Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Cathays Surgery, Cardiff & Vale Health Board

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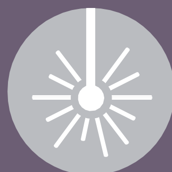

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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:

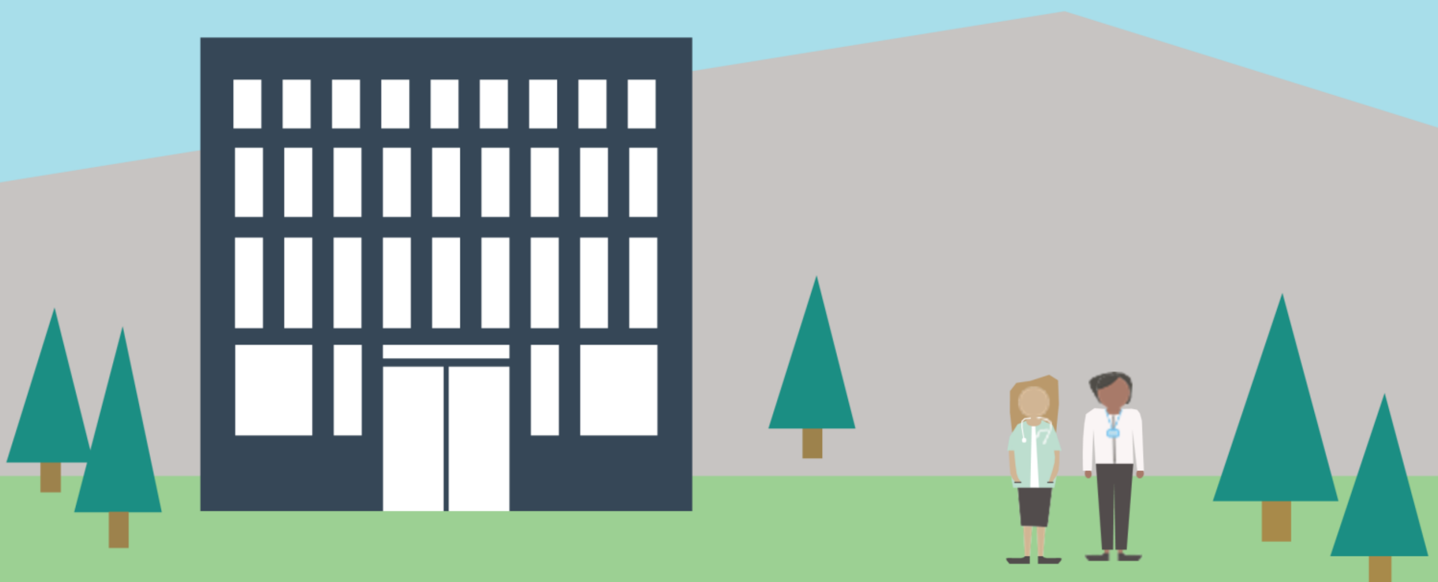
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and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



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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 Cathays Surgery, Cardiff & Vale Health Board on 02 December 2024.

Our team for the inspection comprised of two HIW healthcare inspectors and three clinical peer reviewers.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of six questionnaires were completed by patients or their carers and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

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

There were processes in place that enabled patients to access the right service at the right time. The practice ensured vulnerable patients receive timely care. They have lists of patients that they call to make certain they have access to services specific to their needs.

There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The practice also used translation services and the Red Cross to support their diverse community with specific language needs.

This is what the service did well:

- Good patient access
- Ensured patients felt they were treated with dignity and respect
- Access to translation services to support patients with specific language requirements.

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.

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.

There were good processes in place for care home visits which helped facilitate prompt action by the practice.

The IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients. These included updating key policies

and procedures with practice specific information and improvements to the nursing room environment; updating the sinks, taps and tiling.

Daily temperature checks were taking place for medicines that require refrigeration. We found one fridge was full, which could impede the flow of air to maintain an appropriate temperature, therefore advice must be sought to ensure the correct storage of stock.

Cleaning schedules need to be updated to include regular steam cleaning of the carpeted areas accessible by patients and ensuring the privacy curtains are regularly checked/replaced depending on their date or appearance.

The safeguarding procedures in place were satisfactory with a policy in place and named safeguard leads at the practice. Some staff were identified as not having up to date training in this area.

The patient medical notes were overall a good quality, containing clear and appropriate information.

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

This is what we recommend the service can improve:

- All staff need to have up to date safeguarding training, appropriate to their role
- The practice must ensure that the weekly process for checking emergency drugs and equipment does take place and is recorded
- Guidance must be sought from the fridge manufacturer to ensure the storage of stock is appropriate and ensures proper cool air flow.

