Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Greenhill Medical Centre, Swansea Bay University Health Board

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Greenhill Medical Centre at 1 Greenhill Street, Swansea SA1 1QW, within Swansea Bay University Health Board on the 15 October 2019.

Our team, for the inspection comprised of two HIW inspection managers (including one inspection lead), GP and practice manager peer reviewers and a lay reviewer.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct GP inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found that the practice was focussed on delivering safe and effective care, however, it was not fully compliant with all Health and Care Standards.

We observed positive and friendly interactions between staff and patients. The environment was welcoming to all, and patient's comments were generally positive about the practice.

Communication between staff within the practice was reported as good, and staff told us they felt supported by the management team.

We found areas of concern that could pose an immediate risk to the safety of patients, including processes in place for protecting drugs and equipment, ensuring staff had appropriate Hepatitis B immunity and processes for the safe recruitment of staff. These issues were dealt with under HIW's immediate assurance process.

This is what we found the service did well:

- Positive and friendly interactions between staff and patients
- There was a positive relationship between staff and managers.
- The practice was committed to providing a good quality of care using the language line to support patients of a variety of languages
- The practice was trialling new methods of information sharing and preventative healthcare by using an app for patients.

This is what we recommend the service could improve:

- Some areas of patient record keeping

Our concerns regarding the resuscitation equipment, security of patient identifiable information, hepatitis B immunity status records, medicines management and the recruitment process were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately

following the inspection, requesting that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

3. What we found

Background of the service

Greenhill Medical Practice currently provides services to approximately 4,300 patients in the Swansea area. The practice forms part of GP services provided within the area served by Swansea Bay University Health Board.

The practice employs a staff team which includes two partner GPs, two nurses, one medical secretary, one practice manager, two data clerks and two receptionists.

The practice provides a range of services, including:

- Minor surgery
- Warfarin clinic
- Asthma clinics
- Diabetic clinics
- Baby clinics

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed friendly and polite interactions between staff and patients. Generally, patients' comment were positive about their experience at the practice. Patients reported that they were happy with gaining access to appointments.

The practice should provide patients with the opportunity to provide the practice with feedback and comments.

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice.

In total, we received 36 completed questionnaires. The majority of the patients who completed a questionnaire were long term patients at the practice (those who had been a patient for more than two years).

Patients were asked in the questionnaire to rate the service provided by the practice. Responses were positive; almost all of the patients rated the service as excellent or very good. Patient comments included:

> *"Always very helpful doctors, nurses and receptionists"*
>
> *"Very excellent GP, I am pleased with the service they provided"*
>
> *"I'm happy with the service"*

Patients were also asked in the questionnaires how the practice could improve the service it provides. Patient comments included:

> *"Do not ask at reception what appointment is for. Allow more chance to book appointments"*
>
> *"It would be more helpful if you could get past the receptionists apart from one"*

"Have a nurse who can do local surgery"

Staying healthy

We saw there was a variety of posters displayed in the practice waiting area, for patients to read whilst waiting for their appointment. We also noted that the practice had access to an app which could be downloaded, and provided patients with a wide range of information on good health and support for initiatives, such as healthy eating and quitting smoking. However, aside from this app, health promotion activity appeared limited and this could restrict patients who are unable to access this service.

Improvement needed

The practice must provide a range of health promotion information to patients in a variety of formats.

Dignified care

All but one of the patients who completed a questionnaire felt that they had been treated with dignity and respect by staff at the practice.

We observed patients being greeted and welcomed by reception staff in a professional and friendly manner. A number of staff had worked at the practice for many years, and appeared to know their patients well.

The reception was located just inside the entrance of the practice, and separated to the waiting room by a door. This ensured that patients had privacy from those within the waiting room. Reception staff told us that a room could be used if required, for patients to discuss any sensitive information in order to protect their privacy.

We were able to see that during appointments the doors to the consultation rooms were closed, to help protect patient privacy. Some of the consultation rooms were divided into two areas, with the treatment couch being in a separate area. This meant that patients were able to undress, when required, in privacy, prior to any treatment or examination. We saw that the doors could be locked to ensure privacy was maintained.

There were a number of staff trained to appropriately provide a chaperone service for patients during intimate examinations, however, this was not clearly advertised to patients. We did not see evidence on the day of a chaperone

policy in place. This is covered in more detail under the Leadership and Management section of this report.

Improvement needed

The practice must ensure that information is displayed within the waiting area and consulting rooms, informing patients they can request a chaperone if required.

