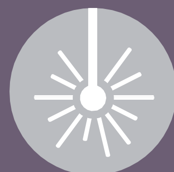
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Veincentre Cardiff, Cardiff

Inspection date: 01 October 2024

Publication date: 02 January 2025



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

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

Digital ISBN 978-1-83715-084-7

© Crown copyright 2025

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:

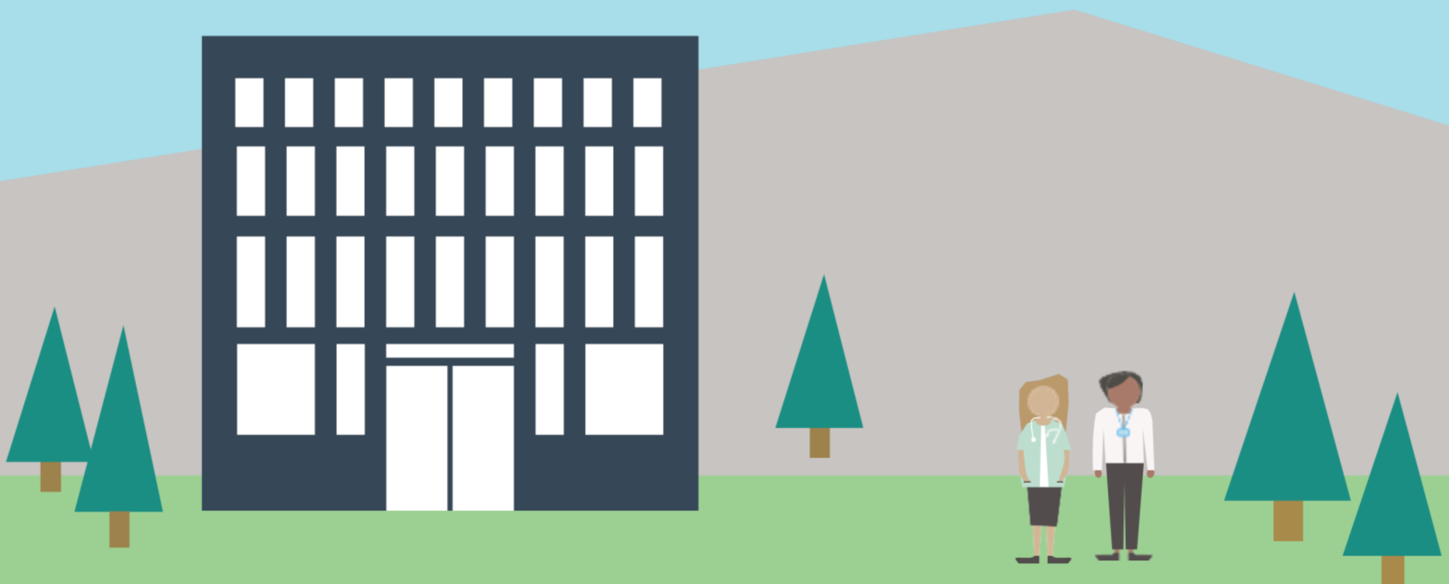
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 5
2. Summary of inspection 6
3. What we found 9
   - Quality of Patient Experience 9
   - Delivery of Safe and Effective Care 13
   - Quality of Management and Leadership 17
4. Next steps 20

Appendix A – Summary of concerns resolved during the inspection 21

Appendix B – Immediate improvement plan 22

Appendix C – Improvement plan 23

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Veincentre Cardiff, 17 Windsor Place, Cardiff, CF10 3BY on 01 October 2024.

The inspection was conducted by a HIW Healthcare Inspector and a surgical laser peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also spoke to staff working at the service during our inspection. In total, we received one response from patients and one response from staff at this setting. 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:
It was apparent that staff at Veincentre Cardiff were committed to providing a high standard of care for patients, in a comfortable, well maintained environment.

Systems and processes were in place to ensure patients were being treated with dignity, respect and professionalism. However, there were steps into the premises which made access difficult for patients with mobility impairment.

We saw lots of information was available for patients to make an informed decision about their care, and found consent was obtained prior to each treatment. Patient needs were incorporated into treatment plans with consideration to National Institute for Health and Care Excellence (NICE) guidelines and clinic protocols.