This is what the service did well:

- Emergency drugs and equipment were stored appropriately, and staff were able to locate these in an emergency situation
- Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection
- Patient records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

Quality of Management and Leadership

Overall summary:
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.

The practice had a suite of relevant policies and procedures and there were processes in place to share any information updates with staff. Some policies required updating to reflect Welsh guidance and to make them specific to the practice.

Despite there being an appropriate skill mix across the teams to deliver the services required, the practice reported there were no substantive nurses in post at the time of our visit. However, we were told that regular agency nurses are available to deliver the practices' services and clinics, and recruitment was underway to ensure nursing posts are filled.

Some staff were compliant with most aspects of mandatory training; however, our review of staff records highlighted several examples of non-compliance with safeguarding children and adult training and resuscitation. We were told that training courses were being organised and recommend these are arranged without delay, to ensure the safety of patients and staff.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

This is what we recommend the service can improve:

- The practice must ensure all staff are compliant with all mandatory training relevant to their role
- Policies and procedures need to be updated so the information is specific to the practice
- Successful recruitment of nursing staff to compliment the practices services and deliver these consistently.

This is what the service did well:

- Staff were friendly and engaging with patients and each other
- The practice understood their responsibility when processing information and demonstrated that data is managed in a safe and secure way
- Well managed complaints process with minimal complaints.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
During our inspection we saw that the practice had a wide range of written health promotion information available for patients. The information was displayed in the patient waiting areas and promoted through the practice website. We saw health promotion information on a variety of topics including vaccinations, weight management and carers information.

We were told the practice engaged with several agencies to improve access to various healthcare professionals via their cluster group. These included access to physiotherapy, mental health services and pharmacists, and enables patients to access help and support from other agencies in a timely manner.

Staff at the practice work closely with their patient group to ensure they receive the right care from the right services. To ensure vulnerable patients receive timely care, the practice has lists of patients that they call to make certain they have access to services specific to their needs.

A 'was not brought' policy was in place and staff confirmed that any person who misses two appointments receives a letter, including any children who do not attend their appointments. The policy did not include any information on the process used where people do not attend their hospital appointments.

The practice must update the 'did not attend/was not brought' policy to include the process they must follow for people who do not attend their hospital appointments.

Preparations by the practice to manage the annual winter vaccination programme were suitable and included arrangements for vulnerable and care home residents and those without digital access.

All respondents to the HIW patient questionnaire told us there was health promotion information on display at the practice and told us they were offered healthy lifestyle advice. All patients agreed that their GP explained things well to them and answered their questions. All patients said they felt listened to and they were involved as much as they wanted to be in decisions about their healthcare.

Dignified and respectful care
We found patients were treated with dignity and respect throughout their patient journey. Clinical rooms provided patients with an appropriate level of privacy, with doors kept closed during consultations. Privacy curtains were also available.

All respondents to the patient questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

Reception staff were observed welcoming patients in a professional and friendly manner. To protect confidentiality, some telephone calls were taken in the administration office, away from the reception desk. The reception desk was partitioned by glass, including at the sides, which offered some level of privacy from the waiting area.

For the patients who responded in the questionnaire regarding about their ability to talk to reception staff without being overheard; three agreed and three disagreed.

We saw notices displayed offering a chaperone service. The surgery offered male and female chaperones, and this included clinical and non-clinical staff. The patients who responded to the question, one said they were offered a chaperone, and one said they had not.

Timely

Timely care
There were processes in place to ensure patients could access the right service at the right time and in a timely manner. Appointments were mostly made via telephone, but online booking and in-person appointments could also be made. All the respondents to the survey told us they had made their appointment in person at the practice.

We were told most of the appointments are not triaged. If a patient requests to be seen, they will be given an appointment. If all appointments have been booked, then staff will complete a triage form. This form is reviewed by the duty doctor and if the patient needs to be seen, they will be offered an afternoon appointment. Children requiring a face-to-face appointment are accommodated. We found the care navigators had a good pathway in place, assigning patients to the most appropriate person or service. The pathway was available to all staff in both electronic and written format. The care navigators had access to the on-call doctor who was available to provide guidance as necessary. We found the practice made good use of cluster-based support services.

There were suitable processes in place to support patients in a mental health crisis, with good working relationships between the practice and community mental health team. Where appropriate, patients are referred to the acute mental health team, with appropriate interventions in place for anyone requiring support after 4pm. Alternative support and signposting were also available for patients needing mental health support, including counselling and therapy services.

