Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report

(Announced)

Vauxhall Surgery, Aneurin Bevan University Health Board

Inspection date: 12 December 2024
Publication date: 14 March 2025

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-83715-461-6

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Vauxhall Surgery, Aneurin Bevan University Health Board on 12 December 2024.

Our team for the inspection comprised of a HIW healthcare inspector and three clinical peer reviewers.

During the inspection we invited staff to complete a questionnaire to tell us their views on working for the service. A total of nine questionnaires were completed by staff members, and some of the results and 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 observed friendly and caring interactions between staff and patients throughout the inspection. Patients were able to access information to help promote their health and wellbeing and lead a healthy lifestyle, and patients received sufficient information to allow informed decisions to be made about their care.

Patients were able to have a chaperone present during their consultation. However, we noted that offers of a chaperone to patients were not always recorded within their medical records.

Reception staff had received training in care navigation to help direct patients to the most appropriate member of the practice team, or to other healthcare professionals in the community. Same day appointments were offered for all urgent cases, with dedicated GP time available each day to review queries and to attend home visits.

Equality and diversity was promoted through practice policies and staff training, and a hearing loop was available to support patients with hearing difficulties. We found all areas of the practice to be accessible, and an access ramp was available to the front entrance to assist patients with mobility needs. However, the language and communication needs of patients should be routinely recorded within their records, and the provision of services to Welsh speakers should be improved in accordance with the guidelines set out in 'More than just words'.

Delivery of Safe and Effective Care

Overall summary:
We found appropriate processes in place to protect the health, safety and wellbeing of patients and staff. All areas of the practice were in a good state of repair and clinical rooms were well stocked with items and equipment. Appropriate cold chain processes were in place for vaccines and immunisations that required refrigeration. However, clinical fridges must not be overstocked to allow for effective cool air movement to maintain the viability of medications or vaccines.

Some effective infection prevention and control (IPC) procedures and processes were evident, but other aspects needed strengthening. Improvements identified

included consideration of updating some of the sinks and taps throughout the practice that do not conform to current guidance, updating the IPC audit to ensure it is aligned with current and recognised standards, and ensuring weekly cleaning schedules are implemented and maintained.

Resuscitation equipment and emergency drugs were available at the practice to manage a patient emergency. Checks were being undertaken to replace any expired resuscitation equipment and emergency drugs when required. However, we found that the emergency drugs were being stored within a locked cupboard. We discussed this with staff who arranged for the emergency drugs to be taken out of the locked cupboard immediately and subsequently stored with the resuscitation equipment.

The practice had a 'Did Not Attend' policy to manage patients (including children), who did not attend for appointments at the practice or the local hospital.

The patient records we reviewed were being maintained to a very good standard. Consultation narratives were well documented and there was evidence of shared decision making and appropriate investigations and referrals where required. Suitable processes were in place to ensure the safe prescribing of medication. However, a more detailed documentation is also needed within medication reviews, and there is a requirement for improved coding and linkage of repeat prescriptions to clinical conditions. In addition, audits of clinical coding must be completed to monitor their accuracy.

Quality of Management and Leadership

Overall summary:
The GP partners were long serving staff who provided stability at the practice. We saw evidence of regular team and practice meetings, including use of various platforms for general and urgent communication between staff. A wide range of policies and procedures were in place to support the effective running of the practice.

Questionnaires were regularly issued to patients to request feedback on their experiences of using the service.

The practice had recently introduced an online triage and patient flow management tool, and the staff we spoke with said this had been a beneficial and positive experience.

The feedback we received from staff was mixed. Most staff felt they were satisfied with the quality of care and support they give to patients, and that they would be

happy with the standard of care provided by the practice for themselves or friends and family. However, some felt they would not recommend the practice as a good place to work and identified areas for improvement in their feedback highlighting poor communication from the leadership team and a lack of team work to drive improvements. We recommend the practice liaises further with staff to fully understand their concerns in relation to working at the practice, and we need assurance on the actions the practice will take to strengthen its governance and leadership arrangements.