This is what we recommend the service can improve:

- To ensure the statement of purpose is available upon request to every patient or any person acting on their behalf
- To ensure patient records are fully completed including a World Health Organisation (WHO) checklist and venous thromboembolism (VTE) assessment form
- Clarify what is the clinic policy regarding sharing patient information with their GP and amend the clinic documentation accordingly.

This is what the service did well:

- The clinic website contained lots of information and guidance
- Patients had an in-depth consultation and were provided with clear pre-treatment and aftercare advice
- Robust feedback systems were in place to request, record, analyse and respond to patient suggestions and concerns.

Delivery of Safe and Effective Care

Overall summary:
We found that Veincentre Cardiff was very well maintained and well equipped to provide the services and treatments they are registered to deliver. All areas were very clean with evidence of regular Infection Prevention and Control (IPC) audits.

We found arrangements in place to ensure that the lasers were used appropriately. The clinic was using a model of laser that was different to that registered. This was added to an ongoing variation application.

There was suitable eye protection available in each room. However, we found an additional pair of eye protection that was not in accordance with the Laser Protection Advisor (LPA) guidance.

Overall, we saw good arrangements for safeguarding vulnerable adults and children, with an up-to-date policy in place and a lead appointed.

Immediate assurances:

- Local rules to be reviewed and updated in accordance with registration conditions
- To remove eye protection that did not comply with LPA guidelines.

This is what we recommend the service can improve:

- To ensure all staff complete first aid training
- To put in place a system to check emergency equipment on a weekly basis.

This is what the service did well:

- Good compliance with fire safety requirements
- Extensive clinical governance system enhanced through regular audit and data analysis
- Patient records were stored securely and controlled by an information governance lead.

Quality of Management and Leadership

Overall summary:
The clinic has a dedicated team with good leadership and clear lines of accountability. Day-to-day management of the clinic was the responsibility of the registered manager, who we found to be very committed to providing high quality patient care.

We found a comprehensive range of up-to-date policies and procedures with a full version history. However, there was no evidence to confirm that all staff had read and understood the latest versions.

There was an appropriate complaints procedure in place with evidence of well documented responses completed in accordance with the clinic policy. We saw evidence of changes made as a result of incident reports.

We saw Disclosure and Barring Service (DBS) checks were in place for all staff and that doctors had signed declarations to confirm their DBS status had not changed. However, this process was not in place for nurses and other staff.
This is what we recommend the service can improve:

- To implement a system to record that all policies and subsequent reviews are read and understood by staff
- To ensure that all staff complete and sign an annual declaration that there had not been any changes that would affect their DBS status.

This is what the service did well:

- A range of comprehensive well written policies with full version history
- Critical incidents were documented and shared with clinicians through governance meetings and webinars
- There were comprehensive documented recruitment and induction processes in place.

3. What we found

Quality of Patient Experience

Patient Feedback
Before our inspection we invited the clinic to hand out HIW questionnaires to patients to obtain their views on the service provided at the clinic. We received one completed questionnaire.

The patient commented:

> *"Thank you, I am really happy with the treatment I had and really pleased with the outcome."*

Health protection and improvement
We saw lots of healthcare information and guidance was available on the clinic website and within the clinic information brochure. Underlying health issues were checked via a pre-consultation questionnaire, whilst healthy lifestyle discussions formed part of the consultation process and aftercare guidance.

Dignity and respect
We saw that Veincentre Cardiff had two treatment rooms located across the first floor of the premises. We found each room to be very clean, tidy, and uncluttered. The rooms had lockable doors and privacy screens enabling patients to change in privacy and each room had appropriate window coverings. Gowns and disposable underwear were available for patients to use throughout treatments to protect their dignity.

We were told that chaperones were available if requested, and that staff were appropriately trained to act in this capacity. A suitable chaperone policy was in place.

The respondent who answered the HIW questionnaire confirmed they were treated with dignity and respect and felt staff listened to them and answered their questions.

Communicating effectively
We reviewed the patients' guide and the statement of purpose provided to us by the registered manager. Whilst we found the statement of purpose compliant with the regulations, a copy was not available for patients either in the clinic or on the website.

The registered manager must ensure the statement of purpose is available upon request to every patient or any person acting on their behalf.

We found the patients' guide to be largely compliant with the regulations and was available in Welsh and English. However, it was missing a summary of the complaints procedure and lacked the contact details for HIW.

The registered manager must review the patients' guide to ensure it is fully compliant with the regulations.

