Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Darcy Healthcare, Llandarcy Academy of Sport, Neath

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Darcy Healthcare, Llandarcy Academy of Sport, Neath on 5 December 2024.

Our team for the inspection comprised of a HIW healthcare inspector and two 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. No questionnaires were completed by patients or their carers and none were completed by staff.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that the registered manager and staff at the clinic worked to provide a positive experience for patients. The clinic ensured easy access to patients with mobility issues which included bathroom facilities suitable for patients with mobility access requirements. In addition, staff at the clinic had undertaken training in equality and diversity.

The setting had suitable processes in place for patients to provide feedback about their experiences of using the service before and after treatment. However, we identified that more could be done to inform patients of the actions taken by the service as a result of their feedback.

There could be more information on display to help patients look after their own general health. Most of the information on display was in English.

This is what we recommend the service can improve:

- Display a sample of patient feedback such as a 'you said, we did' board
- Provide more health promotion information on how patients can maintain their general health
- Ensure all patient information is readily available and routinely provided in both Welsh and English.

This is what the service did well:

- There were good arrangements in place to support the dignified and respectful care of patients throughout their treatment journey
- Staff said they had sufficient time to provide effective and safe care to patients
- There was a complaints policy containing all the relevant information.

Delivery of Safe and Effective Care

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

The clinic environment was well maintained and free from obvious hazards. Infection prevention and control (IPC) processes were in place at the setting.

However, there were some areas that could be improved such as the use of tristel trio wipes and documentation on sharps boxes.

The clinic had the right equipment and medical devices to meet the needs of patients. The equipment was maintained in a timely manner. Medication was seen to be stored correctly and stock was appropriate for the procedures undertaken by the service.

We saw that medical records were well maintained and were easy to navigate. However, we found that the recording of chaperones and allergies was not recorded on every instance.

This is what we recommend the service can improve:

- Ensure the practice has access to the relevant, risk assessments and environmental hazards completed by the academy
- IPC arrangements at the clinic
- Recording of chaperones on medical records.

This is what the service did well:

- A welcoming and clean environment for patients
- Medicines management was thorough and appropriately stored
- Medical records were well maintained, secure and easy to navigate.

Quality of Management and Leadership

Overall summary:
We found that the clinic governance and leadership was clear and structured. The registered manager was patient focused and had appropriate skills and knowledge to deliver safe treatments to patients.

Staffing levels were appropriate to support patient safety. Staff appraisals had taken place and there was a plan to ensure these were carried out appropriately. We viewed staff training records and found that staff had completed mandatory training.

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

This is what the service did well:

- Robust governance arrangements in place
- We saw training records that showed staff had received a variety of training
- Up to date policies and procedures.

3. What we found

Quality of Patient Experience

Health protection and improvement
There was health promotion material displayed within the clinic relating to warming up and cooling down during exercise and smoking cessation. However, there was a need for additional signage relating to how patients can look after their own general health including losing weight and maintaining a healthy lifestyle. Additionally, the certificates relating to the registration of the clinic with HIW were not displayed as required. We were told that this was because of a recent refurbishment to the clinic.

The clinic must ensure that:

- **Additional health promotion information is displayed at the clinic including healthy lifestyle and managing weight**

- **The registration certificates issued by HIW are displayed prominently at the clinic.**

Dignity and respect
There were no patients at the clinic during our inspection. We noted good arrangements in place to support the dignified and respectful care of patients throughout their treatment journey. The waiting room and treatment rooms provided patients with an appropriate level of privacy. There were lockable doors and blinds to the treatment room windows. We found the rooms were tidy and uncluttered.

Communicating effectively
There was information on the website relating to the various types of scans. The clinic provided the patient with all the information they needed prior to their visit, including any special instructions required to prepare for the particular scan.

Patients would have the benefits and risks of the scan explained prior to the procedure. The patient would have a scan first and then a guided injection. Following the injection, the patient would be kept at the clinic for 15 mins in case of a reaction. They also had to keep a pain diary so that they could record how they responded to the injection. Patients would not generally be given a copy of their report immediately following the scan, this would be emailed back to the referrer or the patients GP in case of self-referrers.

Patients could request a copy of their report and access their scan images through a time limited web link if they requested this.

There were no Welsh speaking staff at the clinic and there was little in the way of Welsh signage.

