Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Acorn Private Clinic, Penarth

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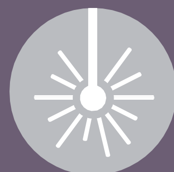

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

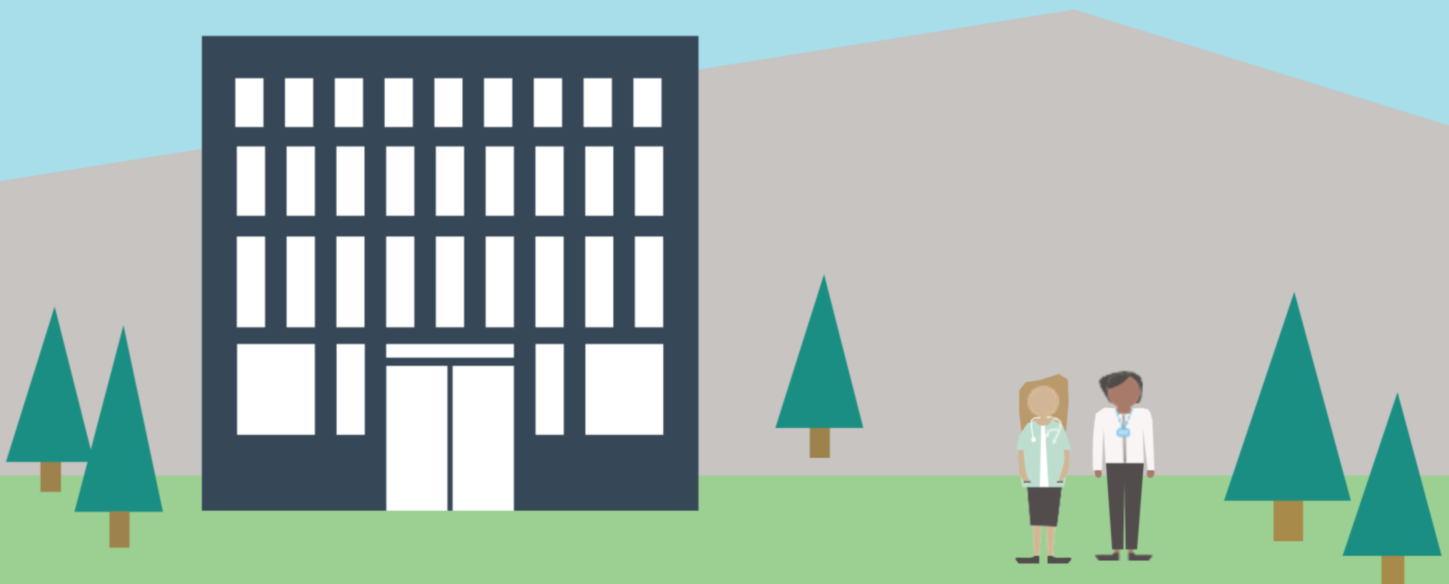
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and 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 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience 9
- Delivery of Safe and Effective Care 12
- Quality of Management and Leadership 19

4. Next steps 21

Appendix A – Summary of concerns resolved during the inspection 22

Appendix B – Immediate improvement plan 23

Appendix C – Improvement plan 24

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 Acorn Private Clinic on 14 November 2024.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 24 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that the registered manager and staff at the clinic worked hard to provide a positive experience for patients. Patients who completed a HIW questionnaire provided positive feedback about their experiences of using the services provided at the clinic.

There were good arrangements in place to protect the privacy and dignity of patients. The registered manager and clinicians ensured patients were provided with detailed information pre and post treatment so they could make informed decisions about their treatment.

There was easy access to patients with mobility issues which included bathroom facilities suitable for patients with mobility access requirements. In addition, staff at the clinic had undertaken training in equality and diversity.

This is what we recommend the service can improve:

- Display a sample of patient feedback such as a 'You said, we did' board
- Provide more health promotion information on how patients can maintain their general health.