In response to the HIW questionnaire, all patients agreed:

- they were satisfied with the opening hours of the practice
- they were able to contact the practice when they need to by phone/online booking system

Five out of six respondents said their appointment was on time and four told us they were able to have a same-day appointment when they need to see a GP urgently. One patient commented:

> *"They seem incredibly understaffed and appointment times can be up to 3 weeks in advance which is just quite inconvenient"*.

Equitable

Communication and language

We found staff communicating in a clear manner and in a language appropriate to patient needs. They provided information in a way that enabled patients to make informed decisions about their care. The surgery had a hearing loop to support those hard of hearing.

Patients are usually informed about the services offered at the practice through the website and by sharing information and updates via a text messaging service. Where patients are known not to have digital access, letters would be sent to individuals, and communication through telephone calls.

We were told there were no Welsh speaking staff at the practice and that there were very few patients who had requested services in Welsh. However, the practice is in a diverse community, and they used translation services and the Red Cross frequently to support patients who required services in a different language.

There were appropriate processes in place for the recording and action of information from secondary care. Letters and documents are scanned onto patient notes and directed to the correct health care practitioner to action as required. From the notes observed, we saw health care staff had provided information to patients in a way that met their individual needs.

The practice ensured messages were communicated internally to the appropriate people, by using the practices communication and technology (ICT) systems.

Rights and equality

The practice offered good access for patients. We noted that patient areas including treatment rooms, and an accessible toilet were located on the ground floor.

All patients responding to our questionnaire thought the building was easily accessible.

We saw evidence of an equality and diversity policy in place, and staff had completed equality and diversity training. All respondents who answered the question confirmed they had not faced discrimination when accessing or using this health service.

The rights of transgender patients were also upheld, staff confirmed that preferred pronouns and names were used from the outset of transition.

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.

A business continuity plan (BCP) was in place and included the contingencies for any long-term staff absence. At the time of the visit, the practice was using agency nurses until they complete their recruitment process for substantive nursing staff. The practice was using the same agency staff, as far as possible, in order to provide continuity. We recommend that the BCP is available to all staff for clarity on responsibilities and contact details in the event of an urgent or emergency impacting the business.

The business continuity plan must be shared with all staff and a copy available in the reception area.

The practice demonstrated good cluster cooperation to ensure patient care could continue in the event of an extreme situation.

We saw how patient safety alerts were received and disseminated to the practice and communicated in meetings. The process in place for managing patient safety alerts and significant incidents was robust.

The emergency drugs and equipment were stored appropriately, and staff were able to locate this in an emergency.

We discussed the action taken when home visits are requested and found the duty doctor triages all home visits before attending. For care home visits, a SBAR (situation, background, assessment and recommendation) form is completed to help facilitate prompt action.

Infection, prevention and control (IPC) and decontamination
Overall, the IPC arrangements in place were acceptable, but some arrangements need strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

The policy in place was not specific to the practice, but an overarching document. We saw there were specific local policies for Hepatitis B vaccination, management

of blood borne viruses, cold chain management, sharps management, hand hygiene, aseptic non-touch technique and equipment decontamination, however, we recommended a local IPC policy is implemented and includes a named IPC lead.

The practice must implement an IPC policy specific to the practice and ensure a named IPC lead is included.

A blood borne virus policy was in place but needs to be updated so it is specific to the practice. This policy also referenced a needlestick injury policy, which was not present within the suite of IPC documents we saw on the day.

The practice must update the blood borne virus policy, ensuring it is specific to the practice.

The practice must ensure that a needlestick policy is implemented and is available with the suite of IPC policies.

There were no substantive nursing staff on duty during the inspection for us to interview, since there were recent resignations. The practice managed this issue by using agency practice nurses to ensure services are maintained. Communication with other staff highlighted that staff would receive appropriate IPC training on an on-going basis. The training matrix included IPC training as a mandatory course for staff.

Suitable procedures were in place for the management and disposal of all waste, and a policy was in place to support this. However, we recommended that the policy is updated to be specific to the practice. We noted that the waste was secure, with no public access, but did see that two neighbouring houses could access this space. Staff told us that there had been no issues to date regarding this, but there was no formal risk assessment in place to ascertain if the security of the clinical waste collection is satisfactory.

The practice must ensure that the policy for waste management is reviewed and updated to be specific for the practice.

The practice must ensure that the security of the clinical waste is included in a formal risk assessment.

Suitable arrangements were in place to segregate people with transmissible infections to reduce the risk of cross infection. All patients responding to the questionnaire agreed there were signs at the entrance explaining what to do if they had a contagious infection.