The clinic should ensure all patient information is readily available and routinely provided in both Welsh and English. Patients should be actively offered the opportunity to speak in their preferred language wherever possible.

Care planning and provision
Patient specific requirements and needs would be picked up during the telephone booking process or via the initial referral letter. However, there were no additional aids or provisions in place for any specific disabilities, other than accessible toilets.

Staff that we spoke with said that they had sufficient time to provide effective and safe care to patients and that the number of staff was appropriate to meet the needs of the patients. They also knew where the relevant clinical policies and procedures were kept and had access to these on the clinic shared drive.

We were told that appointments were booked based on the availability of staff and patient requirements. The time slot for the patients was booked depending on the time required for the procedure, the radiologist would decide the duration of the appointment. Patients waiting in the waiting room would be informed if there was a delay in receiving the treatment, but this had not been an issue to date.

The HCA checked the patient identification then they took the patient to the radiologist who carried out the six point identification check and obtained their verbal or written consent depending on the procedure to perform the examination. The radiologist would provide limited feedback to the patient following the scan. The full report on the procedure would be emailed to the referrer.

Equality, diversity and human rights
The service had policies in place to help promote the equality and diversity of patients. The clinic benefitted from level access with wheelchair accessible doorways. Treatment rooms were large and situated on the ground floor with wide doorways. The clinic had use of an accessible toilet situated on the ground floor near to the entrance. However, the accessible toilet in the academy male changing rooms was out of order at the time of the inspection.

Senior staff we spoke with said that the staff were a diverse group. We were told equality and diversity was ingrained into staff and the understanding of what was required in how people wanted to be treated. Senior staff also said that whilst they had not provided treatment for transgender patients at the time of the inspection, any treatment provided would ensure their rights and personal preferences were respected.

Citizen engagement and feedback

The practice maintained a record of emails received from patients with their views of the service, both positive and less positive on a word document. Information was not displayed at the clinic about how patients could make a complaint, but there was a quick response (QR) code for patient feedback, however no results from this feedback were available.

The clinic must ensure that the a 'you said, we did' is displayed at the clinic to give the patients the results of any feedback and the action taken by the clinic.

The clinic had a complaints policy containing all the relevant information, included the person responsible for addressing the complaints and details of organisation for assistance in raising concerns. We were told that there had not been any formal complaints about the clinic, although there had been informal comments, which were also listed on the feedback document relating to parking and signage which we were told had since been addressed.

Delivery of Safe and Effective Care

Environment
The clinic was accessible and easy to find with facilities for people with mobility difficulties. It was well maintained, clean, spacious and in a good state of repair, including furniture, fixtures and fittings. The clinic was fit for purpose and suitable for the way it was used. We found the clinic was safe and secure, free from clutter and tripping hazards.

Managing risk and health and safety
The records of the environmental hazards, facilities risk assessments, risk management and general facilities were managed by academy management, who leased the treatment rooms to the clinic. At the time of the inspection, the clinic had no sight of, or direct access to, these records, although we were told they could request these. Similarly, the clinic had not accessed the academy policies and processes such as fire checks. However, this information was available if specifically requested by the clinic. The entries on the risk register for the clinic included high level risks such as demand outstripping capacity and failure of the ultrasound equipment or the radiology information system (RIS) or the picture archiving and communication system (PACS).

The clinic must ensure they have access to the relevant, risk assessments, environmental hazards, policies and procedures, including records of fire checks, held by the academy.

There was a resuscitation bag and oxygen cylinder available at the clinic as well as an automated external defibrillator (AED) at the academy reception. In the event of an emergency, a call would be made by the academy reception for other academy operations managers to come and assist in event of a medical emergency and reception staff would make a 999 call, if the radiologist requested this. The resuscitation equipment had been checked on a monthly basis and evidence of this was documented. These checks should be carried out weekly in accordance with the Resuscitation Council UK guidance.

The clinic must ensure that the resuscitation equipment, including the drugs, are checked on a weekly basis.

Infection prevention and control (IPC) and decontamination
We noted that personal protective equipment (PPE) was used and available. We were told this would be changed appropriately between patients. Hand washing stations were available in all consultation rooms. There was an in date relevant IPC policy in place.