Appointments for consultations could either be arranged by telephone or in person at reception for follow ups. We were told there are plans for an online booking system via the clinic website. The clinic had a Welsh interpretation service available on request and a hearing loop was installed for patients with hearing impairment.

Patient information and consent

During the inspection we reviewed a sample of five patient records. There were detailed individual patient notes available with evidence of good record keeping processes. Overall, we found records were clear and accurate, with patients clearly identified and treatment details, including equipment parameters, suitably recorded. However, we found one record where the World Health Organisation (WHO) checklist and the venous thromboembolism (VTE) assessment form was not ticked as checked.

The registered manager must provide HIW with details of the action taken to address our findings in relation to the completeness of patient records.

We were told that an in-depth initial consultation is conducted where the procedure, expected outcomes and risks and benefits are discussed. A consent form is provided and signed on the day of the procedure. Patients were asked to provide a comprehensive medical history and any changes to their condition was checked prior to each treatment. We found an up-to-date consent policy in place.

We were told information sharing with general practitioners (GPs) is left to the patients due to confidentiality and data sharing obligations. However, on paper notes we inspected, there was a section that stated 'if a patient has provided us with their GP details, we will automatically send their GP a copy of their report…' unless patients opt-out via email.

The registered manager must clarify what is the clinic policy regarding sharing patient information with their GP and amend the relevant documentation accordingly.

The patient who responded to the HIW questionnaire said they had received enough information to understand the treatment options and the risks and benefits. They also confirmed they had their medical history checked before undertaking treatment and that they had signed a consent form prior to each treatment.

Care planning and provision

We saw evidence that patient health and wellbeing needs were incorporated into individualised treatment plans with consideration to National Institute for Health and Care Excellence (NICE) guidelines and the clinic treatment protocols. We saw that care management options were listed in patient notes, with the one agreed with the patient recorded in the treatment plan.

Pre-treatment and aftercare advice was very clear, with lots of information provided through one-to-one discussions, the clinic website and information brochure. We saw recovery and aftercare guidance was available at reception. The clinic also had a central helpline which provided patient support during daytime hours, Monday to Saturday. Out of hours support was available via the website, although for emergencies, patients would need to contact the NHS.

The patient who answered the HIW questionnaire said they were given adequate aftercare instructions and were given clear guidance on what to do and who to contact in the event of an infection or emergency.

Equality, diversity and human rights

The clinic had an up-to-date equality and diversity policy, and we saw evidence that all staff had received appropriate training on the subject. There were also bullying and harassment, and anti-discrimination policies in place at the clinic.

There were several steps into the premises from the street with a further flight of stairs to access the patient treatment areas making access difficult for patients with impaired mobility. We also found additional steps between the treatment rooms. The premises were not considered wheelchair accessible and this was indicated within the statement of purpose and clinic website.

We were told that the human rights of transgender patients were actively upheld with preferred names and pronouns used as requested.

Citizen engagement and feedback

We found robust systems in place to request, record and respond to patient feedback. Patients were automatically contacted to request written feedback following their appointment, and verbal feedback was also requested where necessary. The central compliance team would monitor and analyse feedback received.

We were advised that several changes had been implemented as a result of patient feedback, such as amending recovery and care information to more accurately convey expected pain during and after treatment and changing the colour of the disposable underwear.

Delivery of Safe and Effective Care

Managing risk and health and safety
The building appeared well maintained both internally and externally with good security measures in place. The waiting room was a good size, comfortable, light and airy and furnished to a high standard. Treatment rooms were modern in appearance and appeared well equipped. All patient areas in the clinic appeared clutter-free, well organised and could be effectively cleaned.

We saw an up-to-date Health and Safety risk assessment had been completed. Apart from lots of steps, there were no other trip hazards found within the clinic. We were told that one patient had fallen in the toilet due to a step and found that this had been marked with hazard warning tape and a warning sign put up as a result.

Portable Appliance Testing (PAT) had been conducted recently and a current five yearly electrical system inspection was in place, providing assurance that electrical appliances within the clinic were safe to use. We saw a current gas safety certificate was in place with evidence that the recommended remedial work had been carried out.

We inspected the fire safety arrangements and found all to be satisfactory. We saw a fire safety risk assessment had been carried out and that all recommendations had been actioned. We saw that checks of the fire alarm system were recorded weekly and that fire drills were conducted regularly. All fire exits were clear and signposted, emergency lighting present and all fire extinguishing equipment had been serviced within the last 12 months. No smoking signs were displayed in accordance with the regulations.