We noted that improvements should be made to the nurses' treatment room. We found the room had tiles with grouting and the sinks did not have full elbow levers fitted. Both sinks had overflow drains where bacteria can colonise. The most recent audits seen did not identify these areas and recognise that the sinks do not comply with current guidance on sink design in clinical areas. We were told that extensive refurbishment works are being planned for the treatment room and we recommend that these issues are considered for the planned work.

The practice should consider updating the sinks, taps, and removing the tiles with grouting in the planned refurbishment work to uphold the standards of IPC.

We recommend that a more thorough IPC audit is designed to measure the physical estate against recognised standards. This would help ensure that the wooden skirting boards within the treatment room would be identified as not upholding current standards of IPC. Therefore, it would be appropriate for the practice to consider replacement of wooden skirting boards with seamless continuous flooring in the planned refurbishment of the treatment room.

The practice must update their IPC audit to ensure it is comprehensive and aligned with current, recognised IPC standards.

We observed carpet on the stairs used by patients to access the upstairs clinical rooms. We recommended that regular carpet steam cleaning is undertaken by the new cleaning contractor and added to the cleaning schedules. In addition, we saw disposable clinical privacy curtains were in use and dated. However, two curtains were more than 6-months old, and we recommended that these are changed every six months or sooner if there is visible soiling, marks or dirt.

The practice must update the cleaning schedule to include regular carpet steam cleaning and ensure dignity curtains are regularly checked and/or replaced within a 6-month timeframe.

The patients responding to the questionnaire felt there were hand sanitizers available, and those that answered the question said that healthcare staff washed their hands before and after being treated.

The patients who indicated they had received an invasive procedure at the practice, said that staff used PPE during the procedure. One patient said the equipment used was individually packaged or sanitised; one was unsure. One patient told us that antibacterial wipes were used to clean the skin prior to a procedure, and one patient disagreed.

Medicines management
Processes were in place to ensure the safe prescribing of medication. We saw prescriptions were kept securely and any unused prescription pads are returned to the health board for appropriate disposal and prevention of unauthorised use. We were told there was no audit trail in place for when and who collects prescriptions for patients or the pharmacy. The process was stopped some time ago, and we suggested that this is reviewed to ensure any issues with missing prescriptions or potential abuse could be minimised.

The practice must consider the risk of not having an audit trail in place for when and who collects prescriptions from the surgery.

The process for patients to request repeat medication was clear. Staff told us that most patients order prescriptions through the surgery or via the NHS app. Prescriptions were processed in a timely manner by suitably trained clerks and authorised by a doctor.

A prescribing policy was in place and prescribing clerks had access to regular training to ensure their skills and knowledge remains up to date.

A medication cold chain policy was in place for medicines and vaccines that require refrigeration, and clinical refrigerators were used to store them as appropriate. Daily temperature checks were completed and recorded.

We found one refrigerator was full, with stock being kept on the fridge base. This could impede the flow of air and the maintenance of appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain guidance on the correct storage of stock to maintain adequate circulation of cool air.

The practice must contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool air flow.

At the time of the visit, a locum nurse was allocated time for checking the drugs and emergency equipment, this was being recorded appropriately. We were told this was completed weekly, however the last entry was dated 07 November 2024. There was no ambient temperature monitoring for the emergency drugs and other medications stored in the treatment room. Staff told us they would seek guidance from the health board or their cluster group on how to monitor and log this information.

The practice must ensure that the process for checking emergency drugs and equipment is completed weekly and is recorded.

The practice must seek guidance, such as from the health board and/or their cluster group on how to monitor and record ambient temperatures for emergency drugs and other medications stored at the practice.

All necessary emergency equipment was in place. However, the practice may benefit from storing a checklist of required items in line with the Resuscitation Council UK Quality Standards for Primary Care.

The practice must implement a check list of required emergency equipment and drugs.

An automated external defibrillator (AED) was in place and was fully charged, we suggested staff consider storing a spare battery.

We saw that oxygen cylinders were in date, with appropriate stock levels and arrangements were in place for reporting any incidents. We referred staff to a recent safety alert regarding staff training requirements for the use of oxygen and ensuring cylinders are correctly opened.

The practice must ensure all safety alerts are circulated to all staff and are accessible as appropriate to agency nurses. Given the practice is currently reliant on agency nurses, the practice must ensure a process is in place to check they are suitably trained to operate oxygen cylinders.

No controlled drugs are kept at the practice.

Safeguarding of children and adults

We considered the safeguarding procedures in place at the practice and found a policy in place which included both adults and children. The policy referenced the national Wales safeguarding procedures and was available for all staff on the shared drive. The practice had named safeguarding leads which were recorded in the policy.

On review of patient records, we saw examples where people were appropriately flagged with any safeguarding concerns and followed a suitable safeguarding pathway. This included care experienced children.