All the rooms in the clinic were clean, tidy, with appropriate flooring. The clinic did not have direct access to cleaning schedule records for the cleaning of the facilities. Cleaning was arranged by the academy, but there were no records at the clinic or the academy of the cleaning carried out, though all areas were visibly clean. We saw the monthly audit carried out by the cleaning company and sent to the academy. A copy should be sent on receipt to the clinic by the academy.

Equipment and probe cleaning was carried out by clinic staff, but unless it was an invasive procedure, a record was not kept of the probe and equipment cleaning. For transvaginal scans we were told that tristel trio was used to decontaminate the probe and some evidence was seen of this on a relevant patient record providing a part audit trail. The tristel trio wipes system was a three-part decontamination system for medical devices. It comprised three wipes which, in sequence, perform the steps of the decontamination procedure. However, there were no tristel trio cleaning materials found on site, but we were told there were. This could possibly result in a scan being booked and not being able to properly decontaminate the probe.

The clinic scanned the tristel trio labels into a pdf and attached this to the patients RIS record. However, this did not specifically record the date and time of the procedure, the patient name and details, operators name, transducer serial number used, who performed the cleaning and decontamination. Sterile probe covers and sterile gel were used for cleaning after the steroid injections and scans. The sterile gel bottles had the manufacturers expiry date on them and were not refillable. However, they were not following the latest guidelines that indicated a label with the date of first use or opening, written on the individual bottle and then disposed of if still in use after one month.

There were two sharps bins open and in use in the scanning room, one was at least two thirds full, but none of the details on either sharps bin had been filled out, such as date of first use or who opened the sharps bin.

We were told that staff do not currently check the infectious status of any patients. However, there was a room available should a patient need to be isolated.

When speaking to the registered manager and health care assistant, neither were aware of who had responsibility for the disposal of the clinical waste and sharp bins.

The clinic must carry out the following to ensure effective IPC at the clinic:

- **A monthly copy of the audit of the cleaning carried out is provide to the clinic**

- **A record of equipment cleaning is kept of the probe and general equipment cleaning at the clinic**

- **There is stock of tristel trio available at all times**

- **The recording of the use of tristel trio is accurately recorded including, the date and time of the procedure, the patient name and details, operators name, transducer serial number used, who performed the cleaning and decontamination**

- **Gel bottles used for the sterile probe covers and for steroid injections and scans follow the latest guidelines**

- **The information on the sharps bins is completed when the sharps bin is taken into use**

- **Patients are checked for infectious diseases, ideally when the booking is made, but also on arrival at the clinic**

- **Staff are made aware of who is responsible for the disposal of clinical waste and sharps bins.**

We saw evidence that safer sharp devices were used and that staff were trained in maintaining a sterile field through aseptic non-touch techniques. Staff had completed IPC training as required. We were told that staff had access to occupation health through the academy.

Records of the staff immunisation status against hepatitis B were appropriate.

Medicines management
There were arrangements in place to order, obtain, store, control, supply, prescribe, administer and dispose of medicines. Medicines held at the clinic were all kept in a locked cupboard. Medicines were stored in a locked cupboard in one of the treatment rooms. The ambient temperature of the room was not recorded to ensure that medicines were fit for purpose at the point of administration to patients.

The clinic must ensure that the ambient temperatures of rooms where medication is kept, are checked and recorded on a daily basis.

There was an in-date medicines management policy in place that included information on how to manage adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme.

Safeguarding children and safeguarding vulnerable adults
There was an up-to-date safeguarding policy in place for children and adults, which included information on local services with relevant contact details. The medical director was the designated safeguarding lead and staff said they would escalate any safeguarding concerns to coordinate any action required.

Senior staff we spoke with said that they had a copy of the Wales Safeguarding Procedures application on their phones.

Medical devices, equipment and diagnostic systems
The service had the right equipment and medical devices to meet the needs of patients, this included an ultrasound machine, ergonomic scanning stool and an electrically operated couch. All the equipment had been tested for electrical safety in July 2024.

This equipment was appropriate for its intended use and the environment in which it was used. There were sinks with elbow taps and personal protective equipment (PPE) in the rooms. The flooring was appropriate and facilitated the ease of cleaning, to prevent a dust build up. The doors to the treatment rooms were lockable from the inside during patient examinations. The academy was responsible for the maintenance arrangements of the equipment on an annual service and breakdown cover. No routine quality assurance (QA) was undertaken between service visits by on-site staff, not even a visual inspection of probes and cables recorded. There were QA tests readily available via the British Medical Ultrasound Service (BMUS) website.

