First Practice Management

HIW Inspection Reports of GP Practices Published in November 2026

Poor practice to avoid: what the HIW advised practices

	INSPECTION COMMENTS
Safe	
Risk management	• We noted that, following the recent repainting of the practice, some strip light covers had not been replaced and remained absent at the time of the inspection. **The practice should ensure that all strip light covers removed during recent redecoration are replaced securely in their correct position.** • We saw fire, health and safety, and legionella risk assessments which had not been reviewed or updated recently by the health board. Staff also told us that they were awaiting fire warden training to be provided by the health board. These arrangements did not provide sufficient assurance that relevant risks were being reviewed and managed in a timely manner. **The practice should liaise with the health board to ensure that fire, health and safety, and legionella risk assessments are reviewed and updated at appropriate intervals, and that relevant staff complete fire warden training as soon as practicable.** • A named member of staff was responsible for receiving and accessing patient safety alerts. However, there was no additional named member of staff identified to undertake this responsibility in the event of prolonged absence. **The practice should identify an additional named member of staff who is able to access and manage patient safety alerts if the designated member of staff is unavailable for an extended period.**

First Practice Management

	• A business continuity plan was in place and suitably accessible to practice management. However, this required updating to include accurate practice specific information, fully assign roles and responsibilities for implementing actions and display comprehensive version control. **The practice should review their Business Continuity Plan to ensure this is up-to date, sufficiently detailed and fully personalised to the practice and displays clear version control.**

Infection prevention and control (IPC) and decontamination	• Not all sinks within clinical areas were fitted with elbow-operated taps. **The practice should review and update handwashing facilities within a reasonable timeframe and ensure they meet current infection prevention and control standards.**
	• We saw a healthcare waste audit dated July 2026 which identified several recommendations for improvement. **The practice should address the recommendations identified within the July 2026 healthcare waste audit at the earliest opportunity.**
	• An up-to-date needlestick and sharps policy was also available. However, we found that the policy would benefit from additional practical information to support staff in the event of an incident, including clear reporting arrangements and details of where staff should attend for further assessment and support**. The practice should strengthen the needlestick and sharps policy by including a 19 clear flowchart, relevant contact details, reporting arrangements and information on where staff should attend for further assistance, such as occupational health or the emergency department.**
	• We did not see evidence that regular IPC audits were being undertaken by the practice. Without routine auditing, the practice could not fully demonstrate that IPC standards were being consistently monitored and maintained. **The practice should undertake regular infection prevention and control audit, including as a minimum a comprehensive annual IPC audit, and take appropriate action in response to any findings.**
	• Staff told us there were outstanding estates issues within the practice. We observed that all but one of the clinical rooms had carpeted flooring. We found that fabric curtains were in use within clinical rooms. **The practice must ensure that:**
	  ○ **regular cleaning of fabric curtains occurs in accordance with current IPC guidelines or consider transitioning to disposable alternatives to support effective infection control**
	  ○ **Clear documentation is maintained to evidence the frequency and dates of curtain changes or laundering.**
	• Cleaning services for the practice were provided by the health board. Clinical rooms were generally tidy and free from unnecessary clutter. However, we identified some areas where standards of cleanliness could be improved, including dust on top of the vaccine refrigerator. We did not see cleaning checklists displayed or available within rooms throughout the practice. **The practice should ensure that cleaning records are maintained and available to demonstrate that cleaning has been completed in accordance with the**

	agreed schedule. The practice should also ensure that all relevant water outlets are run in accordance with the practice risk assessment and this activity is recorded as part of its legionella control arrangements.
	• During the inspection, we observed that disposable mop heads in the cleaner's storeroom were stored head-down in water within the mop bucket. The practice should:
	  ○ ensure that cleaning equipment is stored appropriately after use, with mop buckets emptied and mop heads stored in a manner that allows them to dry effectively
	  ○ review the availability and use of colour-coded cleaning equipment to ensure that appropriate equipment is available for different areas of the premises.
	• Suitable foot operated bins were available within clinical areas. However, we noted that no waste management policy or audits were available. **The practice should ensure that a waste management policy is implemented and audits completed at suitable regular intervals.**
	• Hand sanitiser was observed to be available to patients at reception only. However, this did not display an expiry date and stored stocks of hand sanitiser had expired in 2025. Stocks of hand wash had also expired in 2025.
	• Hot water had been turned off for the summer months resulting in **hot water running at temperatures too low to effectively prevent the risk of legionella contamination and to enable effective hand washing**. **Cold water was also at a temperature too high to prevent the risk of legionella contamination.**