During the inspection we did not see evidence that all staff had completed safeguarding training at the required level.

The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.

Management of medical devices and equipment
We found medical devices and equipment were in good condition, safe to use and had been appropriately checked. Suitable contracts were in place for the repair or replacement of relevant equipment. Single use items were used where appropriate and disposed of correctly.

Effective

Effective care
Suitable processes were in place to support the safe and effective treatment and care for patients. We were told that any changes or new guidance is emailed and discussed with staff and the information is stored on the shared drive where all staff can access.

Appropriate processes were in place for reporting incidents, including discussions at internal clinical meetings and logs kept.

Patient referrals were managed to a good standard, including those which are urgent. Patient records contained investigation/ test results and had narrative as to why investigations were requested.

Patients in need of urgent medical help or those in a mental health crisis were provided with suitable support and information. The practice has access to the local mental health crisis team and also the local hospital psychiatric liaison team.

Patient records
We reviewed ten electronic patient records, which were stored securely and were password protected from unauthorised access. Overall, the records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and information was easy to understand for other clinicians reviewing the records.

We found there was a good and consistent use of clinical read codes, which makes analysis and audit easier. The patient records where chronic disease was recorded contained a full summary of conditions, including all past and continuing problems, as well as the medication being taken.

We found the continuity of care was good, with close oversight and supervision of patients and patients records by all the GPs. The records seen evidenced good quality patient consultations.

From the notes reviewed we found that the patient's language choice was not always recorded, however we found that new patient registrations, language choice was recorded.

The practice must ensure that patient language preference is recorded and easily identified in their clinical records.

Efficient

Efficient

We found that services were arranged in an efficient manner and are person centred, to ensure people feel empowered in their healthcare journey.

The practice can refer to physiotherapy and mental health services, including counselling via the cluster group. The common ailments services are from community pharmacists and for any surge in capacity of patients during busy periods the practice can refer to the Cardiff Royal Infirmary.

Other services patients could access via the surgery included emergency dental care, optician, exercise referrals, smoking cessation, sexual health clinic and alcohol and gambling support.

Quality of Management and Leadership

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.

The practice had a process in place for sharing information with staff, such as changes in policies or procedures. All policies and procedures were on the shared drive and all staff would be told about any changes via Teams and through team meetings.

The document control on the polices we saw included version, review date, edited by, approved by and comments. We found two policies that require version control information to be added; these were the business continuity plan and repeat prescribing policy. In addition, we saw the waste management policy referenced English guidance, and this should be updated to reflect Welsh guidance from WHTM 07-01

The practice must ensure that the business continuity plan and repeat prescribing policies are updated with version control information.

The practice must review and update the waste management policy to reflect Welsh guidance from WHTM 07-01.

We were told staff meetings were routine and we saw minutes of the various meetings which take place. Any lessons to be learned are shared with staff to ensure the practice retains good service standards and improvements, where applicable.

The practice is part of a cluster group and attend regular meetings with them. However, we were told the practice sometimes feels frustrated that it is not always a collaborative process with some cluster initiatives being put on them.

Workforce

Skilled and enabled workforce

We spoke with staff across a range of roles. They all had sound knowledge of their roles and responsibilities, and each appeared committed to providing a quality service to patients.

Despite there being an appropriate skill mix across the teams to deliver the services required, the practice reported there were no substantive nurses in post. No nursing staff were at the practice on the day of our inspection; however, we were told that regular agency nurses are available to deliver the practices' services and clinics.

We were told of the workforce plan and the recruitment currently taking place to ensure appropriate capacity is maintained. Staff also described the process for recruitment and conducting pre-employment checks. This included obtaining a Disclosure Barring Service (DBS) check, two references and a check of a healthcare professional's registration with their regulatory body to ensure it was current.

An induction process was available for new staff and a recruitment policy was in place. The contents of which included what we had been told.

A review of five staff records did show that some information was missing from their files. This information included DBS checks, contracts of employment and Hepatitis B screening. There was no system in place to check a person remains suitable to work for the practice after they had received their initial DBS check. We therefore recommend that this is conducted as part of their annual appraisal discussions.

The practice must ensure all employment information is collected and saved on each staff members file.

The practice must implement a process to check that staff remain suitable to work at the practice regarding their DBS status.

Some staff were compliant with most aspects of mandatory training; however, our review of staff records highlighted several examples of non-compliance with safeguarding children and adult training and resuscitation. We were told that training courses were being organised and recommend these are arranged without delay, to ensure the safety of patients and staff.

The practice must ensure all staff are compliant with all mandatory training relevant to their role and provide HIW with evidence once completed.

