to allow them to do their job properly and were involved in deciding on changes introduced that affected their work.

Patient records

We reviewed a sample of ten electronic patient records. These were stored securely and were password protected from unauthorised access. We found overall that the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and were easy to understand by other clinicians reviewing the records.

However, we noted that patient language preferences were not always recorded and there was a need for some improvement with appropriate linkage between repeat medication coding and the patient clinical condition is recorded, and the recording on how the GP come to that conclusion. There were six patients on repeat medications, but only one had a timely medication review in the last 12 months. The 12-month medication review audits should be completed regularly. This may support the management of patients with chronic disease.

We also noted that the planned annual audit of clinical records had not been completed to review the appropriateness of clinical coding.

The practice must ensure that:

- **Timely medication reviews are completed, and compliance should be audited**

- **Patient language preference should be recorded**

- **An annual audit of clinical coding is completed to monitor accuracy**

- **Appropriate linkage between repeat medication coding and the patient clinical condition is recorded.**

Read codes were generally used well and all illnesses appeared to have appropriate Read coding. There was a good standard of chronic disease management, with evidence of appropriate first- and second-line management of atrial fibrillation, chronic kidney disease and hypertension that followed NICE guidelines.

Quality of Management and Leadership

Staff feedback

We received nine responses to our staff survey. The responses were overall, positive. All staff felt that patients care was this practice's top priority and staff were content with the efforts made to keep staff and patients safe. They would also recommend this practice as a good place to work and would be happy with the standard of care provided by the practice for themselves or family.

Leadership

Governance and leadership
There were processes in place to support effective governance, leadership and accountability, to ensure a sustainable delivery of safe and effective care. Staff were clear about their roles, responsibilities and reporting lines and the importance of working within their scope of practice.

Senior staff we spoke with said they made themselves visible and approachable to the wider practice team and had an open-door policy. Non-clinical staff were also encouraged to attend practice meetings. Practice team meeting minutes were shared with staff and were of a good standard.

There was a clear process for sharing information including changes in policies or procedures. All policies and procedures were on the shared drive and all staff were emailed when changes occurred. These emails required a read receipt. However, the policies and procedures in place were not all version controlled.

The practice must ensure that all policies and procedures are all version controlled, contain a policy author and have implementation date and review dates.

There was access to wellbeing programmes including those within the local health board. Information on staff wellbeing was circulated to all staff, which included a pilates groups. Staff also had access to well-being counselling services through the health board. The practice could also link with the community hub as needed.

All but one member of staff generally agreed that their job was not detrimental to their health. All staff felt the practice took positive action on health and wellbeing and that their current working pattern allowed for a good work-life balance. They were also aware of the occupational health support available to them.

Workforce

Skilled and enabled workforce
The practice had enough staff with the right knowledge and skills available at the right time to meet demand.

Staff described the process for recruitment and conducting pre-employment checks. This included a Disclosure Barring Service (DBS) check, references and a contract. New staff were issued with a comprehensive practice handbook when they started work. There would also be a check of a healthcare professional's registration with their regulatory body to ensure it was current. Whilst the process described by senior staff was satisfactory, there was no recruitment policy in place to support this. In addition, there was no process in place to establish any change to an employee's DBS status.

The practice must implement a recruitment policy.

The practice should consider the benefits of implementing a self-certification for staff during their appraisal process to establish whether there is any change to their DBS status.

There was a good induction programme in place for new and locum staff. However, we found examples where not all staff appeared to have completed the full induction process, or that completion was not captured by the practice. This did not allow the practice to assure itself that all staff were aware of and compliant with procedures, polices and processes.

The practice must ensure that evidence is recorded for completion of the staff induction process.

We reviewed a sample of mandatory training records for five members of staff. We found that the compliance in each topic varied from 100% in safeguarding and the duty of candour, to 60% in resuscitation and health and safety at work. We were told there was a plan in place to ensure all staff had training in all areas of mandatory training within the next two months. The practice had just started to maintain the records of compliance on a training matrix.

A total of 89% of staff said that they had appropriate training to undertake their role, including both mandatory and role-specific training. All staff said they received an annual appraisal in the last 12 months.

The practice must ensure that all staff are compliant with all mandatory training.

It was positive to note that the nursing staff were keen to develop their knowledge of chronic disease management such as asthma and diabetes and when this was discussed with management, they said they would look to develop this in the future.

The practice had two main sites (Newport and Crymych) approximately a 20-minute drive from each other and several staff work across both sites. This meant that staff were able to cover both sites if there were shortages.