This is what the service did well:

- .
- Treated patients with dignity and respect
- The environment was easily accessible to patients with mobility issues
- Patients were given the opportunity to feedback following their procedure.

Delivery of Safe and Effective Care

Overall summary:
The service had suitable arrangements in place to provide safe and effective care to patients. These arrangements were supported by a range of up-to-date and relevant written policies and procedures.

Infection prevention and control processes were appropriate for the setting. The registered manager described sufficient decontamination arrangements. All

patients said that the clinic was clean and that infection control measures were being followed.

Medication management could be improved to include securing medication and checking it regularly to ensure it remained in date. The patient records were well organised and easy to understand, clear, accurate and legible. However, some areas needed to be improved.

This is what we recommend the service can improve:

- Assembling sharps bins correctly, including being signed and dated
- Carrying out documented checks on all medications on a weekly basis
- Ensuring the room or cupboard containing the medications is locked at all times.

This is what the service did well:

- Infection prevention processes were suitable and appropriate
- Established processes were in place to ensure that the clinic safeguarded adults and children.

Quality of Management and Leadership

Overall summary:

The clinic's governance and leadership was clear and structured. The registered manager was patient focused and had appropriate skills and knowledge.

We viewed staff training records and found that staff had completed mandatory training.

Staffing levels were appropriate to support patient safety during the inspection. We were told of regular meetings to capture staff feedback and act upon any issues raised. All staff had received an appraisal of their performance within the last 12 months.

The clinic had a range of policies and procedures in place which were being reviewed and updated regularly.

This is what we recommend the service can improve:

- Displaying registration certificates prominently in the clinic.

This is what the service did well:

- Clear and structured governance and leadership
- Staff compliance with mandatory training
- Employee appraisals had been completed for all staff.

3. What we found

Quality of Patient Experience

Patient feedback
HIW issued a questionnaire to obtain patient views on the care at the Acorn Private Clinic for the inspection in November 2024. In total, we received 24 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 24 responses.

Overall, the respondents' comments were positive. All patients who answered rated the service as 'very good' or 'good'. We received the following comments about the setting:

> ***"Fantastic facility and staff. Very accommodating in clean environment."***
>
> ***"Excellent setting and staff. More treatments please/advice on perimenopause for example."***
>
> ***"Lovely clinic, staff lovely, really happy with the service."***
>
> ***"Excellent clinic, answered my questions."***
>
> ***"Lovely clinic, lovely staff, helpful and friendly."***
>
> ***"Very caring staff who helped with answering any questions of mine."***

Health protection and improvement
There was health promotion material displayed within the clinic on the services provided and in how patients could manage their health such as dietary and high blood pressure information. Most of the information on display was in English.

The clinic should:

- **Provide more health promotion information on how patients could maintain their general health**
- **Ensure all patient information is readily available and routinely provided in both Welsh and English. Patients should be actively offered the opportunity to speak in their preferred language wherever possible.**

Dignity and respect
The clinic was found to be light, airy and clean. Access to the clinic was on the ground floor at street level and therefore suitable for patients with mobility issues. We witnessed staff speaking to patients politely and treating them with kindness throughout our inspection.

All patients who completed a HIW questionnaire told us staff had treated them with dignity and respect and measures were taken to protect their privacy during their appointment at the clinic. All patients agreed that staff listened to them and answered their questions.

Patient information and consent
Appointments at the clinic could be made by email, telephone and online as well as by calling at the clinic. We were told that there was a one week wait for appointments. For patients without digital access, information relating to any procedure were either available at the clinic or the information would be printed off for the patient.

The registration form did not include any language preference nor any disabilities, patient would be triaged over the phone, as to whether the clinic and the procedure was suitable for the patient.

There were two Welsh speaking staff who worked on the premises, one of whom worked in the podiatry setting at the clinic. There were also staff who could speak other languages other than English or Welsh.

We were told that informed consent forms and medical history forms were sent out when the appointment was booked, if the forms were not completed online then they would be completed when the patient arrived at the clinic. This was carried out on each visit to the clinic.