A training matrix was in place and recorded the training completed by the administration staff, but this was not in place for clinical staff. We recommended

the training matrix is updated to include all clinical staff. This will enable the practice to ensure compliance can be monitored effectively and to ensure staff skills and knowledge are up to date in line with their role.

The practice must update the training matrix with all clinical staff and ensure it is monitored regularly to ensure staff skills and knowledge remain current.

We saw that appraisals had been completed for the administrative staff. We found no evidence that clinical supervision or annual appraisals were taking place for clinical staff. Annual appraisals are mandatory for GPs in the UK, and for nurses as part of their revalidation process.

The practice must ensure annual appraisals and clinical supervision is undertaken for all clinical staff, and evidence recorded.

We were assured that staff would be supported to raise a concern should the need arise, and we were provided with the practice whistleblowing policy.

Two staff members completed a questionnaire, and both felt they had fair and equal access to workplace opportunities. Additionally, they felt their workplace was supportive of equality, diversity and inclusion, and they had not faced discrimination within the last 12 months.

Staff had access to appropriate ICT systems to support the provision of care and support for patients. The survey respondents felt there was an appropriate skill mix at the practice, along with enough staff to allow them to do their job properly, and they could meet all conflicting demands on their time at work. In addition, they felt all relevant materials, supplies and equipment was available, to enable them to do their job.

Culture

People engagement, feedback and learning

Of those who responded to our survey, one out of six patients confirmed they had been asked by the practice about their experience of the service provided. Four out of six patients knew how to make a complaint about the service, and all agreed that the service they had received was 'very good' or 'good'.

The practice had a patient complaints procedure and policy which was aligned to the NHS Wales Putting Things Right process. The practice manager was responsible for managing all complaints and this was clear within the complaints policy. Complaints/concerns are monitored to identify any themes and trends, and any actions for improvement are communicated to staff.

There was a poster displayed in the waiting area indicating the ways a patient can submit feedback. We were told that one form had been received to date and any feedback collected by the practice would be used to inform any service improvement.

Staff felt able to speak to the practice manager regarding any concerns they may have, in addition, they felt comfortable to share any suggestions they might have with the practice manager for their consideration.

We spoke to staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was in place and records showed that staff had completed training on this topic. Respondents to the staff survey agreed that the organisation encourages them to raise concerns when something has gone wrong and to share this with the patient. All respondents agreed they knew and understood their role in line with Duty of Candour.

Information

Information governance and digital technology
The practice understood its responsibility when processing information and demonstrated that data is managed in a safe and secure way. A current information governance policy was in place to support this.

The practice's process for handling patient data was available for review on the website.

Learning, improvement and research

Quality improvement activities
There was evidence of some clinical and internal audit in place to monitor quality. We were told learning was shared across the practice to make improvements.

Whole-systems approach

Partnership working and development
The practice provided examples of how it, as a stakeholder in patient care, impacts on other parts of the healthcare system. This included following health board clinical pathways. The practice also interacts and engages with system partners at various multidisciplinary meetings, such as cluster meetings and practice manager meetings.

There were good collaborative relationships in place with external partners and within the cluster. The practice worked within the local GP 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 summarises 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 were unable to locate the level 3 safeguarding training certificate for the deputy safeguard lead at the practice.	We were unable to confirm the deputy safeguard lead had up to date skills and knowledge in this area to ensure they are equipped to respond to any emerging risks and challenges.	The concern was raised with the practice manager.	Evidence of the appropriate training certificate was provided.

Appendix B - Immediate improvement plan

Service: Cathays Surgery

Date of inspection: 2 December 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.	No immediate assurances were identified on this inspection.					
2.						

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: Cathays Surgery

Date of inspection: 2 December 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.	The 'was not brought' policy did not include any information on the process used where people do not attend their hospital appointments.	**The practice must update the 'did not attend/was not brought' policy to include the process they must follow for people who do not attend their hospital appointments.**	Health & Care Quality Standards - Information	This was stated in the Safeguarding policy, we have now updated the "was not brought" in the DNA policy	Nicola Short PM	Completed
2.	A business continuity plan (BCP) was in place and included the	**The business continuity plan must be shared with all staff and a copy**	Health & Care Quality Standards - Information	Business Continuity Plan has now been shared electronically	Nicola Short PM	Completed

	contingencies for any long-term staff absence. At the time of the visit, the practice was using agency nurses until they complete their recruitment process for substantive nursing staff. The practice were using the same agency staff, as far as possible, in order to provide continuity. We recommend that the BCP is available to all staff for clarity on responsibilities and contact details in the event of an urgent or emergency situation impacting the business.	**available in the reception area.**		with all staff and a paper copy in reception folder		