The inspection team were not assured that the practice can assure itself regarding the hepatitis B immunity status of its clinical staff. During our inspection we found that the practice had started to request evidence from its clinical staff regarding immunity. Verbal or email assurance was provided to the practice manager for nine of the 16 clinical staff, that they had received the course of vaccinations and could confirm their immunity status. However, evidence of actual immunity was absent, to ensure the staff safety regarding hepatitis B is maintained. This was dealt with under our immediate assurance process at Appendix B.

Culture

People engagement, feedback and learning
The practice was able to demonstrate they acted and learnt from any patient feedback. If a patient wanted to make a complaint, senior staff said they would initially aim to resolve the concern informally. However, if unresolved, the complaint would be managed in line with the practice complaints process. A spreadsheet was maintained with details of the complaint. There had only been seven complaints in the last 12 months and there were no themes. The complaints policy aligned with the NHS Wales Putting Things Right procedure and both were displayed in the waiting room.

A Patient NHS Experience survey had been undertaken in line with the General Medical Services (GMS) Wales Contract. The survey was available to patients in English and Welsh, in both paper format and electronically. The results were mainly positive and were displayed on the practice website and at the practice.

Of those who responded, only 19% of patients confirmed in our survey that they had been asked by the practice about their experience of the service provided and just 61% knew how to complain about the service. However, all staff who responded to our survey felt that patient feedback was collected in their practice.

Senior staff described an open-door policy, so that staff at all levels were encouraged to speak up when they had new ideas or concerns. In our survey, all

staff felt that they encouraged to report errors, near misses or incidents and they were treated fairly with any incidents they were involved with. Staff also felt that the practice took action to ensure that errors, near misses or incidents did not reoccur. Staff also felt they were given feedback about any changes made in response to incidents.

From speaking with senior staff and reviewing training records the practice clearly understood its responsibilities under the duty of candour. This was also evidenced in the staff questionnaire where all said they knew and understood the duty and their role in meeting the duty of candour standards. Staff also said that the practice encouraged them to raise concerns when something had gone wrong and to share this with the patient.

In relation to equality, all staff said in our survey they had not faced discrimination at work within the last 12 months. They also said they had fair and equal access to workplace opportunities. Staff also agreed that their workplace was supportive of equality, diversity and inclusion.

Information

Information governance and digital technology

The practice understood its responsibility when processing information and demonstrated that they were able to manage data in a safe and secure way. They had an up-to-date information governance policy.

The practice used the Digital Health and Care Wales (DHCW) service to support the data protection officer, the information governance lead. The practice process for handling data was available for patients to see on the internet, there was also a notice in the waiting room to advise patients.

The practice ensured that all information was accurate, valid and reliable through completing audits of patient information. There were effective sharing arrangements in place to ensure that data or notifications were submitted to external bodies as required.

Learning, improvement and research

Quality improvement activities

The practice engaged with quality improvement by developing and implementing innovative ways of delivering care. These included direct involvement in cluster projects, such as the self-referral to physiotherapy introduced to reduce waiting times for patients. There was also evidence of a programme of clinical and internal audit in place to monitor quality.

The practice engaged in learning from internal and external reviews, including mortality reviews, incidents and complaints. All learning was shared across the practice to make improvements, through weekly meetings, which were thought to be very good.

Whole-systems approach

Partnership working and development
The practice provided examples of how it took account of the implications of their actions on other parts of the system, these included following the health board clinical pathways. They interacted and engaged with system partners at various meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships with external partners and within the cluster. The practice worked closely within the local GP collaborative / cluster to build a shared understanding of the challenges and the needs of the local population and to help integrate healthcare services for the wider area.

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
During the tour of the practice, we noted that there was only one mop in the cleaners cupboard which meant that the same mop was used throughout the practice. To reduce the risk of cross-infection equipment used in bathrooms should be red, blue for general areas and cleaning materials for isolation areas should be yellow.	Cross infection between clinical areas, including potentially isolation areas, bathrooms and other areas such as waiting rooms and the kitchen.	We informed the practice senior staff.	The practice staff immediately acquired several mops and colour coded them temporarily and then ordered mops with the correct colours to arrive the next day.