Other areas that should be strengthened include ensuring that all staff receive an annual appraisal to discuss their performance, set annual objectives and identify any learning needs. In addition, the practice must ensure all staff receive training and understand their role with the Duty of Candour, and the process to follow if staff are involved in a needlestick injury.

Immediate assurances:
During the inspection we could not determine whether staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery. This is because the training matrix being maintained by the practice was incomplete in several areas. Details of our concerns and the immediate improvements and remedial actions taken by the practice are provided in Appendix B.

3. What we found

Quality of Patient Experience

Person-centred

Health promotion
A wide range of health information leaflets and posters were available for patients in the reception area. This included information on smoking cessation, well baby clinics, patient transport and physiotherapy. A display screen in the waiting area informed patients about flu clinics, exercise referral schemes and the menopause. We were told that patients could also access an app which helped patients to directly access services and support to manage their own wellbeing and health. Most staff members who completed a HIW questionnaire agreed that the practice offered health promotion advice and information about chronic conditions to patients.

We were told that a midwife holds a weekly clinic at the practice to provide pregnancy support to patients. In addition, physiotherapy treatment has recently been funded by the South Monmouthshire cluster group and has been available to patients at the practice since April 2024.

The practice was inviting eligible patients to make an appointment for their flu and COVID-19 vaccinations at Chepstow Community Hospital. The service was promoted on the practice website and patients also received their invitation by letter which helped inform patients without digital access. We were told that patients could receive their vaccinations at the practice if they could not attend the hospital.

Dignified and respectful care
We observed friendly and caring interactions between staff and patients during the inspection. We found that the environment generally supported the rights of patients to be treated with dignity and respect. The consultation rooms provided appropriate levels of privacy, with lockable doors, frosted glass and privacy curtains. However, we noted that treatment room 14 did not have a privacy curtain.

The practice must ensure that privacy curtains are installed in treatment room 14 to help protect the privacy and dignity of patients receiving treatment.

Patients used a computer to sign in on their arrival. The waiting area was located behind a glass partition wall which helped ensure most conversations were held in private between reception staff and patients. A sign was displayed on the reception desk informing patients to notify reception staff if they required extra privacy, which we noted as good practice.

Patients were advised through well-placed posters and verbally that they were welcome to have a chaperone present during their consultation. We confirmed that male and female staff were available. However, during our review of patient records we found one instance where the verbal consent and offer of a chaperone had not been recorded.

The practice must ensure that verbal consent for intimate examinations and offer of a chaperone is always recorded into patient medical records in accordance with General Medical Council (GMC) guidelines.

Timely

Timely care

An up-to-date patient access policy was in place which set out the arrangements for patients to access care in a timely manner. Patients could book routine appointments through Klinik, an online enquiry and triage system, or via telephone. We were told that assistance is available from staff for those patients unable to complete an online Klinik form themselves.

Reception staff had received training in care navigation to help ensure patients could access the right service for their needs. Patients would be directed to the most appropriate member of the practice team or to other healthcare professionals in the community if necessary.

Same day appointments were offered for all urgent cases, with dedicated GP time available each day to review queries and to attend home visits. We saw that Klinik directed patients to contact 999 when presenting with urgent symptoms, such as heart attack, stroke, or heavy bleeding.

Five of the nine staff members who completed a HIW questionnaire agreed that patients can access the practice's services in a timely way.

We were told that patients often wait between four to six weeks for an appointment following referral to secondary mental health services. All patients requiring urgent mental health support are directed to the Community Mental Health Team in South Monmouthshire for an assessment the same day.

Patients not accepted by secondary care mental health services are signposted to other resources, such as SilverCloud, a self-help therapy platform, and other organisations in the community, such as CRUSE bereavement counselling and MIND Monmouthshire.