All patients who completed the questionnaire agreed they were provided with enough information to help them understand their healthcare. Patients said that staff explained what they were doing throughout and that they were involved as much as they wanted to be in making decisions about their healthcare.

Communicating effectively
The clinic provided information to patients and communicated in a way that was clear, accessible and in a manner appropriate to their individual needs. They also provided information to patients in a way to enable them to make informed decisions about their care.

All patients who responded to the questionnaire confirmed that they were given post treatment aftercare instructions and clear guidance on what to do and who to contact in the event of an infection or emergency. All patients also said that the cost was made clear to them before they received treatment. In total two patients who responded to the questionnaire said they were Welsh speakers.

Care planning and provision

We saw staff providing patients with help in a timely manner, such as helping patients to open doors. We also saw staff telling patients that there would be a delay, as the doctor was running behind time. We observed passionate staff when interacting and dealing with patients.

There were a number of ways that patients could access treatment such as face to face, by telephone or video consultations. Patients would be initially triaged by staff to decide the best way to assess the patient and provide the best service. There was evidence of flexibility from staff to accommodate specific patient needs or requests.

There were initiatives described by staff to assist in caring for patients with additional needs, sensory problems or cognitive difficulties. These included providing audio reports to patients and allocating more time for the appointment. A hearing, visual and cognitive impairments policy was available for staff reference. We were told that the clinic had plans to implement an induction loop system for patients with hearing impairment and patient information could be made available in braille on request.

Staff we spoke with believed that they had enough time to provide care safely and that the number of staff was appropriate to meet the needs of the patients. Appointments were booked electively and took into account the number of staff working in the clinic.

There were 10 patients who completed the questionnaire who said that they underwent a procedure or treatment. They said that they had received enough information to understand the treatment options and the risks and benefits and agreed that they were given adequate aftercare instructions. We received the following comments on patient care:

> ***"All staff are always lovely, patient and caring. I have terrible health anxiety, and they always see me. They are always so kind and will always have time to see me. I have so much good to say. Amazing place."***

Equality, diversity and human rights

We saw an Equality and Diversity Policy and were told all staff completed equality and diversity training. We were told that the clinic was an inclusive environment irrespective of any protected characteristic. We were assured that the rights of transgender patients would be actively upheld and preferred pronouns would always be used.

The clinic benefitted from level access with wheelchair accessible doorways. Treatment rooms were large and situated on the ground floor with wide doorways. The clinic had an accessible toilet situated on the ground floor near to the entrance.

Patients who completed a HIW questionnaire told us they had not faced discrimination when accessing or using the clinics' services and felt that they could access the right healthcare at the right time regardless of any protected characteristic.

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Citizen engagement and feedback

The method used to obtain the views of service users to inform service improvement and development was described. In addition to quoting google reviews on the clinic website, the practice also used a system called net promoter score (NPS) a measure for assessing customer loyalty and satisfaction. It was noted from the evidence provided that of 175 respondents, 164 scored the between 6 and 10 out of 10, these were called promoters, most scores seen were nine and above. We were told that those that scored five or less were known as passive and detractors and that the clinic called the detractors to ask how the clinic could improve. Whilst the clinic displayed the google reviews results on a television screen in reception, there was not a 'you said, we did' board to show the results of feedback and the action taken as a result of the feedback.

The clinic should display the results of the feedback obtained on a 'you said, we did' board to also show the action taken.

Delivery of Safe and Effective Care

Environment
There were no issues noted with the patients dignity. However, the storeroom was cluttered with various equipment including a vacuum and floor cleaner, as well as cardboard boxes. Additionally, equipment was stored on top of one of the cupboards in the kitchen, posing a health and safety risk. This needed to be tidied as it posed a potential fire and health and safety risk.

The registered manager must ensure that the storeroom and kitchen is cleared of excess items of equipment and boxes on the floor.

We saw evidence that environment hazards had been considered, including relating to The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, as well as health and safety and fire safety policies, which were available to staff.