Medicines management	• We reviewed the Patient Group Directions (PGDs) in use within the practice and found that a number had not been updated and had passed their review or expiry date. Current PGDs are required to ensure that medicines are supplied and administered in accordance with approved protocols and governance arrangements. **The practice must ensure that all Patient Group Directions are current, authorised and reviewed within the required timescales. Arrangements should also be implemented to routinely monitor PGD review and expiry dates and ensure expired PGDs are promptly removed from use.** • Although refrigerator temperatures were monitored during the working week, there was no continuous monitoring in place to provide assurance that temperatures remained within the required range during weekends or in the event of a power interruption. **The practice should consider introducing a data logger or other continuous temperature-monitoring system to provide assurance that vaccine refrigerator temperatures remain within the required range outside normal working hours and during any power disruption.** • A portable oxygen cylinder was available; however, it had passed its expiry date and was therefore not suitable for use. We additionally found that the oxygen cylinder was not secured to prevent it from falling and was stored separately from the other emergency medicines and equipment. **The practice should ensure that the oxygen cylinder is stored securely to prevent it from falling and should consider storing it with**

	the other emergency medicines and equipment, in a location that enables prompt access in an emergency. • An AED was available for use. This was a community AED located externally at the entrance to the building. However, paediatric pads were not available with the emergency equipment held within the practice. Therefore, while most of the expected emergency medicines and equipment were available, the practice could not demonstrate full compliance with the minimum primary care standards at the time of the inspection. **The practice should obtain paediatric AED pads and store them with the emergency equipment within the practice to ensure they are readily available when required.** • There was no signage on the door to identify the location of the emergency medicines and equipment. **The practice should place clear signage on the door of the room where emergency medicines and equipment are stored to support prompt access in an emergency.** • We saw that clinical fridges were not overstocked. However, items stored at the top, bottom and close to the sides of the fridge needed to be moved to allow more air flow around the fridge from the fan. **The practice should ensure that clinical fridges are suitably stocked to enable air flow for temperature control.** • Training specific to the oxygen cylinders used at the practice was also required following Patient Safety Notice 041. **The practice should ensure that all relevant staff have completed training regarding the safe use of the oxygen cylinders available at the practice.** • Patients could nominate a pharmacy to collect their prescriptions for preparation of the medicines prescribed. However, there was no log of prescriptions collected. This is particularly important for high-risk medication prescriptions. **The practice should introduce a system to log the collection of high-risk medication prescriptions.** • Emergency medicines were being checked monthly rather than weekly and did not include a list of all emergency drugs held and expiry dates. In addition, no oxygen cylinder was available on site and the practice manager had been asked to review this arrangement. Until the relevant oxygen cylinders are in place the setting had drafted a risk assessment. Consideration should also be given to improving signage identifying the location of emergency equipment and medicines**. The registered manager must ensure:** ○ **Emergency medicines include a list of individual medications with dates and are checked weekly** ○ **Oxygen cylinders are available for use as required and staff receive the appropriate training in their use** ○ **AED pads are available for all ages** ○ **Appropriate signage must be displayed to identify the location of emergency equipment and medicines.**