Patient information

The majority of patients who completed a questionnaire told us that they would know how to access the out of hours GP service.

The practice had a practice leaflet which contained information for patients about the practice and the services it offered. The leaflet was available behind reception, so we advised that this was placed in an area that was readily available to patients. The practice manager agreed to action this.

Patients were called by the receptionists for their appointments, and we saw that patients were directed to the consulting rooms as appropriate.

Communicating effectively

Every patient who completed a questionnaire told us that they were always able to speak with staff in their preferred language.

We were told that there was a Welsh speaking receptionist at the practice, however, we were informed that no patients had ever requested to speak in Welsh. In addition, people could receive a service in a language of their choice, and we saw evidence that the language line was frequently offered and used. We found that there was very little patient health promotion information provided in Welsh and other languages.

The practice had a hearing loop to aid communication for patients with hearing difficulties, and we saw a poster advertising this in the waiting area.

Staff explained the arrangements that were in place to ensure that messages (from patients and others), were brought to the attention of the doctors, nurse or other visiting professionals, in a timely way.

All but one of the patients who completed a questionnaire felt that things are always explained to them during their appointment in a way that they can

understand, and all of the patients told us that they are involved as much as they wanted to be in decisions made about their care.

Improvement needed

The practice must ensure that information and health promotion material is available in Welsh, and accessible on request, in a variety of languages.

Timely care

The majority of patients who completed a questionnaire told us that they were very satisfied or fairly satisfied with the hours that the practice was open. Over two thirds of the patients who completed a questionnaire said that it was very easy or fairly easy to get an appointment when they needed one.

We found that the practice made efforts to ensure that patients were seen in a timely manner. Staff also described a process for keeping patients informed about any delays to their appointment times, telling us they would verbally update patients.

Patients were able to book appointments in advance, and patients told us they were able to make appointments when they needed them. The practice also offered on the day appointments for non-routine consultations.

We were told that requests for same day appointments were triaged by a receptionist, and then patients would be either offered an appointment with a relevant healthcare professional, or signposted to another service. The practice also promoted Choose Pharmacy[1] for minor ailments.

During the inspection, we were not assured that appropriate training had been provided to the receptionists for triage, neither were they supported by a checklist or guide for triaging to signpost patient to the most appropriate

[1] http://www.choosewellwales.org.uk/sitesplus/documents/994/Minor%20Ailments%20Services_Leaflet_English.pdf

healthcare provider. We recommended that until training and an adequate process was in place to ensure that the receptionists were assessed as competent to undertake a triage role, this should be stopped.

Staff told us that there was an open door policy, and that they would be happy and confident to speak with the GP's, should they need advice regarding those patients being triaged, including the timeliness and appropriateness of appointments.

When asked to describe their overall experience of making an appointment the majority of the patients who completed a questionnaire described their experience as very good or good.

Improvement needed

The practice must ensure that training and an appropriate process is implemented, to ensure that the receptionists are assessed as competent and supported to triage calls for appointments.

Individual care

Planning care to promote independence

The practice was accessible to patients using wheelchairs, those with mobility difficulties, and for those with pushchairs, as the practice was all on ground floor level. There was no designated parking for patients outside the practice, however we saw parking outside, including disabled spaces directly outside the practice entrance.

We noted that the reception desk was on one level, and the we noticed that this could pose challenges for people in wheelchairs to gain the attention of receptionists. We found that the practice had not completed a disability access assessment of the environment, and suggested this should be done, as it may highlight areas within the practice that may need improvement. The practice agreed to do this.

The practice held clinics for patients with specific healthcare needs, such as asthma and diabetes, to help support them in the management of their conditions.

Improvement needed

The practice must consider undertaking a disability access assessment, and take action where improvements are highlighted.

People's rights

Our findings that are described throughout this section indicate that the practice was aware of its responsibilities around people's rights. As mentioned earlier in the report, a disability access assessment is required to be undertaken.

Listening and learning from feedback

The practice did not have any formal processes in place to obtain patient feedback. We were told that there was a suggestions box in the reception area, however, this was not used. Staff we spoke with on the day of the inspection were unaware of any actions related to gathering feedback from patients. The practice did not have a patient participation group, which may provide an avenue for the practice and patients to be able to discuss issues relevant to them.

We saw that the NHS Wales Putting Things Right[2] process was displayed in the reception area. The practice did not display information about the Community Health Council, who are able to provide support to patients wishing to raise a complaint.