Managing risk and health and safety
The premises were accessible with easy access for patients with disabilities and there were facilities for people with mobility difficulties. There was limited on street parking. We noted that staff helped patients who had difficulty in opening the front door.

The practice was well maintained, clean and in a good state of repair, including furniture, fixtures and fittings. The environment was suitable for the way it was used. Whilst there were no hazards in the environment such as blocked corridors, clutter and tripping hazards. We noted a "grinder" used for podiatry in the kitchen, but this was not in use and we were told this would only be used once an extraction system is installed.

Doors were closed when not in use as well as "in use" signs on the treatment room doors. However, there was not a system in place to call for help in an emergency in the clinical room.

The registered manager must ensure that there is a system in place, such as an emergency button, to call for help in the consultation rooms.

All but one patient found the building to be accessible, with the remaining respondent saying the clinic was partially accessible. A patient commented:

> ***"Clinic has a really wide space in the waiting room so that patients can use their wheelchair or have enough space for moving."***

Infection prevention and control (IPC) and decontamination
The clinic was visibly clean and well maintained. All clinical equipment within the procedure rooms were found to be clean and appeared new. We found the clinic to have appropriate IPC processes in place. We noted that personal protective equipment (PPE) was used, available and changed appropriately between patients. Hand washing stations were available in all consultation rooms. The majority of equipment used was single use. Reusable equipment was found to have appropriate decontamination processes. The registered manager explained the process by which equipment was decontaminated.

An up-to-date written IPC policy was in place at the clinic to provide clear guidance to staff. Overall staff compliance with mandatory IPC training was 100%.

There were cleaning records and schedules noted at the clinic. Shared equipment and reusable medical devices were stored and decontaminated appropriately. The ultrasound machine was clean and appropriately stocked. We saw evidence of appropriate decontamination prior to, and after, internal cavity ultrasound. There were appropriate decontamination solutions and wipes available.

We noted an in-date policy on water management, with risk assessments for legionella, both hot and cold water. There was also a monthly log and legionella certification. However, the legionella risk assessment needed to be reviewed as it was dated October 2023.

The registered manager must ensure that the legionella risk assessment is reviewed and updated.

We noted an ongoing audit programme for IPC compliance and arrangements for feeding back the results. The audits included IPC, hand hygiene and surgical site infections, with action plans where there were deviations from the expected results.

The clinic also had records of staff immunisation with hepatitis B.

The environment enabled effective IPC with lighting flush to the ceiling, reducing the need for dusting and suitable flooring. There were hand washing technique posters displayed by the sinks with extractor fans present throughout the clinic with frequent air turnover.

Safer sharp devices and sharp bins were used. However, the sharps bins were not signed or dated with who had assembled the sharps bins and when. Additionally, the sharps bin in the minor surgery room had not been assembled correctly so

there was a risk of sharps spilling out if tipped. There was a maintenance contract in place to collect waste and sharps.

The registered manager must ensure that sharps bins are assembled correctly, signed and dated.

All patients who completed the questionnaire said the setting was 'very clean'. All patients with an opinion said that infection control measures were being followed.

Medicines management
Staff ensured refrigerators remained fit for use through checking and recording the temperatures daily. They used a quick response (QR) code system that ensured easy checking of the temperatures. However, there was not a policy in place to inform staff of the actions to take if the temperature went outside the agreed tolerances.

The practice manager must ensure there is policy in place to detail the actions to be taken with the medications should the temperature of the refrigerator fall outside tolerances.

A named individual was responsible for checking the medication and staff were aware of who this was.

The clinic reported suspected adverse drug reactions directly to the Medicines and Healthcare products Regulatory Agency (MHRA) through the 'Yellow Card' scheme.

The emergency equipment at the premises was adequate for the services provided at the clinic. This included a defibrillator available with in-date pads, which was checked daily, and individual ampules of adrenaline and administration needles secured in a cupboard. However, all three ampules and the administration needles were out of date. The future checking of the dates on these items would be carried out with the defibrillator check. During the inspection the clinic replaced the adrenaline and needles and these are dealt with at Appendix A.