There was evidence that the equipment had been recently serviced and calibrated in accordance with manufacturer's guidelines. The equipment was operated within manufacturers guidelines and training had been given by the manufacturers application specialist on the use of the equipment. There had been a routine preventative maintenance engineers report seen, but there had not been a handover form between the clinic and the engineer.

Whilst there had not been any faults or breakdowns since the purchase of the equipment, there was not a fault log yet in place to record these should they occur.

The clinic must ensure that the following actions are carried out:

- **Regular QA tests of the equipment and documenting these tests**

- **A documented handover of equipment between the clinic and an engineer during maintenance or repair**

- **Draft a fault log to include the fault and actions carried out to rectify as well as names and dates.**

Safe and clinically effective care
Staff were aware of the clinical guidelines associated with their area of practice, as they were all NHS accredited consultants. The radiologist were also all co-directors of the clinic.

An audit of the image quality following a patients treatment was completed for 2024. The clinic intended to complete these every six months from 2025 onwards. There had also been an audit of the placement of steroid injection procedures. Whilst there had not been any radiology reporting audits in place, the clinic relied on the results of the radiologists NHS reporting audits through their annual appraisal summary.

We noted 'paused and checked' notices in the ultrasound room, a checklist for operators about to treat patients, to ensure the right patient, right anatomy and right treatment. Staff we spoke staff said that a six-point check was carried out before the treatment that included patient identification, name, date of birth and address, as well as body part, laterality and clinical indications or symptoms. This was to ensure that it agreed with the referral for treatment.

There was a facility in place to transfer images via a secure system to NHS facilities for any ongoing treatment or management of the patient. Also, the images could be sent to another email address if there was a need to review previous scans or images before finalising an ultrasound report.

The only scanned information that would be sent to a patient was the steroid injections leaflet which described the process as well as the benefits and risks associated with the injection. There was not a formal process in place for assessing or providing referral rights for non-medical practitioners and no list of known referrers in place.

Participating in quality improvement activities
Senior staff we spoke with said that the clinic would follow best practice from the Royal College of Radiologist (RCR), National Institute for Health and Care Excellence (NICE), the Royal Colleges and the basics of ultrasound. There had been one audit completed on the ultrasound site injection, with the audit aim of

improving the image. We were told that the clinic was considering the introduction of a new prostate cancer assessment.

Information management and communications technology
All clinical records were kept on a cloud based RIS and PACS system. This included the relevant documents such as referral letters and consent forms, which were scanned into the patient online record and then disposed of in a confidential waste bin.

The cloud-based imaging network was a secure platform that facilitated the exchange and sharing of diagnostic imaging data among healthcare providers and systems which radiologist could access form home as well as the facility. The policies and procedures were held on a shared area of a computer system. The clinic must ensure that any personal information is kept in a secure area.

There was a cyber essential plus certificate, for the cloud based RIS and PACS, system. This was an industry-supported certification scheme to help organisations demonstrate operational security against common cyber-attacks.

Records management
We reviewed a sample of five patient records and found these to be concise and contained all the appropriate information we would expect. However, the offer of a chaperone was not recorded in the records checked. For injections, the radiologist would verbally ask patients if they had any allergies but this would not be recorded on the report. All patient records were maintained electronically and we found appropriate arrangements in place to ensure the security of these records. The patient records we examined were clear and well organised and showed that valid consent was obtained. A template on the report writing would help to ensure that chaperones, consent and allergies were recorded.

The clinic must ensure that, the offer of a chaperone, whether consent is given and any allergies are recorded in every instance.

For invasive or transvaginal scans, written consent was usually obtained in accordance with the policy and recorded in patients record. For all other scans, verbal consent was obtained and this would be recorded in the patient report.

There was clear accountability and evidence of how decisions relating to patient care were made, which were of a good quality in terms of accuracy, being up to date, complete, understandable and contemporaneous. Patients had access, on request, to their patient records.

The report followed RCR guidelines on layout and clarity. The management of the patients conditions found at the scan were the responsibility of the referrer. In the case of a self-referral, the report would be sent to the patients general practitioner (GP) for any further action or management. There was no process in place for ensuring that the referrer or GP instigated an appropriate management plan of the patient as the result of any scan findings. Where there were significant unexpected findings found that required immediate or urgent attention and management, the referrer would be called and the report discussed with them or the patients GP in the case of self-referrals.