We inspected the first aid kit and found all items present and in date. The clinic had an up-to-date policy for managing medical emergencies and we saw grab-cards for various emergency situations including syncope and anaphylaxis. All staff were trained in Basic Life Support and required to act as first aid responders. However, we did not see evidence of first aid training for staff.

The registered manager must ensure all staff complete first aid training and provide evidence to HIW when completed.

Infection prevention and control (IPC) and decontamination
The clinic was visibly very clean and tidy. Furniture, equipment and fittings were of materials that were easy to wipe down. Surgical handwashing facilities and hand

hygiene posters were available in each treatment room. Appropriate personal protective equipment (PPE) was available for staff to use.

We discussed the infection control arrangements with the registered manager and considered these to be appropriate to protect patients from cross infection. A comprehensive up-to-date IPC policy was in place and subject to regular reviews. We saw staff had undergone IPC training and that regular audits had been completed to monitor cleanliness and compliance with procedures.

We saw that cleaning schedules were being maintained, with checks completed before clinic starts and at the end of the day. We were told the clinic undergoes a deep clean every week.

We found that a suitable contract was in place for the collection and disposal of clinical waste. We saw clinical waste was securely stored within the premises while awaiting collection.

Both staff and patient respondents to the HIW questionnaire agreed that appropriate infection and prevention control measures were being followed. The patient rated the setting as very clean.

Medicines Management
We saw an up-to-date policy was available for the safe management of medicines. There were suitable processes in place for obtaining, storing and handling medicines with medication ordered as and when required via the group head office.

There was evidence that appropriate checks were conducted prior to prescribing medicines and that medicines administered were recorded consistently in clinical records. The clinic had access to the British National Formulary (BNF) for advice on any aspect of medicines management relevant to the services provided.

We saw appropriate policies were in place for resuscitation and responding to a medical emergency at the clinic. There was sufficient equipment and medicines for use in the event of an emergency as per national guidelines. However, we saw evidence that emergency kit checks were conducted monthly and not weekly.

The registered manager must put in place a system to check emergency equipment on a weekly basis.

We found evidence that oxygen cylinders had service maintenance checks and that all staff had completed relevant training in their use.

Medical devices, equipment and diagnostic systems
We saw that the lasers available at the clinic were suitable to provide the services as registered with HIW. Whilst the clinic was in the process of varying their registration for an additional treatment room, we found the clinic were also using a new model of laser machine to that registered. We discussed this with the senior management team who arranged for the new laser device to be included in the variation application.

We were told servicing and maintenance of equipment was controlled centrally via the group head office. We found the annual service and calibration check for the one laser were in date, whilst the additional new laser was not yet due a service and calibration. Evidence of daily laser systems checks were seen.

There was a current contract in place with a Laser Protection Adviser (LPA) and we found that a risk assessment had been recently conducted by them in July 2024. There were treatment protocols in place for the use of the lasers and these had been recently reviewed. However, the local rules detailing the safe operation of the laser machines indicated they had last been reviewed in October 2021. We raised this immediately with the senior management team who arranged for new local rules to be prepared. An up-to-date copy was supplied shortly following the inspection.

Our concern regarding this was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

There was an emergency power supply to prevent interruptions in surgical treatment should there be a power cut.

Safe and clinically effective care
We were told that the medical director signed off any new or revised clinical guidelines, which were then suitably disseminated via webinars, newsletters, townhall meetings, and Teams recordings. Safety bulletins and alerts were shared electronically and via team forums. Continuous professional development was supported through these channels, ensuring staff remain informed and trained to provide safe, effective care.

We found NICE guidelines on vein management were followed to provide evidence based care and treatment to patients.

Sufficient eye protection was available for patients and the laser operators. These were found to be clean, in a good condition and consistent with the local rules. However, we did find an additional set of eyewear that did not comply with the local rules. These were immediately removed to prevent unintended use.

Our concern regarding this was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

There were signs on the outside of all treatment rooms to indicate the presence of the laser machines. Doors were locked to prevent unauthorised entry when the machine is in use. We were told that the keycode to activate the machines were known only to clinical staff to prevent unauthorised use.