Appendix B – Immediate improvement plan

Service: Preseli Practice Newport

Date of inspection: 30 July 2024

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Findings The inspection team were not provided with evidence that the practice can assure itself regarding the Hepatitis B immunity status of clinical staff, to protect themselves, those they are close to and work with, and people attending the practice for clinical consultations or care.	The practice must ensure that: • A Hepatitis B immunity register is implemented, to record the immunity status of the clinical staff • Staff provide evidence to the practice manager of their immunity status	Health and care Quality Standards 2023 - Workforce - Risk Management Immunisation against infectious disease (The Green Book) 2006 – Chapter 18	<u>Immediate Action Taken by Julie Evans Practice Manager</u> • 14 Clinical Staff were asked once again for their Hepatitis B status including evidence of immunity • Risk Assessment done on all 11 non-clinical staff including our newly appointed Cleaner • Clinical Staff unable to provide evidence of immunity were asked to have a blood test.	Julie Evans Practice Manager	8 August 2024

	During our inspection we found that the practice had started to request evidence from its clinical staff for their Hepatitis B immunity. Verbal or email assurance was provided to the practice manager for nine of the 16 clinical staff, that they had received the vaccinations and who confirmed their immunisation status. However, evidence of immunity was absent.	• Risk assessments are undertaken and action implemented where applicable, for staff who are unable to demonstrate immunity following Hepatitis B vaccination.		<u>Findings by Julie Evans Practice Manager</u> • 9 clinical staff have sufficient Hepatitis B immunity confirmed, and evidence of their immunity has been provided • 2 clinical staff have 10iu/L or less of antibody to Hep B detected • 3 clinical staff have <100iu/L or less of antibody to Hep B detected • 10 non-clinical staff do not undertake any exposure prone procedures and are not in direct contact with patients' bodily fluids and do not wish to be vaccinated • 1 Cleaner may be in in-direct contact with waste that has been exposed to patients' bodily fluids via clinical waste bags and does wish to be vaccinated. <u>Further action confirmed by Dr Will Barr GP Partner</u>	Dr Will Barr GP Partner	8 August 2024

				• 2 clinical staff with 10iu/L or less will need a Hep B course in accordance with the green book • 3 clinical staff with 100iu/L or less have Hep B booster recommendation • 1 Cleaner will need a Hep B course in accordance with the appropriate time frame in line with the green book. <u>Further Action taken by Julie Evans, Practice Manager</u> • All staff advised of their immunity or not as the case may be • Engerix B (Hep B) vaccinations ordered from pharmacy • Vaccinations have been delivered on the afternoon of 08/08/2024 • Employees who need vaccinating have been advised to make an appointment as soon as possible once vaccinations arrive.	Julie Evans, Practice Manager	8 August 2024

				Timescale overseen by Julie Evans, Practice Manager • All staff who need a booster will be vaccinated within the next 2 weeks (deadline 22/8/24) • Staff who need a course will start their vaccination programme within the next 2 weeks • Cleaner who needs a course will start their vaccination programme within the next 2 weeks • Re-testing will be done within the appropriate timeframe in line with the green book (usually 4 – 8 weeks for booster and after 6 months for new course) • Review timescales in 2 weeks regarding boosters • Ensure completed course(s) and re-testing is overseen and that the	Julie Evans, Practice Manager	22 August 2024 22 August 2024 22 August 2024 22 October 2024 22 August 2024 22 August 2024

				vaccination course and re-testing is done within the appropriate timeframe in line with the green book (deadline 6 months).		

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): **Julie Evans**

Job role: **Practice Manager**

Date: **8 August 2024**

Appendix C - Improvement plan

Service: Preseli Practice Newport

Date of inspection: 30 July 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.	We were told that several health promotion leaflets had been removed from waiting areas during the COVID-19 pandemic, however, these had not been re-introduced since then. Health promotion information should be made readily available to patients, about the services they can access, particularly relating to smoking	The practice must ensure that more health information is available at the practice to ensure that patients are aware of the options available to improve their healthy lifestyle choices.	Health promotion	Practice is in the process of acquiring shelving for the waiting room to display practice leaflets. Practice to decide what is appropriate to display. We will be adding health promotion advice to our interactive screen in the waiting room once we are in touch with	Julie Evans Julie Evans	31/12/2024 31/12/2024

	cessation, healthy eating and healthy lifestyle.			the person with admin rights at PAVS		
2.	Only two of the nine patients who answered the questionnaire that they cared for someone with disabilities, long-term care needs or a terminal illness, said they had been offered an assessment of their needs as a carer.	The practice must ensure that all patients registered as carers are offered an assessment of their needs as a carer and are signposted to carer support services.	Health promotion	All newly registered patients are asked if they are a Carer on their registration form and if they are a Carer, they are asked to complete a Carers Registration form giving consent to add them to their medical record as a Carer and we can sign post them to Carers Support and Information. The same applies if other patients are recognised as Carers by forward thinking receptionists. They will sign post to the appropriate support. Carers needing an assessment is now	Julie Evans	Ongoing

				flagged on the yellow sticker, and we are re-engaging with the Investors in Carers Scheme which will assist with staff awareness to identify carers and to offer needs assessments etc		
				Carers Information can be found on our website. Carers Information is displayed on our waiting room interactive screen.	Melanie Stark	Ongoing
				We will put a poster in our waiting room asking “Are you a Carer? Do you need a health assessment? Please ask at Reception for further advice.	Francesca Phillips	31/10/2024