The records were of good quality in terms of accuracy, being up to date, complete, understandable and contemporaneous.

Quality of Management and Leadership

Governance and accountability framework
There was a clear management structure in place, with clear lines of reporting and accountability shown. Both the registered manager and responsible individual were based at the clinic and were available to support staff and to monitor the quality of the services provided.

The statement of purpose and patient guide were reviewed and contained all the information required by regulation six and seven of the Independent Health Care (Wales) Regulations 2011. Paper copies would be printed off on request for patients to take as required. We were told that patients could receive copies of these via email prior to their procedure.

Governance arrangements were in place including an organisation chart, clinical governance meetings with both the magnetic resonance imaging (MRI) (registered separately) and ultrasound personnel. There were monthly team meetings and some audits had also been undertaken. Safety notices from the MHRA and Welsh Government were managed by a member of staff and would be passed onto staff on receipt, by email or verbally.

Workforce
Senior staff we spoke with felt that the number and skill mix of staff at the service was appropriate for the patients' needs and acuity. Staff believed that they had enough time to give patients the care they needed.

The mandatory training that we checked for staff was in order, including basic life support, safeguarding, IPC and oxygen cylinder training. However, there was not a record in one place to show which staff had completed each individual element of the training. The clinic would benefit from a training matrix to show who had completed what training and when, also when that training was due to be renewed.

We reviewed a sample of staff files and found that pre-employment checks were performed and staff had a contract and job description. We saw that appraisals had been arranged to take place in the month following the inspection to ensure that they were completed annually. A disclosure and barring services (DBS) check on all members of staff was completed. We were told that the clinic was looking at signing up to an annual certification of DBS, as part of the DBS referral service.

Staff we spoke with said they were very happy working in the clinic with the team and that everyone was very good, professional, helpful and friendly.

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
No immediate concerns were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Darcy Healthcare

Date of inspection: 5 December 2024

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There were no immediate non-compliance issues					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Darcy Healthcare

Date of inspection: 5 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.	There was a need for additional signage relating to how patients can look after their own general health including losing weight and maintaining a healthy lifestyle.	The clinic must ensure that: • Additional health promotion information is displayed at the clinic including healthy lifestyle and managing weight	National Minimum Standards - Health protection and improvement	We will display a poster about the importance of weight management, eating healthily and exercising. The poster will provide links to weight management programmes in the local area, including the Swansea Bay University Health Board's healthy weight – support and advice page. The HIW certificate for the Darcy Healthcare MRI facility is displayed in the welfare unit in MRI on a wall unit. A similar wall unit has been	Martin Hart (design team)	To be implemented by 03.03.2025

	Additionally, the certificates relating to the registration of the clinic with HIW were not displayed as required.	• The registration certificates issued by HIW are displayed prominently at the clinic.	Care Standards Act 2000 Regulation 28	purchased and the HIW registration certificates for the ultrasound facility will be displayed in the ultrasound clinic waiting area.	Martin Hart	To be implemented by 17.02.2025
2.	There were no Welsh speaking staff at the clinic and there was little in the way of Welsh signage.	The clinic should ensure all patient information is readily available and routinely provided in both Welsh and English. Patients should be actively offered the opportunity to speak in their preferred language wherever possible.	National Minimum Standards - Communicating effectively Independent Health Care Regulations (Wales) 2011 Regulation 9 (1) (g)	During the booking process our admin staff will ask about patient's preference to speak in Welsh. This will be documented on SharePoint within the patient record. If the patient expresses a preference to converse in Welsh, a Welsh speaker from the team will contact the patient to complete the booking process. We have two team members who can speak Welsh and one member who can greet patients and speak short phrases in Welsh.	Wyn Evans	Booking staff will be checking and recording preferences from 10.02.2025.