Dispensary	• Refrigerator temperatures were recorded twice daily and medicines requiring temperature controlled storage were appropriately stored in the refrigerator. However, we found that ambient room temperatures were not being monitored for medicines stored at room temperature. Without this monitoring, the practice could not fully demonstrate that all medicines were consistently stored within appropriate temperature ranges. **The practice should undertake and record regular ambient room temperature checks within the dispensary to provide assurance that medicines are stored under appropriate conditions.**
Safeguarding of children and adults	• Most staff had completed safeguarding training at a level appropriate to their role. However, this was not the case for all staff. **The practice must ensure that all staff complete safeguarding training at a level appropriate to their role and that this training is kept up to date.** • We noted that safeguarding alerts were not routinely added to the records of household contacts of children on the child protection register. **The practice must implement a process to ensure safeguarding flags are added to the records of household contacts of children on the child protection register.** • We reviewed the practice's current WNB policy and found it was up to date. However, the policy did not include arrangements for the follow-up of children and vulnerable adults who did not attend hospital appointments. We recommend that the practice review its WNB policy and introduce a documented process to ensure that children under the age of 16, and vulnerable adults, who did not attend secondary care appointments were followed up appropriately. This should include reviewing the status of referrals and recording all actions taken within the patient record. **The practice must review and update its WNB policy to include a documented process for following up children under 16 and vulnerable adults who did not attend hospital appointments, ensuring referral status is reviewed and all actions are recorded.**
Management of medical devices and equipment	• During our inspection, we found a number of expired medical consumables within clinical areas. These included partially used dressings that had been opened, blood collection tubes and other consumable items that had exceeded their recommended expiry or use-by date but remained within clinical stock. We also identified some reusable clinical equipment that remained available for use despite the practice not having access to appropriate sterilisation facilities. **The practice must:** ○ **undertake a review of all clinical consumables and equipment to ensure expired items are removed from use and safely disposed of** ○ **ensure that any reusable equipment requiring sterilisation is removed from use and replaced with suitable alternatives** ○ **implement a system to routinely monitor stock expiry dates and provide assurance that only safe and appropriate equipment is available for clinical use.** • We found that an oxygen saturation probe and thermometer included within the emergency equipment had been omitted from the most recent calibration checks. As a result, the practice could not provide assurance that these devices were accurate and safe for continued use. **The practice must ensure that the oxygen**

	saturation probe and thermometer are fit for use and are included in routine practice calibration checks. • All clinical staff had received basic life support (BLS) training. In addition to the annual BLS training, **we also recommend that staff must complete the British Oxygen Company (BOC) Oxygen Cylinder training. The practice must arrange for all staff to receive BOC Oxygen Cylinder training.** • The emergency drugs were stored securely and there was a system in place to check the emergency drugs and equipment to ensure they remained in date and ready for use. However, we recommend that checks are completed more frequently, in accordance with standards set out by the Resuscitation Council (UK). **The practice must ensure that emergency drugs and equipment checks are completed on at least a weekly basis, in line with Resuscitation Council guidelines.**
Participating in quality improvement activities	• The service recognised the value of further developing its clinical audit programme and outcome monitoring processes. While data was collected on some aspects of care, there was limited analysis of clinical outcomes and complications across the range of treatments provided. The practice acknowledged this as an area for future development to strengthen assurance regarding the effectiveness and quality of services. **The registered manager must ensure clinical audit including audit and quality assurance of work carried out, injections, procedures to establish discernible benefit, medical records and weight loss audits.**
Timely	
Timely care	• Practice staff told us that communication with mental health services generally worked well. There was concern expressed that **communication was more challenging with respect to accessing children's mental health services sometimes resulting in multiple referrals to different agencies**. However, the practice told us they were able to escalate service access concerns to the health board.
Effective	
Effective care	• Staff encouraged patients to access NHS 111 Option 2 for urgent mental health support. However, we found that information about NHS 111 Option 2 was not promoted on the practice website. **The practice should add information and appropriate links for NHS 111 Option 2 to its website to improve awareness and access to urgent mental health support.**
Patient records	• We identified some inconsistencies in the way clinical information had been coded. Prescribed medicines were not always linked to the relevant clinical problem within the patient's record. We also found examples where diagnoses had been recorded as free text within the history field rather than being entered within the appropriate problem field. Staff told us that these issues may have been associated with the practice's recent migration to a new clinical IT system. **The practice should review clinical coding and patient problem lists following the recent migration to the new clinical IT system. This should include ensuring**