The practice held a folder for patient complaints, and kept a record that demonstrated the actions they had taken. However, we found that key information such as timescales, lessons learned and themes and trends, which is a key process for improving and developing as a practice, were not included. This meant that the policy was not in line with Putting Things Right.

[2] http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright

Improvement needed

The practice must:

- Ensure that patients have the opportunity to provide feedback on the services provided
- Display contact details for the local Community Health Council
- Implement a process to record complaints appropriately, including demonstrating where actions have been taken, themes and trends identified, lessons learned and information shared with staff where necessary.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The practice had comprehensive policies in place for checking of emergency equipment and medicines. Patient records were maintained to an acceptable standard.

Clinical staff reported that there was a positive working relationship, which enabled clinical discussions about patients when required.

We found that improvements were needed to ensure that information governance arrangements were robust.

More robust arrangements were also required to ensure that records of staff hepatitis B immunisation status was documented.

The practice was not complaint with Health and Care Standards 2015, and were issued with an immediate assurance notification in relation to our immediate concerns regarding patient safety.

Safe care

Managing risk and promoting health and safety

All of the patients who completed a questionnaire felt that it was very easy or fairly easy to get into the building that the GP practice is in.

During a tour of the practice, we found that it was generally clean and uncluttered, which reduced the risk of trips and falls to patients and staff. However, we found during the inspection that an environmental risk assessment had not been carried out. This is important to ensure that the practice environment remains safe and fit for purpose.

We found that checks of the fire safety equipment had been carried out. We did not however, see evidence that any staff had undertaken fire safety training. A recommendation is made about training compliance within the Management and Leadership section of this report.

Improvement needed

The practice must ensure that environmental risk assessments are undertaken on a regular basis.

Infection prevention and control

Staff told us that they had personal protective equipment, such as gloves and disposable plastic aprons, to reduce cross infection. The clinical treatment areas we saw were generally clean and tidy, however we did see dust on weighing scales within a treatment room. We advised that this was rectified immediately.

We saw that hand washing and drying facilities were provided in clinical areas and toilet facilities. Within the staff toilet there was a hand towel alongside paper towels, which could pose an infection control risk. Hand sanitisers were available in the treatment rooms to GPs and nurses, however these were not readily available to all around the practice. We advised that hand sanitisers should be available around the practice for the benefit of all visitors to the practice.

There was no provision for feminine hygiene in the toilet facilities.

There were no concerns given by patients over the cleanliness of the GP practice; the majority of patients who completed a questionnaire felt that, in their opinion, the GP practice was very clean.

We saw that some of the flooring within one treatment room was torn, which may inhibit effective cleaning and also harbour microorganisms (bacteria/germs).

The practice did not maintain an overall register of the hepatitis B immunisation status for their clinical staff. This is required to protect staff and patients. Our concerns regarding the above issue 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 B.

Improvement needed

The practice must:

- Remove fabric hand towels from all toilets
- Ensure that feminine hygiene facilities are available to staff and patients
- Ensure the flooring within the treatment room is either repaired or replaced.

Medicines management

The practice had a pharmacist appointed by the local cluster[3], for one and a half days a week. They were able to assist the practice by carrying out patient medication reviews, hospital discharge summaries and undertaking the anticoagulant clinic. Staff told us that they found this service beneficial.

We reviewed the arrangements for the storage and handling of drugs and equipment to be used in a patient emergency (such as collapse). The Resuscitation Council UK Quality Standards for Resuscitation[4] stipulate, that healthcare organisations/ providers have an obligation to provide a high-quality resuscitation service. We noted that numerous staff members were not aware during the course of the inspection where the defibrillator[5] was kept within the practice. Our concerns regarding emergency resuscitation equipment were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

[3] A cluster is a group of GPs working with other health care professionals to plan and provide local services.

[4] Resuscitation Council UK Quality Standards for Resuscitation

[5]A defibrillator delivers a dose of electric current to the heart as a treatment for life-threatening cardiac dysrhythmias including cardiac arrest.

We found that the practice had a process in place for checking and recording the emergency drugs and equipment on a regular basis, to ensure items remained safe and ready to use and within their expiry dates.

Due to the filing system in place for staff training, we were not able to see on the day that cardiopulmonary resuscitation (CPR) training was carried out on an annual basis for all staff. We noted appropriate training for a number of staff, however, a recommendation is made about training within the Management and Leadership section of this report. Medication and vaccinations were stored in a medication fridge within a side room of the office area, however the fridge was not locked.