3.	The policy we saw was not specific to the practice, but an overarching document.	**The practice must implement an IPC policy specific to the practice and ensure a named IPC lead is included.**	Health & Care Quality Standards - Information	New IPC policy specific to the practice with a named IPC lead has now been implemented	Nicola Short PM	Completed
4.	A blood borne virus policy was in place but needs to be updated so it is specific to the practice.	**The practice must update the blood borne virus policy, ensuring it is specific to the practice.**	Health & Care Quality Standards - Information	Blood borne virus policy forms part of the new IPC policy	Nicola Short PM	Completed
5.	The blood borne virus policy referenced a needlestick injury policy, which was not observed to be present with the suite of IPC documents we saw on the day.	**The practice must ensure that a needlestick policy is implemented and is available with the suite of IPC policies.**	Health & Care Quality Standards - Information	Needlestick policy forms part of the new IPC policy	Nicola Short PM	Completed
6.	The waste management policy needs to be updated to be specific to the practice.	**The practice must ensure that the policy for waste management is reviewed and updated to be specific for the practice.**	Health & Care Quality Standards - Information	A new waste management policy has been implemented	Nicola Short PM	Completed

7.	We noted that the waste was secure, with no public access, but did see that two neighbouring houses could access this space. Staff told us that there had been no issues to date regarding this, but there was no formal risk assessment in place to ascertain if the security of the clinical waste collection is satisfactory.	**The practice must ensure that the security of the clinical waste is included in a formal risk assessment.**	Health & Care Quality Standards - Information; Safe	Risk assessment has been carried out and found that as the clinical waste bins are always locked it is deemed to be low risk.	Nicola Short PM	Completed
8.	We were told that extensive refurbishment works are being planned for the treatment room and we recommend that these issues are	**The practice should consider updating the sinks, taps, and removing the tiles with grouting in the planned refurbishment work to uphold the standards of IPC.**	Health & Care Quality Standards - Safe	Improvements started on the surgery with a plan to refurbish the treatment room but is currently on hold due to the financial situation. If/when this	Nicola Short PM	2/3 years depending on financial situation

	considered for the planned work.			improves, we will refurbish.		
9.	We recommend that a more thorough IPC audit is designed to measure the physical estate against recognised standards. This would ensure that the wooden skirting boards that were in the treatment room would be identified as not upholding current standards of IPC.	**The practice must update their IPC audit to ensure it is comprehensive and aligned with current, recognised IPC standards.**	Health & Care Quality Standards - Information; Safe	Our newly appointed practice nurse will update IPC audit	Sarah Baker Practice Nurse	3 months
10.	We recommended that regular carpet steam cleaning is undertaken by the new cleaning contractor and added to the cleaning schedules. In addition, we saw disposable clinical privacy curtains were in use and dated.	**The practice must update the cleaning schedule to include regular carpet steam cleaning and ensure dignity curtains are regularly checked and/or replaced within a 6-month timeframe.**	Health & Care Quality Standards - Information; Safe	Awaiting confirmation from cleaning company if they offer steam cleaning if not will source elsewhere. In the future we will look to replace with safety flooring or similar. Curtains have now been replaced	Nicola Short PM	3 months

	However, two curtains were more than 6-months old, and we recommended that these are changed every six months or sooner if there is visible soiling, marks or dirt.					
11.	We were told there was no audit trail in place for when and who collects prescriptions for patients or the pharmacy. The process was stopped some time ago, and we suggested that this is reviewed to ensure any issues with missing prescriptions or potential abuse could be removed.	**The practice must consider the risk of not having an audit trail in place for when and who collects prescriptions from the surgery.**	Health & Care Quality Standards - Information; Safe	At the point of collection by a patient we require Name, DOB & address to release the prescription. Patient records state which pharmacy they have agreed will collect prescriptions on their behalf.	Nicola Short Pm	Completed

12.	We found one refrigerator was full, with stock being kept on the fridge floor. This could impede the flow of air and maintain appropriate temperatures. We recommended the practice contact the fridge manufacturer to obtain the correct storage of stock so as to allow adequate circulation of air.	**The practice must contact the fridge manufacturer to obtain guidance to ensure the storage of stock is appropriate and ensure appropriate cool air flow.**	Health & Care Quality Standards - Information; Safe	Stock has now been split between the 2 fridges in the treatment room.	Nicola Short PM	Completed
13.	Emergency drugs and equipment was being recorded appropriately. We were told this was being completed weekly, however the last entry was dated 07 November 2024.	**The practice must ensure that the process for checking emergency drugs and equipment is completed weekly and is recorded.**	Health & Care Quality Standards - Information; Safe	We have a new practice nurse in post and checks and logs weekly	Sarah Baker PN	Completed