Equitable

Communication and language
We found that staff communicated in a clear manner and in a language appropriate to patient needs. The patient records we reviewed evidenced that sufficient information was being provided to patients to allow informed decisions to be made about their care.

The practice had a hearing loop to support those with hearing difficulties. Bilingual signage and patient information was available. We were told that there were currently no Welsh speaking members of clinical staff at the practice. Staff told us that they would accommodate any known language or communication needs and were familiar with services, such as Language Line, to support the need for translation. However, we saw no evidence that the service was making an 'active offer' to Welsh speakers in line with 'More than just words'. The language and communication needs of patients were also not routinely recorded within the patient records we reviewed. We discussed this with staff, who arranged for a sign to be displayed informing patients to notify reception staff if they wish to speak in Welsh. While this was a positive step, we felt the practice could still do more to ensure Welsh speakers receive services in the language of their choice.

The practice must ensure that language and communication needs are routinely recorded within patient records and do more to implement the characteristics of a service that provides an 'Active Offer' as set out in 'More than just words'.

We saw that information specific to each patient was recorded promptly within their patient records. This included appropriate actions and follow-up requirements when patients interact with the Out of Hours GP service.

Rights and equality
Equality and diversity was promoted through practice policies and staff training. It was currently not possible to record pronouns within patient records, but staff told us that the correct pronouns for patients would be used where known. The practice manager informed us that they would look to amend the electronic patient record system to allow pronouns to be recorded in future.

We found all areas of the practice to be accessible. An access ramp was available to the front entrance to assist patients with mobility needs and all surgeries and patient facilities were located on the ground floor.

Delivery of Safe and Effective Care

Safe

Risk management
We found appropriate processes in place to protect the health, safety and wellbeing of patients and staff. All areas of the practice were in a good state of repair. Clinical rooms were well stocked with items and equipment.

Consultation and treatment rooms had emergency call bells should help be urgently required. The alarm system indicated to staff where the incident was located within the practice to ensure a timely response.

We saw a suitable up-to-date business continuity and recovery plan in place which was available on the shared drive. The plan included contact details for staff and maintenance services; we noted these contact details were also displayed in the practice for staff to access easily in the event of an emergency.

There was a clear process in place for managing patient safety alerts. These were disseminated to relevant staff by email. The practice reviewed and discussed significant events (including patient safety incidents) in weekly clinical meetings.

We saw that an up-to-date home visit policy was in place, which set out the procedures for triaging and prioritisation of home visits, as well as identifying and mitigating against any potential risks. We noted that while the home visit policy contained a brief section on lone working, a separate lone working policy was not available. We recommended to staff that a formal lone working policy should be developed to help protect staff who are required to work alone, either on the premises or at other locations, and not just when undertaking a home visit. We received evidence shortly following the inspection that a lone working policy had been developed and ratified by practice staff.

Infection, prevention and control (IPC) and decontamination
We found that some effective IPC procedures and processes were in place, but some aspects needed strengthening to ensure the practice always upholds the required standards of IPC to maintain the safety of staff and patients.

The practice appeared visibly clean and was free of clutter in all areas. A nurse had been designated as the IPC lead for the practice. An up-to-date IPC policy and other supporting policies were available, which included blood-borne virus and staff vaccination. Suitable procedures were in place for the management and disposal of all waste and we noted that clinical waste was being stored securely.

Staff described how patients presenting with transmissible infections would be segregated to reduce the risk to other patients and staff of cross infection.

However, we identified the following areas for improvement:

- Some clinical room sinks did not have full elbow operated levers fitted and the sink in room nine had an overflow drain where bacteria could colonise
- The most recent IPC audit we reviewed did not recognise that some sinks were not compliant with current guidance on sink design in clinical areas
- Although the practice appeared clean, there was no evidence that weekly cleaning schedules were being maintained
- Although protocols were on display throughout the practice, some staff were unsure of what to do in the event of a needlestick injury.