The arrangements in place to order, obtain, store, control, supply, prescribe, administer and dispose of the limited quantities of medicines were discussed. The clinic employed the services of a pharmacist to advise on this. The limited stocks of medications held were stored in a metal cupboard in a storeroom. The cupboard was not lockable and the room door was propped open during the inspection. We also noted that regular monthly checks had not been carried out. However, we were told that all medicines would be checked before they were given to patients.

The registered manager must ensure that:

- **Documented checks are carried out on all medications on a weekly basis**

- **The room or cupboard containing the medications is locked at all times.**

A medicines management policy was available to explain the processes to staff.

We noted that medicine administration was being recorded consistently and contemporaneously.

The registered manager told us that they were not aware of any training completed in oxygen cylinder management. Staff who were able to prescribe and administer oxygen needed to be competent in medical gases from their medical training.

There was an oxygen policy available for staff and arrangements were in place for the inspection of oxygen cylinder inspection. However, the registered manager told us that there was not a process for reporting issues with oxygen cylinders or administration, which included the lack of staff training. Oxygen had never been required to be administered at the clinic. Any patient safety issues were discussed at the weekly face to face team meetings. We also noted that the oxygen cylinder was stored in an enclosed space and was not secured to the fabric of the building which was not in line with clinic policy. There was also a contract in place for the maintenance of the oxygen cylinder.

The registered manager must ensure that:

- **The clinic documents a process for reporting any issues with the oxygen cylinders**

- **Oxygen cylinder training is undertaken by all members of staff**

- **The oxygen cylinder is securely fixed to the wall at the clinic.**

Safeguarding children and safeguarding vulnerable adults
The registered manager was the allocated safeguarding lead for the clinic. There was an in-date safeguarding policy in place which was dated within the last year and included details of local safeguarding contact numbers and a safeguarding flowchart. Staff were aware of the process to follow in the event of a safeguarding concern.

During the visit, we noted that one of the reception staff on that day had not undertaken safeguarding training. The manager agreed to ensure that everyone

working there would undertake safeguarding training and keep the training updated.

Medical devices, equipment and diagnostic systems
The service had the right equipment and medical devices to meet the needs of patients. There was a range of medical equipment available for the services provided. However, the ultrasound gel was being decanted from a large container into plastic bottles which were reused. Following a patient safety notice (PSN 2023), the ultrasound gel must not be decanted.

The registered manager must ensure that ultrasound gel bottles are single use only and disposed of when empty. Gel must not be decanted into used bottles from a larger ultrasound gel container.

There was appropriate ultrasound equipment available with a choice of probes. Air exchange fans were present throughout the clinic and all equipment observed was used for appropriate purposes. The clinical director carried out monthly checks of ultrasound equipment with evidence of these checks noted.

There was evidence that the equipment had been recently serviced and calibrated in accordance with manufacturer's guidelines, in March 2024. As the machine was leased, faults would be reported and repaired by the lease hire company.

Key members of the clinic were trained in the use of the medical devices and staff would be appropriately trained when the autoclaving process begins.

Safe and clinically effective care
The quality indicators and audits in use to monitor patient care included IPC, hand hygiene and surgical site audits seen. There was also evidence noted of patient note audits and ultrasound image audits.

All staff were aware of the clinical guidelines associated with their area of practice and that they had read the relevant clinic policies and were tested on these as part of the process. Staff were able to locate the policies when asked. Good audit evidence was seen with action plans evident where standards deviated from expectations. Extensive clinic policies were available online with evidence of regular reviews having taken place.

Participating in quality improvement activities
Senior staff we spoked with explained the quality improvement activities which had taken place, these included purchasing a new bone scanner and also the setting were looking at buying a magnetic resonance imaging (MRI) machine. They were also considering expanding into additional premises elsewhere in the county.