3.	A room was also available to maintain discreet conversations between patients and staff next to the reception area. Whilst some telephone conversation could be overheard in reception, we were told that no patient identifiable information would be discussed. However, only 61% of patients said that they were able to talk to reception staff without being overheard.	The practice must ensure that all patients conversations, including telephone conversations, are private to ensure the privacy of all patient issues.	Dignified and respectful care	We will continue as we are to encourage patients to be given the opportunity to speak to a member of staff in private if they wish to do so.	Julie Evans	Ongoing
4.	Whilst there was a sign in reception saying that chaperones were available on request there was not a notice in each clinical room.	The practice must ensure that there is a chaperone availability notice displayed in each consultation and treatment room to advise patients of the service.	Dignified and respectful care	There are now notices in each consulting room offering a chaperone.	Francesca Phillips	Completed

5.	Whilst a clear process was described for care navigation this was not documented. There is a need for a clearly documented care navigation process for staff to follow to ensure consistency in their approach.	The practice must ensure that a process is documented for care navigation.	Timely care	Care Navigation policy is being drafted and will be shared with the whole team.	Francesca Phillips	31/10/2024
6.	There was not a home visit policy eg a safe lone working policy. to ensure the safety of staff and to ensure there us a consistency in allowing home visits.	The practice must ensure that a home visit and lone working policy is written and made known to all staff.	Timely care	Safe-Lone working policy has been written and shared with the whole team.	Francesca Phillips	Completed
7.	Some areas relating to IPC needed to be improved, these included:	The practice must ensure that IPC is improved by carrying out the following actions:	IPC	Improvements made. Staff have been informed again of the correct content of sharps bins and their disposal.	Francesca Phillips	Ongoing

	• Sharps bins, whilst they were located in appropriate places in clinical areas, they were noted as being overfilled and filled with inappropriate items, such as swabs and hand towels	• Staff are informed on the correct contents of sharps bins and their disposal when required.		Posters are displayed in each consulting room to support staff.	Julie Evans	Completed
	• There was no signage displayed to include what should be put into sharps bins and sharps disposal measures will need to be addressed	• Additionally, posters may support staff knowledge on waste segregation		Practice is in the process of acquiring further female hygiene bins for 3 other toilets at the practice.	Julie Evans	31/10/2024
	• There were no female hygiene bins in the downstairs toilets for relevant waste disposal	• Female hygiene bins must be placed in all toilets at the practice		Already done!		Completed
	• Appropriate hand hygiene facilities were available in clinical areas such as hand	• Hand washing instructions must be appropriately displayed above hand washing sinks				

	washing sinks, personal protective equipment (PPE) and hand sanitiser gels, but there was no handwashing signage displayed above the sinks in clinical rooms • Disposable privacy curtains in clinical rooms were not dated as required to show when they had been installed and required replacing • There was not any Control of Substances Hazardous to Health (COSHH) information at the practice. There needed to be a policy and data sheets for the materials used • There was a cleaning contract in place.	• Privacy curtains must be dated to ensure they are replaced in a timely manner • A COSHH policy must be implemented and COSHH data sheets must be available for staff information • Cleaning schedules must be completed and maintained on file.		Practice is in the process of purchasing more curtains. COSHH policy and data safety sheets have been completed and are available to staff. Cleaning schedules are under review.	Julie LaTrobe Francesca Phillips Francesca Phillips	31/10/2024 Completed 31/10/2024