The practice must:

- **Consider updating the sinks and taps throughout the practice that do not conform to current guidance, to fully uphold best practice standards of IPC. Where this is not possible, conduct a risk assessment and manage the risk as appropriate**
- **Update the IPC audit to ensure it is aligned with current and recognised IPC standards so it can more effectively identify areas of non-compliance**
- **Ensure weekly cleaning schedules are implemented and maintained**
- **Provide refresher training to staff on what to do in the event of a needlestick injury.**

The practice could not provide evidence during the inspection that clinical staff members had completed IPC training relevant to their role. The practice submitted documentation following the inspection which certified that all clinical staff had completed their IPC training.

Medicines management
Processes were in place to ensure the safe prescribing of medication. A prescribing policy was in place and prescribing clerks had access to regular training to ensure their skills and knowledge remains up to date. We saw that prescription pads were securely stored in a locked cupboard. We were told there was a process in place to securely dispose of prescription pads when a GP leaves the practice.

There were appropriate cold chain processes in place for vaccines and immunisations that required refrigeration. Daily temperature checks of the fridges were being completed, and the documentation we reviewed confirmed this. Conversations with staff confirmed that they were aware of the upper and lower temperature thresholds and what to do in the event of a breach to the cold chain.

However, we noted that the clinical fridge in room nine was potentially overstocked which could prevent effective circulation of cold air.

The practice must ensure that clinical fridges are not overstocked to allow for effective cool air movement.

Resuscitation equipment and emergency drugs were available at the practice to manage a patient emergency, such as cardiac arrest. We saw that appropriate processes were in place to check and replace any expired resuscitation equipment and emergency drugs when required. Staff were aware of a recent safety alert regarding staff training requirements for the use of oxygen and ensuring cylinders are correctly opened. However, we identified the following issues:

- The emergency drugs were being stored within a locked cupboard; it is best practice for emergency drugs to be readily available in an emergency and not locked away
- The controlled drug morphine was being stored in a safe within the locked cupboard; morphine is not typically included as part of the minimum suggested drug list for primary care as set out by the Resuscitation Council UK
- There were no posters displayed on the door where the emergency drugs and equipment were kept informing staff where the emergency equipment and defibrillator was stored. We were subsequently told that there was a notice in the staff area of the surgery informing staff of where the emergency equipment and defibrillator were stored.

We discussed this with senior management who arranged for the emergency drugs to be taken out of the locked cupboard. We were informed shortly after the inspection that the practice had considered the issues we had identified and had revised their medical emergency guidelines; the use of morphine was subsequently removed from the emergency procedure and the emergency drugs were now contained in boxes with a tamper evident seal on the resuscitation trolley.

The practice must prominently display signs to indicate where emergency equipment is kept ensuring it can be swiftly located in a patient emergency.

Safeguarding of children and adults
The practice had a named safeguarding lead for adults and children. Staff had access to practice safeguarding policies and procedures, which were ratified, up to date and included contact details of designated leads. However, not all staff had completed safeguarding training at the required level. The practice submitted documentation following the inspection which certified that all clinical staff had completed their relevant safeguarding training.

The practice had a 'Did Not Attend' policy to manage patients (including children) who did not attend for appointments. The policy included information on the process to follow should children or vulnerable adults not attend their hospital appointments. We were told that such cases are discussed internally at clinical meetings and that safeguarding leads and health professionals would be notified when appropriate.

The electronic patient record system being used by the practice had a field to record children on the child protection register. However, we noted that not all children on the child protection register had an alert to notify the clinician during appointments, that the patient was a child at risk. Furthermore, we saw instances where family members of children on the child protection register had not been flagged as potentially at risk within their own records. It is vital that all relevant family members are also assessed for potential risks to ensure a comprehensive approach to safeguarding the child and their family.

The practice must undertake an audit to ensure that all family members of children on the child protection register are also identified as potentially at risk, and that all those flagged at risk have an alert function implemented to notify the clinician during appointments.

