Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

The Stables Medical Practice

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of The Stables Medical Practice as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Practice Manager on 08 September 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How has the practice and the services it provides, adapted during this period of COVID-19? What is the practice road map for returning to pre-COVID-19 levels of services?
- How effectively are you able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely? In your answer please refer to both the practice environment and processes to enable patients to access appointments.

COVID-19 arrangements

During this process, we reviewed key policies in relation to the protection of staff and patients from COVID-19. We also reviewed the service arrangements in place for the appropriate securing, use and disposal of PPE.

The following positive evidence was received:

We were told that at the beginning of the pandemic, the practice was closed to members of the public, and face to face consultations were replaced with telephone and video consultations in the vast majority of cases. A programme which enabled patients to submit pictures and documentation via a text message or email was also implemented, to support these remote consultations and allow clinicians to receive evidence from patients.

The practice manager explained the process of access to the building. Access was now controlled by a strict telephone appointment system, where patients were reviewed by a clinician prior to being offered a face to face consultation. There was no other access to

the building. Staff worked from home where possible to minimise the number of people in the practice. Upon agreement of a face to face appointment, patients were provided with strict instructions in attending the practice, and a risk assessment was also undertaken with patients which included confirmation that they did not have any signs and symptoms of COVID-19.

We were told the practice had not found any problems in sourcing Personal Protective Equipment (PPE) during the pandemic. All staff had access to appropriate PPE in the building, and the practice manager felt there was sufficient reserves.

The practice manager advised that they were also making a number of environmental changes as a result of an updated environmental risk assessment which was carried out in light of COVID-19. This is further covered in the Environment section of this report.

The following areas for improvement were identified:

We were told that two partners and one advanced nurse practitioner had undertaken PPE training, however other staff were yet to undertake this training. Also, the practice manager could not confirm if chaperones had undertaken PPE training.

The practice must ensure that all appropriate staff have received training to effectively use PPE, to protect both staff and patients at the practice.

Environment

During this process, we questioned the practice on how they are making sure all patients have safe and appropriate access to services.

The following positive evidence was received:

We saw that a set of updated risk assessments had been undertaken to identify specific needs in light of the COVID-19 pandemic. We were told that changes made as a result of these risk assessments included changing carpet for vinyl flooring, improving the way in which leaflets and communications are made available to patients and ensuring the existing screens in reception fully protected staff and patients.

All calls were triaged by a clinician, and the vast majority of appointments were being undertaken via tele or video conferencing. If a face to face consultation is required, then a risk assessment is undertaken to ensure patients are not anticipated to be symptomatic for COVID-19. Strict instructions for entering the practice was also provided to patients to ensure minimal footfall through the practice.

During the height of the pandemic we were told that many clinics and services were significantly reduced or stopped. Some clinics, such as respiratory clinics where annual reviews were undertaken, were moved to tele or video conferencing. We were told that others, such as B12 injections, were reviewed on a case by case basis by a clinician prior to agreement to go ahead during this period. We were also told that these appointments were extended to allow sufficient time to prevent more than one patient at the practice at a time.

We were advised that there was an alert system in place which identified patients that were shielding, or patients on the chronic disease database which could be clinically extremely vulnerable. This allowed the clinician to consider this when discussing consultation arrangements. We were told that all patients that called were able to speak to a clinician in

one form or another, so there was no need for non-clinical staff to triage patients.

We were told that the practice was still undertaking home visits and visits to care homes. The practice manager explained that GPs first undertook a risk assessment to ensure they were safe to undertake visits. We were told that full equipment was provided, including PPE packs. GPs were responsible for ensuring that all equipment within these packs were returned clean and so were also provided with sufficient cleaning materials for each kit.

Risk assessments were undertaken on all staff to ensure they were safe within the practice, and to ensure staff who were considered at risk were accommodated.

No areas for improvement were identified.

Infection prevention and control

During this process, we reviewed infection control (IPC) policies, cleaning schedules and staff training. We also questioned the setting about how the changes they have introduced to make sure appropriate infection control standard are maintained.

The following positive evidence was received:

We were told that all staff had received an information leaflet around infection prevention and control, to aid them in delivering safe and effective care to patients.

We saw evidence of the cleaning schedules, and spot check records that was undertaken on a monthly basis. Actions from these spot checks were detailed on the log.