Safeguarding children and safeguarding vulnerable adults
The service is registered to treat patients aged 18 years and over. We were assured that this condition of registration was complied with.

The clinic had an up-to-date safeguarding policy in place, with procedures to guide staff on the action to take in the event of a safeguarding concern. This included the contact details for the local safeguarding teams. Quick reference safeguarding action flowcharts and grab sheets were available in each treatment room.

The clinic had a designated safeguarding lead who had access to the current All Wales Safeguarding guidelines. We reviewed training records and saw that staff had completed relevant safeguarding training.

Participating in quality improvement activities
We were told that the service had an extensive clinical governance system across the group of clinics, headed by the medical director. Quality was enhanced through regular audits and data analysis by the medical director, and a research clinical lead. We saw evidence of a programme of clinical audits that had been conducted. Specific audits on critical incidents and leg ulcer practices have led to revised practices and changes to clinic documentation.

We were told how the clinic monitors complaints, incident reviews, audits, industry guidelines, and various key outcome measures. We also saw evidence of in-depth analysis of patient feedback that informed an annual activity report, helping to drive continuous quality improvement at the clinic.

Records management
We found the patient records were kept securely at the service. Digital records were saved on the clinic data system which was password protected. Patient data compliance was controlled by the company’s information governance lead who controlled access and monitored data retention limits. We found retention periods and disposal arrangements to be appropriate.

Quality of Management and Leadership

Governance and accountability framework

Veincentre Cardiff is part of a nationwide company with numerous clinics across the UK. The clinic is run by the registered manager supported by a dedicated team of staff that includes vascular consultants, interventional radiologists and nurses. The clinic has access to a nationwide team of clinical peers as part of the wider group. We considered there to be effective governance and leadership in relation to the size of the service with clear lines of reporting described.

There was a comprehensive range of well written, up-to-date policies and procedures that evidenced version history, review dates and name of person responsible for the policy. We were told that the clinic computer system sends an alert when revisions are due. A system was described for keeping staff updated with policy reviews. However, there was no evidence that the policies we reviewed had been countersigned by staff to confirm they had been read and understood.

The registered manager must implement a system to record that all policies and subsequent reviews are read and understood by staff.

There was evidence of regular staff and management meetings, and a bulletin system for the dissemination of more urgent issues. We saw minutes of the meetings were captured and was told these were distributed to staff. Additional education meetings were recorded and saved onto Teams for reference.

We saw the HIW registration certificate and current certificate of Employer's Liability Insurance on display in accordance with the regulations.

The staff member who responded to the questionnaire told us that senior managers are visible that communication between senior management and staff was effective.

Dealing with concerns and managing incidents

There was an appropriate complaints policy in place included timescales for a response. This was aligned with the Independent Sector Complaints Adjudication Service (ISCAS) guidelines. A summary of the complaint procedure was also included within the statement of purpose and signposted within the patients' guide. We were told a copy was included within the information pack provided to every patient.

We were told that all complaints were handled by a central Patient Care team, who forward the complaint to the relevant clinic management team. All complaints were subject to review at clinical governance meeting with lessons learnt appropriately shared with staff to help prevent recurrence. We were told the complaints log was reviewed annually to identify trends that may require further action.

We saw that there were records of all critical incidents and these were shared with clinicians through governance meetings and webinars. There was evidence of how this has led to change in some of the forms.

Workforce recruitment and employment practices
There was a comprehensive up-to-date recruitment policy in place. We were told that recruitment and staff planning was managed centrally via the HR department. The process covered all stages of the recruitment and selection process to ensure relevant checks had been carried out prior to staff commencing work at the clinic. We found a suitable system in place for granting and reviewing practising privileges to surgeons and doctors at the clinic.

Newly appointed staff were subject to Disclosure and Barring Service (DBS) checks which we found to be completed and in date. We saw that doctors had signed declarations to confirm their DBS status had not changed. However, a similar process was not in place for nurses and other staff.

We recommend the registered manager ensures all staff complete and sign an annual declaration that there had not been any changes (i.e. criminal convictions or cautions etc) that would affect their DBS status.

We saw that new staff undergo an in-depth documented induction process that was signed off by a senior member of the management team. We saw evidence that staff and doctors had regular reviews and appraisals.

Workforce planning, training and organisational development
We considered there were adequate numbers of appropriately trained staff at the clinic. We saw up-to-date core of knowledge training and machine specific training was completed by all staff. To help develop and maintain workforce knowledge and skills the central HR department monitored staff training requirements.