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

Effective

Effective care
Suitable processes were in place to support the safe and effective treatment and care for patients. This included processes to disseminate clinical updates, learning, and new guidance. This was aided through quality improvement initiatives, multidisciplinary meetings, and cluster working arrangements. Processes for reporting incidents through Datix were clear and understood by the practice staff.

Referrals were being managed appropriately, including both standard and urgent referrals. We were told that the practice currently did not undertake analysis of referral rates to identify whether referrals were higher or lower than other practitioners in the local area. The practice may wish to consider working with

other practices in their cluster to compare referral rates and discuss potential reasons for any differences found.
Most staff who completed our questionnaire agreed that care of patients is the practice's top priority and that overall, they were content with the efforts of the practice to keep staff and patients safe.

Patient records
The electronic patient record system was suitably password protected to help prevent unauthorised access. We reviewed ten patient records during the inspection and found evidence that the records were being maintained to a very good standard. Consultation narratives were well documented with evidence of shared decision making and appropriate investigations and referrals where required. The patient records 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 saw that 90 per cent of medication reviews had taken place. However, we felt that some medication reviews lacked detail in their narrative. We also noted that a large proportion of repeat prescriptions did not state what clinical condition it was treating.

The practice must ensure that more information is documented within medication reviews, and that coding and linkage of repeat prescriptions to clinical conditions is improved.

Medical secretaries at the practice were responsible for summarising patient information and undertaking appropriate clinical coding. We were told that the medical secretaries were very experienced and undertaking clinical coding of approximately 600 sets of patient records a year. However, we saw no evidence that audits of the clinical coding and summaries were being undertaken to check the quality of the data entry. One staff member also provided the following feedback in their questionnaire:

> *"The quality and accuracy of clinical coding is not consistent and in some cases, coding is not used at all."*

The practice must ensure that regular audits of clinical coding are completed to monitor their accuracy.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the care at the practice. In total, we received nine responses, and the feedback we received was mixed.

Most staff said that they were satisfied with the quality of care and support they give to patients, and they were able to meet all the conflicting demands on their time at work. Overall, staff also said they would be happy with the standard of care provided by the practice for themselves or friends and family. However, several staff members said they would not recommend the practice as a good place to work, and felt there were not enough staff to allow them to do their job properly.

Staff comments included:

> *"Communication could be improved within the team."*

> *"Lovely practice to work at; great team."*

Leadership

Governance and leadership
There appeared to be a clear management and leadership structure in place, and staff we spoke with were clear about their roles and responsibilities. The GP partners were long serving staff who provided stability at the practice. We saw evidence of regular team and practice meetings, including use of various platforms for general and urgent communication between staff.

A wide range of policies and procedures were in place to support the effective running of the practice.

Most staff who completed a questionnaire generally felt their job was not detrimental to their health, and their current working pattern allowed for good work-life balance. However, some staff felt the practice did not take positive action on health and wellbeing and they were not aware of any occupational health or wellbeing support available to them. Most also felt they were not involved in deciding on changes introduced that affect their work, nor were they able to make suggestions to improve GP services.

We received the following comments within the questionnaires in relation to senior management:

> *"I believe the leadership is poor. Partners don't tend to go out of their way to speak to staff. There doesn't appear to be a strategic direction. Communications are poor."*

> *"There is no mention of the Quality Outcomes Framework or the Quality Assurance and Improvement Framework within the surgery. If the team are not aware of what this is or how we are performing against the measures, then we cannot work as a team to drive improvements."*

The practice must reflect on the staff feedback highlighted in our report and engage with all staff to fully understand their concerns about working at the practice. Subsequently, it must provide assurance to HIW on the actions it will take to strengthen its governance and leadership arrangements to create a culture in which staff feel involved and more likely to recommend the practice as a good place to work.

Workforce

Skilled and enabled workforce

There were appropriate recruitment policies and procedures in place, and the practice manager described the required pre-employment checks for any new members. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks appropriate to their role. The practice also required all staff to certify annually that their DBS status had not changed.