We were told that patients who attended the practice were given specific instructions prior to attending their appointment, to minimise the footfall through the practice and stop patients waiting in the practice at the same time. Patients who were suspected of having an infectious illness were escorted through the side entrance of the main branch and to an isolation room which was stripped to minimise cross-contamination.

We were told that in anticipation of attending appointments in the community, grab bags were created to ensure clinicians had suitable equipment to undertake home visits.. Once used, disposable equipment was bagged appropriately and disposed of in clinical waste bins at the practice upon a clinicians return.

The following areas for improvement were identified:

We were not provided with evidence that staff had completed infection prevention and control training, and a conversation with the practice manager confirmed that only a limited number of staff were up to date with this. Our concerns regarding infection prevention and control were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix A.

Governance

As part of this standard, HIW reviewed policies and procedures for future pandemic emergencies. We also questioned the setting about how they have adapted their service in light of the COVID-19 pandemic, how they are interfacing with wider primary care professionals and their risk management processes.

The following positive evidence was received:

We were told that staffing levels had been well managed during the pandemic, with no disruption to the service. There was currently one member of staff on sick leave.

The practice manager told us that GP partner meetings had continued throughout the pandemic, however other staff meetings had paused. These meetings were now resuming, on a phased basis.

We were told that arrangements with secondary care were working well, and had continued throughout the pandemic. It was identified that phlebotomy services were currently delayed, and the practice manager was monitoring the situation regularly to ensure patient care was not affected.

The following areas for improvement were identified:

We found that the practice was not able to provide evidence relating to training and audit within a reasonable timescale. This information is required to give HIW an assurance that comprehensive governance arrangements are in place in the practice. The practice has a requirement to ensure there is appropriate governance processes and management in place to ensure the service is in line with required standards, and adhering to the health board's policies to maintain safety and compliance. Our concerns regarding the governance arrangements were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix A.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed below:

Where an improvement plan is required, it 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 Quality Check

As a result of the findings from this quality check, 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

Immediate improvement plan

Service: The Stables Medical Centre

Area: Betsi Cadwaladr University Health Board

Date of Quality Check: 08 September 2020

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
Finding The practice did not have suitable arrangements in place for the completion of mandatory training for staff. **Improvement needed** The practice must ensure all appropriate staff have mandatory training including, but not exclusive to, infection prevention and control, cardiopulmonary resuscitation (CPR) and safeguarding of children and vulnerable adults.	2.4 Infection Prevention and Control (IPC) and Decontamination	The practice subscribes to Blue Stream Academy online training system. This system sends notification to staff and managers when any completed training is due for renewal. There has been a delay to training due to the cancellation of PET session and Covid-19 Pandemic. Infection Control and Information Governance is now completed by all staff. CPR training is already up to date. Clinical staff was due for renewal in April but unable to complete face to face,	Sue Carey	6 months

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		online will be completed by end of October Safeguarding is our next priority, with remaining mandatory training to follow as soon as possible		
Finding The practice was not able to provide evidence relating to training and audit within a reasonable timescale, information which is required to give HIW an assurance that comprehensive Governance arrangements are in place in the practice. **Improvement needed** There is appropriate governance processes and management in place to ensure the service is in line with required standards, and adhering to the health board's policies to maintain safety and compliance.	Governance, Leadership and accountability	The practice subscribes to Blue Stream Academy online training system. This system sends notification to staff and managers when any completed training is due for renewal. There has been a delay to training due to the cancellation of PET session and Covid-19 Pandemic. Infection Control and Information Governance is now completed by all staff. CPR training is already up to date. Clinical staff was due for renewal in April but unable to complete face to face, online will be completed by end of October	Sue Carey	4 weeks

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Safeguarding is our next priority, with remaining mandatory training to follow as soon as possible		

Improvement plan

Setting: The Stables Medical Practice

Ward/Department/Service (delete as appropriate): GP Practice

Date of activity: 08 September 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The practice must ensure that all appropriate staff have received training to effectively use PPE, to protect both staff and patients at the practice.	HSE	Final 3 members of staff completed their training on 7th and 14th October	Sue Carey	1 week

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.

Name: Sue Carey

Date: 14/10/2020