	that prescribed medicines are linked to the relevant clinical problems and that diagnoses are recorded within the appropriate field. • Staff told us that the quality of data entry within patient records and summaries was not routinely audited. Regular review would help provide assurance that records remained accurate, complete and consistently coded. **The practice should introduce regular audit of patient medical records to monitor the quality, accuracy and completeness of data entry and clinical coding.** • We identified an opportunity for the practice to strengthen its quality assurance arrangements by introducing routine checks of new patient record summarising completed by administrative staff. This would provide additional assurance that key clinical information is transferred accurately and consistently into patient records. **The practice must introduce a quality assurance process to review new patient record summarising completed by administrative staff.** • Inconsistencies were noted in the recording of allergies and medications were linked to conditions in only some of the notes seen. Coding was also not consistently completed to enable audit or review of patient care in relation to specific conditions. As a new patient records system had recently been implemented we suggested that further training may help to address some of the issues identified. **The practice should:** ○ **Ensure that patient records consistently record sufficient narrative** ○ **Ensure that appropriate codes are used throughout patient records** ○ **Consider further training or other support to consistent and effective use of the new electronic patient record system, thereby supporting high quality record keeping.** • The service utilised a commercial electronic records system, which provided secure and accessible record management. A minor area for improvement was identified regarding the completeness of patient demographic information, as some records did not consistently record sex, gender, or title. Improving data completeness would support future audits, service evaluation and quality improvement activity. The medical record coding could be further improved through additional training and checking that staff coding are aware of the correct actions to take and through auditing the coding. **The registered manager must ensure staff receive the appropriate training for coding medical records and that the medical coding is audited on a regular basis.**
Equitable	
Communicating and language	• From our review of eight patient records we could not see that patient's language preference was routinely recorded to inform forward planning for communication assistance required during appointments. **The practice should ensure that language preference is routinely recorded within patient records to ensure staff are aware of any communication needs in advance of appointments.** • The implementation of the Welsh Language Active Offer was very minimal. The practice website could be translated into Welsh as well as a range of other languages. However, no Welsh language signage was seen

	within the practice premises and other provision was found to be limited. **The practice should strengthen its implementation of the Welsh Language Active Offer.** • Most information displayed within the practice was available in English only. While the number of Welsh speaking staff was considered appropriate for the language needs of the local population, the practice was required to ensure that patients were actively offered the opportunity to communicate and receive services in Welsh in accordance with the Welsh Government's Active Offer principles. **The practice should:** ○ **review the information displayed throughout the premises to ensure that any new patient-facing signs are bi-lingual and that there is an equitable display of posters and other information in both Welsh and English** ○ **ensure that the Active Offer of the Welsh language is promoted to patients.**
Rights and equality	• An accessible toilet was available and was fitted with an emergency pull cord to summon assistance. However, when we tested the alarm during the inspection, it did not work. This presented a potential risk to patients who may require assistance while using the facility. **The practice must ensure that the disabled toilet emergency pull cord alarm is repaired and that regular checks are implemented to ensure it remains functional.** • The practice had an up-to-date written policy relating to equality and diversity and we saw that all staff had completed this training. **The practice may wish to consider providing autism awareness training to further support staff in meeting the needs of autistic patients and delivering person-centred care.** • We saw that the position of the self-service blood pressure machine could prevent safe access to some clinical areas by wheelchair or walking aid users. **The practice should consider the position of self-service blood pressure machine and ensure that this does not obstruct access to any clinical areas for any patients**. • The practice had given some consideration to the needs of children attending the premises. However, no baby-changing facility was available. The practice should consider installing baby changing facilities, where feasible, to better meet the needs of its patient population, particularly families with young children.
Person-centred	
Health promotion	• Not all information available through the practice website was applicable to the practice location and it was unclear how frequently health promotion materials in the practice waiting area were reviewed to ensure they were displayed in a clear and accessible manner. The self-service blood pressure machine available for patient use also did not display any instructions for use or information to support patients in discussing their results with clinicians. **The practice should review practice information and the presentation of health promotion materials to ensure information is clear, relevant and easy for patients to access.**
Dignified and respectful care	• We noted that the Chaperone Service poster was not prominently displayed and may not be easily visible to all patients using the service. **The practice should take steps to improve the visibility of information**