We were told that during weekly team meetings, areas to improve were discussed.

Information management and communications technology
There were appropriate information governance arrangements in place and staff demonstrated an awareness of their responsibilities in respect of accurate record keeping and maintaining confidentiality.

Records management
Patient records were maintained electronically with appropriate arrangements in place to ensure the security of these records. The patient records we examined showed evidence of very good record keeping, including the naming of the chaperone and the cleansing agent used, lot number and type. The records were well organised and easy to understand, clear, accurate and legible. However, the allergy section was not completed even where there were no allergies. Additionally, the consent form needed to be more specific for each area and the preferred language was not documented.

The registered manager must ensure that the:

- **Allergies section is completed even if there were no allergies**
- **Consent forms are completed for each separate and specific procedure**
- **The patients preferred language is documented.**

All patients in the questionnaire confirmed that their medical history was checked before undertaking treatment and that they signed a consent form before receiving new treatment.

Quality of Management and Leadership

Governance and accountability framework
Management and staff engaged with the inspection process and were keen to learn and responsive to the recommendations made.

There was a copy of an up-to-date statement of purpose and patient guide available for patients in the reception area of the clinic. These contained the relevant information as required by the Independent Health Care (Wales) Regulations 2011. Only the services listed on the statement of purpose were provided by the clinic. Whilst there were copies of the HIW registration certificates at the clinic these were not prominently displayed.

The registered manager must ensure that the registration certificates are prominently displayed in the clinic.

We found a suitable management structure with clear lines of reporting and accountability in place. The registered manager (who was also the responsible individual) was based at the clinic and available to support staff and to monitor the quality of the services provided.

We noted regular staff meetings to capture staff feedback and the clinic acted on any issues raised. All staff members we spoke with during the inspection confirmed that they felt supported in their roles.

There were extensive clinical and general policies in place, to which staff had access and we noted that in addition to having to read these policies, staff would be tested by the system used at the end of reading the policies.

Dealing with concerns and managing incidents
Information was displayed about how patients could provide feedback and make a complaint. There was also an in-date complaints and compliments policy, which listed the complaints manager and details of HIW. We saw the complaints register and noted there had been two complaints in 2024 which were both closed within 10 days of receipt of the complaint. Information from complaints would be shared with staff to include any shared learning during the weekly team meetings. However, there was not a concerns policy for the clinic.

The registered manager must ensure there is a concerns policy written for the clinic.

Workforce recruitment and employment practices

There was a documented recruitment process in place and in addition to employing staff, there were also sessional staff employed with practicing privileges to work at the clinic.

There were appropriate pre-employment checks completed on staff including reference checks, registration, revalidation and disclosure barring service (DBS) requirements. This information was held on a cloud-based customer relationship management (CRM) system, accessible through two factor authorisation.

Staff had access to an employer assistance programme and should staff require any mental health support this was also provided.

Workforce planning, training and organisational development
The staffing levels were demand led and appropriate for the patients seen. Staff we spoke with said that there was enough time to give patients the care they needed.

Staff we spoke with said that they felt able to report concerns and they believed that if anything was reported these would be dealt with and responded to.

Whilst there was not a mandatory training matrix, we viewed the training certificates for a sample of five staff on the system used. This showed good compliance with mandatory training including basic life support, fire safety, manual handling, equality and diversity, safeguarding, IPC and training on any medical devices and equipment used.

All staff had received an annual appraisal in the last 12 months.

We noted an innovative way of training staff involving bespoke videos filmed by the Clinical Director.

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
All three ampules of adrenaline and the administration needles held at the clinic were out of date.	The expiry date of a medicine is the latest date that the manufacturer guarantees that the medicine will be as effective, and as safe, as when it was issued. Out of date medication may be less effective and not as safe as in date medication should it need to be used.	Registered Manager told about the issues and immediately withdrew the items from use and ordered replacements.	New ampules and administration needles arrived at the clinic before the end of the inspection. The future checking of the dates on these items would be carried out with the defibrillator check.