				Llandarcy Park is part of the Neath Port Talbot College Group. The College is fully bilingual and can provide translation support to Darcy Healthcare. If the patient advises that they prefer to receive communication and information in Welsh, at present we can use the College translation service. We are also exploring other options such as Helo Blod, The Welsh Government, Business Wales translation and advice service. We are also introducing telephone greeting in Welsh for Darcy Healthcare. This provision already exists in the Llandarcy Academy and will be extended to the Darcy Healthcare telephone lines.		
3.	Information was not displayed at the clinic	The clinic must ensure that the a 'you said, we	National Minimum	A poster is currently with the design team which will		To be implemented

	about how patients could make a complaint, but there was a quick response (QR) code for patient feedback, however no results from this feedback were available.	did' is displayed at the clinic to give the patients the results of any feedback and the action taken by the clinic.	Standards – Citizen engagement and feedback Independent Health Care Regulations (Wales) 2011 Regulation 24	describe our complaints process and ways to make a complaint. The poster will also contain information on how to provide feedback and our QR code link to the feedback form. The You said, we did board is with our design team.		by 03.03.2025. We will also display a meet the team board by 01.04.2025.
4.	The records of the environmental hazards, facilities risk assessments, risk management and general facilities were managed by academy management, who leased the treatment rooms to the clinic. At the time of the inspection, the clinic had no sight of, or direct access to, these records, although we were told they could request these. Similarly, the clinic had not accessed the academy policies and	The clinic must ensure they have access to the relevant, risk assessments, environmental hazards, policies and procedures, including records of fire checks, held by the academy.	National Minimum Standards – Managing risk and health and safety Independent Health Care Regulations (Wales) 2011 Regulation 26	All relevant Academy documents, policies and procedures are now placed within a shared folder on Siarad Medical Services SharePoint, providing transparency and easy access to the required documents.	Wyn Evans	This has already been implemented.

	processes such as fire checks. However, this information was available if specifically requested by the clinic.					
5.	The resuscitation equipment had been checked on a monthly basis and evidence of this was documented. These checks should be carried out weekly in accordance with the Resuscitation Council UK guidance.	The clinic must ensure that the resuscitation equipment, including the drugs, are checked on a weekly basis.	National Minimum Standards – Managing risk and health and safety Resuscitation Council UK guidance	This has already been implemented.	Manu John	This has already been implemented.
6.	Cleaning was arranged by the academy, but there were no records at the clinic or the academy of the cleaning carried out, though all areas were visibly clean. We saw the monthly audit carried out	The clinic must carry out the following to ensure effective IPC at the clinic: • A monthly copy of the audit of the	National Minimum Standards - Infection prevention and control (IPC) and decontamination	Llandarcy Park has agreed to provide a copy of the monthly audit of cleaning to Siarad Medical Services. Llandarcy Park will also display cleaning schedules on the walls in the clinical area as well as toilets to be	Wyn Evans	To be implemented by 03.03.2025

	by the cleaning company and sent to the academy. A copy should be sent on receipt to the clinic by the academy.	cleaning carried out is provide to the clinic	Independent Health Care Regulations (Wales) 2011 Regulation 9(n), 15 (3), 15 (7) (b), 15 (8)	dated and initialled by the person completing the cleaning on a daily basis. Cleaning records will be maintained electronically on SharePoint.		
	Equipment and probe cleaning was carried out by clinic staff, but unless it was an invasive procedure, a record was not kept of the probe and equipment cleaning.	• A record of equipment cleaning is kept of the probe and general equipment cleaning at the clinic		A record of equipment cleaning of the probe and general equipment will be kept	Balan Palaniappan	To be implemented by 17.02.2025
	The tristel trio wipes system was a three-part decontamination system for medical devices. It comprised three wipes which, in sequence, perform the steps of the decontamination procedure. However, there were no tristel trio cleaning materials found on site, but we were told there were. This could possibly result in	• There is stock of tristel trio available at all times		A 50-patient supply of Tristel Trio wipes including the logbook to record all relevant information will be purchased. This is to ensure there is a supply of Tristel trio wipes onsite and the appropriate documentation can be completed.	Balan Palaniappan	To be purchased by 17.02.2025

	a scan being booked and not being able to properly decontaminate the probe.					
	The clinic scanned the tristel trio labels into a pdf and attached this to the patients RIS record. However, this did not specifically record the date and time of the procedure, the patient name and details, operators name, transducer serial number used, who performed the cleaning and decontamination.	• The recording of the use of tristel trio is accurately recorded including, the date and time of the procedure, the patient name and details, operators name, transducer serial number used, who performed the cleaning and decontamination		This action will be completed using the Tristel Trio logbook that captures all the necessary details for future records.	Balan Palaniappan	17.02.2025
	The sterile gel bottles had the manufacturers expiry date on them and were not refillable. However, they were not following the latest guidelines that indicated a label with the date of first use or opening, written on the individual bottle and then disposed of	• Gel bottles used for the sterile probe covers and for steroid injections and scans follow the latest guidelines		We have now moved to using disposable single use ultrasound gel sachets to reduce risk of infection. We are no longer using ultrasound gel bottles.	Suresh Dalavaye	This change has been implemented.