During the inspection we asked to review the training records of clinical and administrative staff working at the practice. We were informed that a training matrix had recently been created, and that management staff were in the process of requesting evidence of completed mandatory training from each member of staff. However, when we reviewed the training matrix, we found that it was incomplete in several areas. This meant we could not determine that staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery. Our concerns in relation to this were dealt with under our immediate assurance process. Details of the remedial actions taken by the service are provided in Appendix B.

Most staff who completed a questionnaire felt they had received appropriate training to undertake their role, and when asked what other training they would find useful, one staff member commented:

"A better induction - some training on EMIS would have been useful."

We were told that all staff receive an annual appraisal. However, only six of the nine staff who completed a questionnaire said they had received an appraisal, annual review or development review within the last 12 months.

The practice must ensure that all members of staff receive an annual appraisal to discuss their performance, set annual objectives and identify any training needs.

Culture

People engagement, feedback and learning
The practice had a patient complaints procedure and policy which was aligned to the NHS Wales Putting Things Right process. The managerial assistant 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. However, we did not see copies of the practice complaints procedure or the Putting Things Right process on display to inform patients.

The practice must ensure that the complaints policy and the NHS Wales Putting Things Right process are displayed clearly for patients.

We spoke to senior staff about the arrangements in place regarding compliance with the Duty of Candour. A Duty of Candour policy was available for staff, however, the records we reviewed showed not all staff members had completed training on this topic. Furthermore, five of the nine staff who completed a questionnaire felt they did not understand the Duty of Candour or their role in meeting the Duty of Candour standards.

The practice must ensure all staff receive training for the Duty of Candour.

We were told that questionnaires are regularly issued to patients to request feedback on their experiences of using the service. It was the responsibility of the practice manger to consider patient feedback and share and implement any learning identified.

Information

Information governance and digital technology
We considered the arrangements in place for patient confidentiality and compliance with Information Governance and the General Data Protection

Regulations (GDPR) 2018. We saw evidence of patient information being stored securely.

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.

Learning, improvement and research

Quality improvement activities
There was evidence of clinical and internal audit in place to monitor quality. This included audits, such as direct oral anticoagulants (DOACs), near-patient testing and lithium monitoring. The outcomes of such audits would be discussed internally with other clinical team members as appropriate and shared across the practice to make improvements.

The practice had recently introduced the Klinik online triage and patient flow management tool, and the staff we spoke with felt this had been a beneficial and positive experience.

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 and referring patients appropriately. The practice also interacts and engages with system partners at various multidisciplinary meetings.

Cluster arrangements were noted to work well, with regular practice manager meetings and a collaborative approach towards piloting different initiatives to help drive improvement in patient care.

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 found that emergency drugs were being stored within a locked cupboard in the treatment room.	It is best practice for emergency drugs to be readily available in an emergency. Having emergency drugs locked away could impact on patients receiving treatment in a timely way.	We discussed this with senior management immediately during the inspection.	Arrangements were made for the emergency drugs to be taken out of the locked cupboard and subsequently stored with the resuscitation equipment.

Appendix B – Immediate improvement plan

Service: Vauxhall Surgery

Date of inspection: 12 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.	HIW was not assured that the management and oversight of mandatory training compliance was sufficiently robust to ensure all staff remained competent to perform their roles safely and appropriately. This is because we found the training matrix to be incomplete in several areas. For example, the matrix indicated that 4 GPs, 2 HCAs and 10 administrative staff had not completed fire safety training, 1	• All staff must complete and provide evidence of completed mandatory training • The training matrix must be kept up to date to monitor mandatory training and identify when staff must update their training.	Workforce	Immediate action has been taken to ensure mandatory training is completed by all practice staff. Staff Development Policy and Induction Policy have been updated to include list of mandatory training required by the practice. Practice looking into paying for the additional Practice Index Learning Package as a management tool to improve training uptake through timely reminders and improve record keeping	G Ferris / J Kent	One month (most staff who are currently working have completed their mandatory training – the staff with outstanding training are mainly those on sick leave or annual leave who will complete their

	administrative staff member had not completed CPR training and 3 administration staff had expired CPR training and 3 Nurses and 2 HCAs had not completed adult safeguarding training. This meant we could not determine that staff had completed the required training to maintain the safety of patients, staff and visitors to the surgery.			through automatic updates to training matrix kept electronically on the system.		mandatory training on their return.