	about the chaperone service to ensure all patients are aware that a chaperone can be requested for consultations and examinations. • As the patient reception area was small we observed patients having to stand close together, compromising confidentiality. Two respondents to the HIW patient questionnaire disagreed that they could talk to reception staff without being overheard. An interview room was available should patients request to have a confidential conversation away from reception and it was positive that one respondent to the HIW patient questionnaire was aware of this facility. However, no signage was seen informing patients of this option and the room provided limited space or comfort due to the storage of practice photocopier and other items of stationery. There was no lowered reception desk to enable communication with wheelchair users and the self-check-in screen was also out of use due to incompatible software since the practice had undergone an information technology upgrade. **The practice should:** ○ **Consider the layout of reception and the interview room to ensure that these promote confidentiality and accessibility for all patients** ○ **Ensure that the offer of a separate room for private conversations is advertised to patients** ○ **Arrange for the self-check-in-screen software to be updated, where possible, so that this option can be reinstated within a reasonable timescale.** • Not all clinical rooms had curtains or a screen available to fully maintain patient dignity and privacy before and after intimate examinations. **The practice should ensure that privacy curtains or screens are available around couches within all clinical rooms.**
Quality of Management and Leadership	
Leadership	
Governance and leadership	• During our inspection staff and inspectors found it difficult to navigate the document storage system and only some 18 policies were available for inspection. Policies that were available did not always provide information specific to the practice or relevant to the delivery of healthcare services in Wales. Some required review and lacked version control. **The practice should ensure that policies and procedures are:** ○ **Personalised to the practice and provide information relevant to the delivery of healthcare services in Wales** ○ **Stored in a manner that ensures they are readily available to staff** ○ **Reviewed at regular, timely intervals to ensure they reflect current guidance** ○ **Display comprehensive version control.** • We found that some documents, including the Blood Borne Virus Policy and Needlestick/Sharps Policy, did not include effective document control information, such as a version number or review date. Without consistent document control, there was a risk that staff could refer to information that was no longer current. **The practice should review its policies and procedures to ensure that they are current,**

	complete and subject to effective document control. This should include the use of version numbers, issue dates and review dates. • We saw evidence that clinical meetings took place and that information was disseminated to staff. However, staff told us that clinical meetings were not always formally minuted. **The practice should ensure that all clinical meetings are appropriately minuted to provide a clear record of discussions, decisions and agreed actions.**
Workforce	
Skilled and enabled workforce	• We found that DBS checks were undertaken when staff commenced employment but were not subsequently repeated at regular intervals, as determined by a practice policy position. There was also no formal process in place requiring staff to make ongoing declarations regarding any changes in circumstances that could affect their suitability to work. **The practice should:** ○ **adopt a clear policy position on when Disclosure and Barring Service checks for staff should be renewed and at a level appropriate to their role** ○ **introduce a process requiring staff to declare any changes that may affect their ongoing suitability to work, such as criminal offences, cautions or relevant investigations. This could be incorporated into the annual appraisal process.** • Systems for induction and appraisals were in place. However, the induction programme was not clearly documented to demonstrate competence by the end of the induction process. A systematic programme of core training requirements and evidence of completion on initial recruitment and an on-going basis were also missing. **The practice should ensure that systematic induction, appraisal and training programmes are defined and evidence of completion maintained for all staff.** • We were told that well-being services were also available to staff and all respondents to the HIW staff questionnaire indicated they were aware of these. However, staff we spoke with were not. We also saw that items were stored within cupboards in a way that placed staff at risk of moving and handling injuries. **The practice should ensure that:** ○ **Health and safety is fully considered in relation to all staff activities** ○ **Information regarding staff well-being services is shared with all staff.**
Culture	
People engagement, feedback, learning	• The practice's complaints policy had not yet been updated to reflect the NHS Listening to People procedure. Information about the NHS Listening to People procedure was displayed within the waiting area and was accessible to patients. **The practice must update its complaints process and policy to ensure that it aligns with the NHS Listening to People procedure.** • Staff provided examples of occasions where patient suggestions had been welcomed and acted upon. However, there was no established process for communicating to patients how their feedback had been

	considered or what changes had been made as a result. **The practice should introduce a suitable process to demonstrate how patient feedback has been considered and acted upon. This could include publishing information on the practice website, displaying updates within the waiting area or introducing a 'You said, we did' approach.** • A complaints policy was available. However, this required updating to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026**). The practice should update their complaints policy to align with the Listening to People: the NHS Wales concerns, complaints and redress framework (2026).** Our review of six practice complaints recorded since 2026 indicated that responses and investigations were completed within appropriate timescales. However, as we saw that a number of complaints were regarding communication we questioned how effectively complaints were learnt from within the practice. **The practice should reflect on this feedback and consider how their approach to learning from complaints could be strengthened.** • Information regarding the complaint's procedure was included within the patients' guide, available online and could be provided in alternative formats, including Welsh and large print, to meet individual communication needs. However, consideration must be given to displaying complaints information more prominently within the service. **The registered manager must ensure that complaints information is displayed more prominently in the setting.**
Learning, improvement and research	
Quality improvement activities	• Whilst arrangements were in place to support non-medical prescribers, we identified an opportunity for the practice to strengthen its governance processes by implementing a strengthened system for monitoring and documenting non-medical 18 prescriber competencies. This would help provide additional assurance that prescribing staff maintain the knowledge, skills and competence required for their role. **The practice must implement a formal process for monitoring and documenting non-medical prescriber competencies.**