	However, the practice was in the process of updating the cleaning schedule process and copies of cleaning schedules were not available for inspection.					
8.	Where prescriptions for controlled drugs (CDs) were raised and given to patients or their nominated representative, there was no requirement to sign for these prescriptions.	The practice must ensure that all prescriptions for controlled drugs are signed for, on collection of the prescription.	Medicines management	Practice is looking at a process to ensure that it is recorded in patient records who collects (controlled drug) prescriptions on behalf of patient. This would work better for us as we are on two sites and keeping a satisfactory audit of “lists” kept on both sites gives too much room for error.	Julie Evans	31/10/2024
9.	It was noted that the vaccine refrigerators where overfilled including storing items	The practice must ensure that the medical refrigerators are not overfilled with vaccines	Medicines management	Practice have already received a new medical fridge to	Francesca Phillips	Completed

	on the bottom of the fridge. This could impede the flow of air.	and medication, and consideration should be given to storing vaccines within both medical refrigerators.		ensure extra storage space.		
10.	There was not a practice safeguarding policy (the practice used the All-Wales Safeguarding process) and there was not a formal child protection register nor a register of looked after children in place. There was not an annual formal audit to check the register was accurate.	The practice must ensure that a: • Local practice safeguarding policy is implemented which can be supported by the Wales Safeguarding Procedures • Discussion takes place at the regular clinical team meetings regarding child protection and children looked after • Regular audit is undertaken of the practice's clinical record system to ensure children subject to the child	Safeguarding	We are reviewing our safeguarding policy to ensure appropriate implementation and support by WSP To ensure that information regarding child protection and looked after children is discussed at our regular clinical team meetings. Admin will undertake quarterly reports to ensure that registers are up to date and	Francesca Phillips Julie Evans Melanie Stark	31/12/2024 31/12/2024 31/12/2024

		protection register are appropriately flagged on the practice's record system.		that flagging on the record is still relevant.		
11.	Whilst there was a child not brought policy, there was not a full DNA policy.	The practice must ensure that a DNA policy is written and made known to all staff.	Safeguarding	This policy is integrated into our appointment policy	Melanie Stark	31/10/2024
12.	However, patient language preferences were not recorded and there was a need for some improvement on linkage and the recording on how the GP come to that conclusion. The prescribing lead needed to encourage the audit of medication reviews recording and aim for 80% completion in next 12 month. Additionally, there had not been an	The practice must ensure that: • Timely medication reviews are completed, and compliance should be audited	Patient records	Regular lists are printed from clinical audit on those patients in need of medication review. Staff invite patients in. There are the opportunistic reviews when patients attend the practice and reviews during the re-authorisation of meds.	Melanie Stark GPs	Ongoing Ongoing

	annual audit of summarising from a sample of notes summarised by non-clinical coders to reassure accurate coding,	• Patient language preference should be recorded • An annual audit of clinical coding is completed to monitor accuracy • Appropriate linkage between repeat medication coding and the patient clinical condition is recorded.		This is marked on patient yellow sticker to remind staff to ask patients. Yes, an annual audit of clinical coding will take place (and ad hoc should the need arise). Appropriate refresher training for all Clinicians will take place to ensure appropriate linkage between medication coding and a problem	Julie Evans Melanie Stark Melanie Stark	Ongoing 31/12/2024 31/12/2024
13.	The policies and procedures in place were not all version controlled.	The practice must ensure that all policies and procedures are all version controlled, contain a policy author and have implementation date and review dates.	Governance and leadership	We are in the process of reviewing our policies and procedures to ensure appropriate version control, policy author and implementation dates and review dates	Melanie Stark	31/12/2024

14.	There was no recruitment policy in place.	The practice must write a recruitment policy and make this known to all staff.	Workforce	We are in the process	Julie Evans	31/10/2024
15.	Regarding whether any checks were carried out to ensure a person remained suitable to work for the service, whilst there were checks of the professional registration, there were no checks of any changes that would affect their DBS status.	The practice should consider the benefits of implementing a self-certification for staff during their appraisal process to establish whether there is any change to their DBS status.	Workforce	Staff Handbook has been amended in so far that staff should makes us aware of any incidents that may affect their DBS status, and this question will be raised at annual appraisal.	Julie Evans	Ongoing
16.	An induction programme for new and locum staff was provide for inspection, whilst the process was good, evidence of the completion of the	The practice must ensure that evidence is recorded for completion of the staff induction process.	Workforce	A form has been drafted to ensure that all evidence relating to staff induction is filed in each individual staff folder	Julie Evans	Ongoing

	induction was not maintained on file at the practice.					
17.	A sample of the mandatory training of five members of staff showed that the percentage in date compliance in each subject varied from 100% in safeguarding and the duty of candour to 60% in resuscitation and health and safety at work.	The practice must ensure that all staff are compliant with all mandatory training.	Workforce	All staff complete mandatory training in line with Learning@Wales and this will continue	Julie Evans	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): **Mrs. Julie Evans**

Job role: **Practice Manager**

Date: **3rd October 2024**