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): **Joanne Kent**

Job role: **Practice Manager**

Date: **19 December 2024**

Appendix C - Improvement plan

Service: Vauxhall Surgery

Date of inspection: 12 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.	Treatment room 14 did not have a privacy curtain.	The practice must ensure that privacy curtains are installed in treatment room 14 to help protect the privacy and dignity of patients receiving treatment.	Dignified and respectful care	The practice is sourcing and arranging for the fitting of a privacy curtain for treatment room 14	J Kent	1 Month
2.	During our review of patient records we found one instance where the verbal consent and offer of a chaperone had not been recorded.	The practice must ensure that verbal consent for intimate examinations and offer of a chaperone is always recorded into patient medical records in accordance with General Medical Council (GMC) guidelines.	Dignified and respectful care	The practice has disseminated this information at a Clinical Meeting and all clinical staff are aware to record this accurately.	Dr G Naik	Already Implemented

3.	The language and communication needs of patients were not routinely recorded within the patient records we reviewed. We felt the practice could do more to ensure Welsh speakers receive services in the language of their care need.	The practice must ensure that language and communication needs are routinely recorded within patient records and do more to implement the characteristics of a service that provides an 'Active Offer' as set out in 'More than just words'.	Communication and language	The Administration Team have been asked to record this information on patient records. A sign is now displayed at the Reception Desk inviting patients to request to speak in Welsh is this is their preference.	J Kent	Already Implemented
4.	Some clinical room sinks did not have full elbow operated levers fitted and the sink in room nine had an overflow drain where bacteria could colonise.	The practice must consider updating the sinks and taps throughout the practice that do not conform to current guidance to fully uphold best practice standards of IPC. Where this is not possible, conduct a risk assessment and manage the risk as appropriate.	Infection, prevention and control (IPC) and decontamination	The Practice is seeking advice and a quotation from a plumbing contractor in respect of implementation of this improvement.	J Kent/G Ferris	3-4 Months
5.	The most recent IPC audit we reviewed did not recognise that some sinks did not comply with current	The practice must update the IPC audit to ensure it is aligned with current and recognised IPC standards so it can more effectively	Infection, prevention and control (IPC) and decontamination	IPC Audit Template will be updated to include a specific section in respect of sinks in clinical areas	J Kent/G Ferris	1 Month

	guidance on sink design in clinical areas.	identify areas of non-compliance.				
6.	Although the practice appeared clean, there was no evidence that weekly cleaning schedules were being maintained.	The practice must ensure weekly cleaning schedules are implemented and maintained.	Infection, prevention and control (IPC) and decontamination	Weekly cleaning schedules have now been implemented in all clinical areas and toilets. Examples have been provided to Healthcare Inspectorate Wales	J Kent	Already Implemented
7.	Although protocols were on display throughout the practice, some staff were unsure of what to do in the event of a needlestick injury.	The practice must provide refresher training to staff on what to do in the event of a needlestick injury.	Infection, prevention and control (IPC) and decontamination	Information has been disseminated at a Clinical Meeting and all relevant staff are now familiar with the Needlestick Policy	G Naik/J Kent/G Ferris	Already Implemented
8.	We noted that the clinical fridge in room nine was potentially overstocked which could prevent effective circulation of cold air.	The practice must ensure that clinical fridges are not overstocked to allow for effective cool air movement.	Medicines management	The Practice is now utilising the third clinical fridge to ensure that none of the three fridges are overstocked, thereby ensuring effective cool air movement in all fridges.	S Evans/J Kent	Already Implemented