Good practice to aim for – what impressed the HIW

	INSPECTION COMMENTS
Safe	

Infection prevention and control (IPC) and decontamination	• We found that **all consulting rooms had disposable curtains**, which could easily be replaced should they become contaminated or dirty.
Effective	
Patient records	• We reviewed the care records of 10 patients and saw that an effective records management system was in place. Records were securely stored to prevent unauthorised access. The records we reviewed were clear, legible and of notable quality. From the records, it was clear who was documenting in the records, the date and details of consultation or treatment. Records were completed contemporaneously. They also evidenced that valid consent was obtained, where appropriate. **We found good examples of acute and chronic illness management, and a clear narrative with evidence of patient-centred decision-making**. The records also reflected known patient allergies, and adverse reactions to medications were also highlighted.
Equitable	
Communicating and language	• The practice had an up-to-date patient consent policy in place. **Staff told us that they were able to accommodate known language and communication needs and were familiar with the use of translation services, such as Language Line**. The practice website could also be viewed in multiple languages, including Welsh and English. • **All staff were able to communicate in both Welsh and English, enabling the needs of Welsh-speaking patients to be met effectively.** Patients were routinely greeted and supported in Welsh, reflecting the service's commitment to bilingual communication. We were told that translation arrangements could be made available as required. • **A Provision of Information to Patients Policy was in place and outlined the information provided before, during and after treatment.** We were told that patients received explanations of proposed treatments, expected benefits, potential risks, alternative options, aftercare requirements and associated costs, with opportunities to ask questions before giving consent.
Rights and equality	• Staff had undertaken training in **equality, diversity and inclusion, together with autism awareness training**. This included **Paul Ridd Foundation training** to promote awareness and understanding of the needs of people with learning disabilities.
Person-centred	
Health promotion	• The primary route for accessing practice services was the AskMyGP application. Staff told us that **patients who were older or who did not have access to, or were unable to use, digital services were supported to access services in alternative ways.** Staff provided assistance with using AskMyGP either by telephone or in person at reception and could also provide information through leaflets or advice during consultations. • During consultations, particularly weight management appointments, we were told that **clinicians offered personalised advice and signposted patients to relevant resources. Evidence was seen of proactive**

	health monitoring, screening and early identification of concerns. Where specialist lifestyle support was required, patients were referred to appropriate private services.
Dignified and respectful care	• Staff interacted with patients in a professional, respectful and sensitive manner and were discreet when discussing patient information. No confidential conversations were observed being conducted in areas where they could be overheard. **Background music in the reception area further helped to maintain confidentiality and reduce the risk of conversations being heard by others**. Telephone calls at reception were managed appropriately, with staff only receiving personal information and not disclosing confidential details.
Quality of Management and Leadership	
Staff feedback	• Most respondents felt they had received training relevant to their role and felt involved in decisions regarding their work. All respondents indicated they would recommend the practice as a good place to work. **Thank you cards and gifts received from patients were placed in an area accessed by all staff to ensure these tokens of appreciation were shared throughout the team.**
Leadership	
Governance and leadership	• Processes were in place to act on safety notices from Welsh Government and the Medicines and Healthcare products Regulatory Agency (MHRA), with information cascaded to relevant staff. **The HIW registration certificates were prominently displayed, registration requirements were being met and appropriate employer and public liability insurance was in place.** Staff and managers demonstrated a clear understanding of their roles, responsibilities and reporting lines, while leaders were visible, approachable and maintained an open-door policy.
Culture	
People engagement, feedback, learning	• Whilst arrangements were in place to gather and review patient feedback, opportunities remain to strengthen this process. Information on how patients could provide feedback or make a complaint was included within the patients' guide and on the service website. **Consideration should be given to introducing a structured patient survey process and ensuring that summaries of patient feedback and resulting service improvements are routinely shared with patients.** The online service used for feedback had overwhelmingly positive result about the experience of patients at the setting. To strengthen patient feedback arrangements and to comply with relevant regulations, feedback information must be included within the patients' guide and on the website. The registered manager must ensure that feedback information is included within the patients' guide.