We were told that staff attend quarterly online CPD meetings, and medical director updates.

We found an appropriate whistleblowing policy in place should staff wish to raise any concerns. The staff member who responded to the questionnaire told us that

they felt secure raising concerns about unsafe clinical practice and felt confident that the organisation would address those concerns.

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 found the local rules were last reviewed in 2021.	Patients and staff could have been put at risk of serious injury due to incorrect and out-of-date information being provided to laser operators.	We raised this immediately with senior staff.	Up-to-date local rules were prepared and a copy was supplied shortly following the inspection.
We found one set of eyewear that did not comply with the LPA specification.	Patients and staff could have been put at risk of serious injury due to lack of adequate eye protection from the laser.	We raised this immediately with senior staff.	The eyewear was removed to prevent unintended use.

Appendix B - Immediate improvement plan

Service: Veincentre Cardiff

Date of inspection: 01 October 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate non-compliance concerns were identified on this inspection.				

Appendix C - Improvement plan

Service: Veincentre Cardiff

Date of inspection: 01 October 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The registered manager must ensure the statement of purpose is available upon request to every patient or any person acting on their behalf.	Regulation 6(2)	The statement of purpose will be made available both as a copy in the clinic and via a link on our website.	Bernadette McCormick	31st December 2024
The registered manager must review the patients' guide to ensure it is fully compliant with the regulations.	Regulation 7(1)(g)	Patients guide will be updated with a summary of the complaints procedure and contact details for HIW. In the meantime a copy of our complaints procedure is available on request and is on the website.	Bernadette McCormick	31st March 2025
The registered manager must provide HIW with details of the action taken to address	Regulation 23(1)(a)	This is a historic issue and discussed in full during the site inspection. The single set of incomplete notes reviewed at the inspection were over 2 years	Bernadette McCormick	No further action

our findings in relation to the completeness of patient records.		old and this issue had been identified at the start of 2023 and both the individual doctor had been challenged and improved his practice and the importance of good note-keeping has been communicated at multiple staff meetings. We also implemented real-time quality assurance process to ensure note-keeping standards in 2023 (as evidenced by more recent notes reviewed at inspection visit).		
The registered manager must clarify what is the clinic policy regarding sharing patient information with their GP and amend the relevant documentation accordingly.	Regulation 9(f)	Draft HIW report commented a notes section stated "we will automatically send their GP a copy of their report". This reflects older paper notes and the current pre-consultation questionnaire has been updated and now states: "As a standard, clinical reports are not sent to your GP following any appointment at Veincentre, and we advise that you retain these yourself in case they are required for future reference with your GP. However, in certain circumstances, we may feel it advisable to send reports to your GP" The following content is also included in the clinic letters. "We advise that you retain your clinical report in the event that you need to provide this to another	Bernadette McCormick	5th December 2024 No further action

		healthcare professional, either now or in the future. Please note we do not routinely forward your clinical reports to General Practice”.		
The registered manager must ensure all staff complete first aid training and provide evidence to HIW when completed.	Regulation 20(2)(a)	All staff will be enrolled on a first aid course. Completion certificate will be sent to HIW as required.	Bernadette McCormick	31st January 2025
The registered manager must put in place a system to check emergency equipment on a weekly basis.	Regulation 15(2)	We currently carry out checks on the emergency equipment prior to the start of each clinic. We have also implemented an additional check where the emergency equipment is checked on a weekly basis.	Bernadette McCormick	No further action
The registered manager must implement a system to record that all policies and subsequent reviews are read and understood by staff.	Regulation 9	We have revised our processes for the circulation and acknowledgment of policies. All policies are circulated via an electronic signing system. Once a document has been sent it is signed electronically by the recipient and a confirmation of read and acknowledged is returned to the sender. Full tracker and reporting facility is available to track non responders.	Bernadette McCormick	Completed No further action

We recommend the registered manager ensures all staff complete and sign an annual declaration that there had not been any changes that would affect their DBS status.	Regulation 21(1)	We are implementing staff annual declaration that there have not been any events that may affect their DBS status. Records will be held on personnel records.	Bernadette McCormick	In progress. These checks will be in place on employee records by 31st December 2024.

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): **Bernadette McCormick**

Job role: **Head of Quality & Compliance**

Date: **4th December 2024**