	if still in use after one month.					
	There were two sharps bins open and in use in the scanning room, one was at least two thirds full, but none of the details on either sharps bin had been filled out, such as date of first use or who opened the sharps bin.	• The information on the sharps bins is completed when the sharps bin is taken into use		This action has been completed	Suresh Dalavaye	Implemented
	We were told that staff do not currently check the infectious status of any patients. However, there was a room available should a patient need to be isolated.	• Patients are checked for infectious diseases, ideally when the booking is made, but also on arrival at the clinic		Admin staff will make this check when booking the patient's appointment	Jade Kermani	To be implemented by 10.02.2025
	When speaking to the registered manager and health care assistant, neither were aware of who had responsibility for the disposal of the clinical waste and sharp bins.	• Staff are made aware of who is responsible for the disposal of clinical waste and sharps bins.		Clinical waste bags and sharps bins are collected from ultrasound and MRI once a month. If the waste bags are full before the date of collection, the helper staff will move the bags to a	Balan Palaniappan	This action is complete

				lockable clinical waste container in MRI. The sharps boxes will be collected from ultrasound by the waste removal company. All the staff have been made aware of the arrangements.		
7.	The ambient temperature of the room was not recorded to ensure that medicines were fit for purpose at the point of administration to patients.	The clinic must ensure that the ambient temperatures of rooms where medication is kept, are checked and recorded on a daily basis.	National Minimum Standards - Medicines management Independent Health Care Regulations (Wales) 2011 Regulation 15 (5)	Temperature and humidity measurement meters have been purchased. The devices will be placed in the clinical room where the medicines are stored. Llandarcy Academy staff will check the temperature daily and record on a sheet placed on the wall. Cumulative records will be stored electronically on SharePoint.	Wyn Evans	To be implemented by 17.02.2025
8.	No routine quality assurance (QA) was undertaken between service visits by on-site	The clinic must ensure that the following actions are carried out:	National Minimum Standards - Medical devices, equipment and	BMUS QA Working Party has published - BMUS guidelines for the regular quality assurance testing of	Balan Palaniappan	To be implemented by 17.02.2025

	staff, not even a visual inspection of probes and cables recorded. There were QA tests readily available via the British Medical Ultrasound Service (BMUS) website.	• Regular QA tests of the equipment and documenting these tests	diagnostic systems Independent Health Care Regulations (Wales) 2011 Regulation 9 (1) (d), 15	ultrasound scanners by sonographers. The document describes levels of QA for US machines: • Level 1. Infection control and scanner damage • Level 2. Basic scanner and transducer testing We are implementing weekly level 1 and level 2 QA adapted from this publication. Cumulative records will be electronically stored on SharePoint.		
	There had been a routine preventative maintenance engineers report seen, but there had not been a handover form between the clinic and the engineer. Whilst there had not been any faults or breakdowns since the purchase of the equipment, there was not a	• A documented handover of equipment between the clinic and an engineer during maintenance or repair • Draft a fault log to include the fault and actions carried out to		Equipment handover document is now in place. Fault log is now part of the QA spreadsheet		Equipment handover document and fault log sheet are now in place.

	fault log yet in place to record these should they occur.	rectify as well as names and dates.				
9.	The offer of a chaperone was not recorded in the records checked. For injections, the radiologist would verbally ask patients if they had any allergies but this would not be recorded on the report.	The clinic must ensure that: • The offer of a chaperone, whether consent is given • Any allergies are recorded in every instance.	National Minimum Standards - Records management	We now use an US reporting template which includes a record of offering a chaperone and if a chaperone was present during the scan or procedure. All US guided injection procedures will have a WHO checklist, consent and prescription completed (containing information regarding allergies). An electronic copy of the three documents will be stored on RIS within the patients US scan visit entry.	Balan Palaniappan	To be implemented by 17.02.2025

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): **Balan Palaniappan**
Job role: **Registered Manager**
Date: **06.02.2025**