9.	There were no posters on display throughout the practice to inform staff where the emergency equipment and defibrillator was stored.	The practice must prominently display signs to indicate where emergency equipment is kept ensuring it can be swiftly located in a patient emergency.	Medicines management	A sign was displayed in the staff area of the surgery indicating to staff where the emergency equipment is kept. A Defibrillator Sign has now been added to the Treatment Room Door	J Kent	Already Implemented
10.	Not all children on the child protection register had an alert within the electronic patient record system to notify the clinician during appointments that the patient was a child at risk. We also saw instances where family members of children on the child protection register had not been flagged as potentially at risk within their own records.	The practice must undertake an audit to ensure that all family members of children on the child protection register are also identified as potentially at risk, and that all those flagged at risk have an alert function implemented to notify the clinician during appointments.	Safeguarding of children and adults	All children on the child protection register now have an alert within the electronic patient record system. An audit has been undertaken and all family members of children on the child protection register are now identified as potentially at risk. All those flagged at risk have an alert function implemented to notify the clinician during appointments.	L Richardson	Already Implemented

11.	We felt that some medication reviews lacked detail in their narrative within the patient records we reviewed. We also noted that a large proportion of repeat prescriptions did not state what clinical condition it was treating.	The practice must ensure that more information is documented within medication reviews and that coding and linkage of repeat prescriptions to clinical conditions is improved.	Patient records	Information has been disseminated at a Clinical Meeting and all relevant staff are now aware of the need to document more information within medication reviews and that coding and linkage of repeat prescriptions to clinical conditions should be improved.	G Naik	Already Implemented
12.	We saw no evidence that audits of the clinical coding and summaries were being undertaken to check the quality of the data entry.	The practice must ensure that regular audits of clinical coding are completed to monitor their accuracy.	Patient records	The Practice has put a process in place to ensure regular audits of clinical coding and the coding of summarised patient records takes place.	J Kent	Already Implemented
13.	Some staff members identified areas for improvement in their HIW staff questionnaires.	The practice must reflect on the staff feedback highlighted in our report and engage with all staff to fully understand their concerns about working at the practice. Subsequently, it must provide assurance	Governance and leadership	The Practice will arrange an all-practice staff meeting to discuss the issues raised in the HIW staff questionnaires. The Partners and Management Team	Partners and Management Team	2 Months

		to HIW on the actions it will take to strengthen its governance and leadership arrangements to create a culture in which staff feel involved and more likely to recommend the practice as a good place to work.		have an open-door policy and feel that they are approachable, however this will be reiterated at the meeting.		
14.	Six of the nine staff members that completed a questionnaire said that they had received an appraisal, annual review or development review of their work within the last 12 months.	The practice must ensure that all members of staff receive an annual appraisal to discuss their performance, set annual objectives and identify any training needs.	Skilled and enabled workforce	The remaining appraisals will be completed.	Partners and Management Team	3 Months
15.	We did not see copies of the practice complaints procedure or the Putting Things Right process on display to inform patients.	The practice must ensure that the complaints policy and the NHS Wales Putting Things Right process are displayed clearly for patients.	People engagement, feedback and learning	The Practice Complaints Policy and NHS Wales Putting Things Right process will be displayed.	J Kent/G Ferris	Already Implemented
16.	Furthermore, five of the nine staff members who	The practice must ensure all staff receive training for the Duty of Candour.	People engagement, feedback and learning	All staff will be asked to complete the e-learning training	J Kent/G Ferris	3 Months

	completed a questionnaire indicated that they did not understand the Duty of Candour or their role in meeting the Duty of Candour standards.			module Training in Duty of Candour. The Duty of Candour Policy is available on the shared drive for all staff to see.		

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): **Joanne Kent**

Job role: **Practice Manager**

Date: **24/02/2025**