Appendix B - Immediate improvement plan

Service: Acorn Private Clinic

Date of inspection: 14 November 2024

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurance issues					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: **Acorn Private Clinic**

Date of inspection: **14 November 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.	There was health promotion material displayed within the clinic on the services provided and in how patients could manage their health such as dietary and high blood pressure information. Most of the information on display was in English.	The clinic should: • Provide more health promotion information on how patients could maintain their general health. • Ensure all patient information is readily	National Minimum Standard - Health Promotion, Protection and Improvement	Multiple posters and leaflets have been created and printed for the patients on the following topics: weight management, dementia, diabetes, heart health. The same posters have also been created in Welsh.	Jessica Jones	Already Completed. (evidence can be provided on demand)

		available and routinely provided in both Welsh and English. Patients should be actively offered the opportunity to speak in their preferred language wherever possible.	National Minimum Standard - Communicating Effectively Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (g)			
2.	The clinic displayed the google reviews results on a television screen in reception, there was not a 'you said, we did' board to show the results of feedback and the action taken as a result of the feedback.	The clinic should display the results of the feedback obtained on a 'you said, we did' board to also show the action taken.	National Minimum Standard – Citizen Engagement and Feedback	Among the previous feedback requiring action, this has been addressed and displayed. Moving forward, this action will be carried out regularly for all feedback received to ensure patients' convenience.	Jessica Jones	This has been completed for the previous feedback, and a plan has been implement ed for the future.

3.	However, the storeroom was cluttered with various equipment including a vacuum and floor cleaner, as well as cardboard boxes. Additionally, equipment was stored on top of one of the cupboards in the kitchen, posing a health and safety risk. This needed to be tidied as it posed a potential fire and health and safety risk.	The registered manager must ensure that the storeroom and kitchen is cleared of excess items of equipment and boxes on the floor.	Independent Health Care (Wales) Regulations 2011, regulation 26 (2)	The storeroom and kitchen have been cleared of excess items and thoroughly cleaned.	Jessica Jones	Already Completed. (evidence can be provided on demand)
4.	There was not a system in place to call for help in an emergency in the clinical room.	The registered manager must ensure that there is a system in place, such as an emergency button, to call	Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (k)	New emergency call system has been installed in the clinical rooms	Pretesh Kerai	Before 30th February 2025

		for help in the consultation rooms.				
5.	The legionella risk assessment needed to be reviewed as it was dated October 2023.	The registered manager must ensure that the legionella risk assessment is reviewed and updated.	Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (e) National Minimum Standards - Managing Risk and Health and Safety	We have contacted TS Heating and Bathrooms to arrange for a review of the Legionella risk assessment. It is booked for Tuesday 28 January 2025	Pretesh Kerai	28 January 2025
6.	The sharps bins were not signed or dated with who had assembled the sharps bins and when. Additionally, the sharps bin in the minor surgery room had not been assembled correctly so	The registered manager must ensure that sharps bins are assembled correctly, signed and dated.	Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (n) National Minimum Standards - Managing	All the sharp bins have been assembled properly, signed with dates.	Jessica Jones	Already Completed. (evidence can be provided on demand)

	there was a risk of sharps spilling out if tipped.		Risk and Health and Safety			
7.	There was not a policy in place to inform staff of the actions to take if the temperature went outside the agreed tolerances.	The practice manager must ensure there is policy in place to detail the actions to be taken with the medications should the temperature of the refrigerator fall outside tolerances.	Independent Health Care (Wales) Regulations 2011, regulation 9	A new policy has been created and shared with all staff. Additionally, a short training session was conducted to ensure that everyone understood the process.	Syed Ehtasham Junaid	Already Completed. (evidence can be provided on demand)
8.	The limited stocks of medications held were stored in a metal cupboard that was not lockable and the room door was propped open during the inspection.	The registered manager must ensure that: ● The room or cupboard containing the medications is locked at all times	Independent Health Care (Wales)	To address the concern, we have implemented the following measures: 1. Staff have been trained on the importance of	Jessica Jones	Already Completed. (evidence can be provided on demand)

	We also noted that regular monthly checks had not been carried out.	• Documented checks are carried out on all medications on a weekly basis.	Regulations 2011, regulation 15 (5)	securely storing medications and maintaining proper room security 2. A sign has been placed on the door to remind staff to lock it after use 3. The door will now remain locked when not in use to ensure the safety and security of the medications 4. Regular Monthly checks for quantity, expiry and condition of the medicine will be done and documented in the form of logs.		Logs will be maintained from now onwards.