14.	There was no ambient temperature monitoring for the emergency drugs and other medications stored in the treatment room. Staff told us they would seek guidance from the health board or their cluster group on how to monitor and log this information.	**The practice must seek guidance, such as from the health board and/or their cluster group on how to monitor and record ambient temperatures for emergency drugs and other medications stored at the practice.**	Health & Care Quality Standards - Information; Safe	Awaiting guidance on how best to facilitate this.	Nicola Short PM	2 months
15.	The contents of the resus bag was not itemised and recommended items should be individually listed.	**The practice must implement a check list of required emergency equipment and drugs.**	Health & Care Quality Standards - Information; Safe	There is now a list in the resus bag	Nicola Short PM	Completed
16.	We referred staff to a recent safety alert regarding staff training requirements for the use of oxygen	**The practice must ensure all safety alerts are circulated to all staff and are accessible as appropriate to agency**	Health & Care Quality Standards - Information; Safe; Workforce	All staff will receive training for oxygen cylinders	Nicola Short PM	2 months

	and ensuring cylinders are correctly opened.	**nurses. Given the practice is currently reliant on agency nurses, the practice must ensure a process is in place to check they are suitably trained to operate oxygen cylinders.**				
17.	During the inspection we did not see evidence that all staff had completed safeguarding training at the required level.	**The practice must ensure all staff undertake the required level of safeguarding training (both children and adult) appropriate to their role, and a record should be kept to evidence this.**	Health & Care Quality Standards - Information; Safe; Workforce	GP's and practice nurse will complete appropriate training	Nicola Short PM	2 months
18.	From the notes reviewed we found that the patient's language choice was not always recorded, however we found that new patient registrations, language choice was recorded.	**The practice must ensure that patient language preference is recorded and easily identified in their clinical records.**	Health & Care Quality Standards - Information	Language choice is part of the new patient questionnaires (including student registrations) and is recorded for all new registrations.	Nicola Short PM	Completed

19.	We found two policies that require version control information to be added; these were the business continuity plan and repeat prescribing policy.	**The practice must ensure that the business continuity plan and repeat prescribing policies are updated with version control information.**	Health & Care Quality Standards - Information	Both policies have now been updated with version control information	Nicola Short PM	Completed
20.	The waste management policy referenced English guidance, and this should be updated to reflect Welsh guidance from WHTM 07-01	**The practice must review and update the waste management policy to reflect Welsh guidance from WHTM 07-01.**	Health & Care Quality Standards - Information	A new waste management policy has been implemented	Nicola Short PM	Completed
21.	A review of five staff records did show that some information was missing from their files. This information included DBS checks, contracts of employment and Hepatitis B screening.	**The practice must ensure all employment information is collected and saved on each staff members file.**	Health & Care Quality Standards - Information; Workforce	All new starters will have this information collected and stored in their staff records.	Nicola Short PM	Completed

22.	There was no system in place to check a person remains suitable to work for the practice after they had received their initial DBS check.	**The practice must implement a process to check that staff remain suitable to work at the practice regarding their DBS status.**	Health & Care Quality Standards - Information; Safe; Workforce	We have implemented annual self-declarations for clinical staff.	Nicola Short PM	Completed
	our review of staff records highlighted several examples of non-compliance with safeguarding children and adult training and resuscitation.	**The practice must ensure all staff are compliant with all mandatory training relevant to their role and provide HIW with evidence once completed.**	Health & Care Quality Standards - Safe; Workforce	We have resus training booked for the whole practice 4/3/25. Clinical staff will complete relevant Safeguarding training.	Nicola Short PM	2 months
23.	A training matrix was in place and recorded the training completed by the administration staff, but this was not in place for clinical staff.	**The practice must update the training matrix with all clinical staff and ensure it is monitored regularly to ensure staff skills and knowledge remain current.**	Health & Care Quality Standards - Information; Workforce	The training matrix has been replicated for clinical staff	Nicola Short PM	Completed
24.	We saw that appraisals had been completed for the administrative staff.	**The practice must ensure annual appraisals and clinical supervision is undertaken for all clinical**	Health & Care Quality Standards - Workforce	We have implemented a self-declaration for GP annual appraisals as they are carried out	Nicola Short PM	1 month

	We found no evidence that clinical supervision or annual appraisals were taking place for clinical staff.	**staff, and evidence recorded**.		externally and will keep a record in files.		

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): **Nicola Short**

Job role: **Practice Manager**

Date: **22/01/2025**