9.	The registered manager told us that there was not a process for reporting issues with oxygen cylinders or administration, which included the lack of staff training not a process for reporting issues with oxygen cylinders or administration. We also noted that the oxygen cylinder was stored in an enclosed space and was not secured to the fabric of the building which was not in line with clinic policy.	The registered manager must ensure that: • The clinic documents a process for reporting any issues with the oxygen cylinders • Oxygen cylinder training is undertaken by all members of staff • The oxygen cylinder is securely fixed to the wall at the clinic.	Independent Health Care (Wales) Regulations 2011, regulation 9 Independent Health Care (Wales) Regulations 2011, regulation 20 (2) (a)	We have taken the following actions to address the issue: 1. All staff have been trained on the proper handling and administration of oxygen cylinders 2. A weekly oxygen cylinder check log is now in place to ensure ongoing monitoring 3. Any issues identified with the oxygen cylinders or oxygen cylinders or administration should be reported directly to the Practice Manager for prompt resolution	Pretesh Kerai	Already Completed. (evidence can be provided on demand) Logs will be maintained from now onwards, Oxygen Cylinder will be fixed to the wall before 30th February 2025

				4. To fix the oxygen cylinder to the wall, we have ordered the wall brackets and holders. Once we get them it will be fixed to wall.		
10.	Following a patient safety notice (PSN 065 2023), the ultrasound gel must not be decanted.	The registered manager must ensure that ultrasound gel bottles are single use only and disposed of when empty. Gel must not be decanted into used bottles from a larger ultrasound gel container.	Welsh Government Patient safety notice (PSN 065 2023) - The safe use of ultrasound gel to reduce infection risk.	A stock of single-use gel has been purchased	Syed Ehtasham Junaid	Already Completed. (evidence can be provided on demand)
11.	The patient records allergy section was not completed even where there were no allergies.	The registered manager must ensure that the:	Independent Health Care (Wales) Regulations 2011, regulation 23	In response, we have taken the following actions: 1. A meeting was conducted with all	Syed Ehtasham Junaid	Already Completed. (evidence can be

	Additionally, the consent form needed to be more specific for each area. Also, the preferred language was not documented.	• Allergies section is completed even if there were no allergies • Consent forms are completed for each separate and specific procedure • The patients preferred language is documented.		doctors to ensure that the allergy section of patient records is consistently completed, even when there are no allergies 2. Our Tech Manager has updated the consent forms to make them more specific for each procedure and consultation, ensuring clarity and precision 3. The pre-appointment registration and medical history form has been edited to highlight allergy areas, ensuring that this information is properly documented in advance.		provided on demand)

12.	Whilst there were copies of the HIW registration certificates at the clinic these were not prominently displayed.	The registered manager must ensure that the registration certificates are prominently displayed in the clinic.	Care Standards Act 2000 The Registration of Social Care and Independent Health Care (Wales) Regulations 2002	All the relevant certificates have been displayed prominently.	Jessica Jones	Already Completed. (evidence can be provided on demand)
13.	There was not a concerns policy for the clinic.	The registered manager must ensure there is a concerns policy written for the clinic.	Independent Health Care (Wales) Regulations 2011, regulation 9	A new Concerns policy has been created and shared with all staff.	Syed Ehtasham Junaid	Already Completed. (evidence can be provided on demand)

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):	**Pretesh Kerai**
Job role:	**Director and Senior Podiatrist**
Date:	**27 January 2025**