Whilst we saw that checks had been carried out of the medication fridge temperature, the records showed that the temperature had consistently been recorded as higher than the maximum recommended temperature. It was unclear what action the practice had taken as a result of these checks. It is important for medicines and vaccination to be stored at the correct temperature to ensure they remain viable and safe to use.

We also found medicines which had been prescribed to patients, which were stored in an unlocked cupboard within the treatment room. These were for some patients who needed regular treatment from the nurse. However, one item did not have a pharmacy label stating who the medicine was prescribed to, and we saw many of these were faded and the cupboard was full, increasing the risk of cross contamination or incorrect use of medication.

Our concerns regarding medicines management were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Safeguarding children and adults at risk

We were unable to access the child and adult safeguarding policies and procedures on the day of the inspection, however we noted an index of policies within the practice included policies for safeguarding. A recommendation on ensuring policies and procedures are readily available has been made in the Leadership and Management section of this report. We saw that a copy of the All Wales safeguarding guidance was available to staff within the office. Staff were not clear on the day of the inspection who the safeguarding lead for the practice was.

As mentioned previously, training records were not clear and we were not able to determine that safeguarding training had either been completed or whether it

was up to date. A recommendation is made about this within the Management and Leadership section of this report.

Improvement needed

The practice must ensure that a safeguarding lead is appointed, and this is clearly communicated to all staff.

Medical devices, equipment and diagnostic systems

We saw that the practice had a process in place to ensure that medical equipment was serviced and calibrated to help make sure they remained safe to use.

Effective care

Safe and clinically effective care

The practice had arrangements in place to report patient safety incidents and significant events. The sharing of safety alerts received into the practice was appropriately managed by the practice manager and shared with relevant staff. We found that any significant incidents were discussed during team meetings.

We spoke with members of the practice team on the day of our inspection, and were able to confirm that staff were encouraged and empowered to raise any concerns they may have about patients' and/or their own safety.

Quality improvement, research and innovation

As part of the local cluster group, the practice had access to a pharmacist on a regular basis. The cluster was also considering other services which would be beneficial to the area.

Information governance and communications technology

A height and blood pressure monitoring machine was located next to a clinical waste bin behind the reception area, next to the staff office where patient records were also stored. The side room which also stored the medicine fridge, was also in this area. We were told that patients would be escorted by a member of staff when using the machines.

However, during the inspection we found that the door to these areas was kept open, meaning that the side room, medicines fridge, as well as patient records in reception could potentially be accessed by patients and visitors.

Our concerns regarding information governance were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The practice must ensure that any staff only areas are highlighted, and are not accessible to patients without escort by staff.

Record keeping

We looked at a sample of patient records and overall, found some but not all were of an acceptable standard. We recommended where some improvements to documentation could be made, to ensure the records were maintained to a consistent standard across the practice, to ensure all care is communicated effectively between relevant clinicians. This included:

- Not enough detail of clinical consultation
- No worsening advice documented
- Inconsistent documentation of important clinical findings such as pulse, blood pressure, temperature and oxygen saturations.
- Minor surgery consent form is not signed by the patient
- Medication are not linked to conditions
- Problems relating to read coding.

Improvement needed

The practice must ensure that patient records are maintained in line with professional standards for record keeping.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

Staff within the practice were positive about the support they received from the management team. We found that there were appropriate communication channels for disseminating information across the practice.

Improvements were required to ensure that staff could easily access policies and procedures.

Improvements were also required with undertaking and the recording of staff training, to ensure that all staff received training in a timely manner.

Governance, leadership and accountability

There were two GP partners within the practice, with the responsibility of the day-to-day running being managed by a practice manager. There was evidence of good relationships between clinical and non-clinical members of the team. Staff told us that communication was good within the practice, and that generally they felt supported by the management team.

The practice did not have a practice development plan in place. Such a plan would be the result of a review of local needs and service provision, to identify priorities for the practice. The practice, and patients, would benefit from having one in place.

Nursing staff we spoke with told us that they felt supported by the GPs. They told us they were able to raise any clinical concerns with them at any time during the course of the day. This was done on an informal basis, allowing for free-flowing discussions about patients.

There were a number of team meetings held within the practice, to share information between staff. These included clinical and non-clinical staff. Staff told us that communication was good within the practice, and felt like they were able to openly discuss any issues that were concerning them.

There were a number of policies and procedures available to staff, however, the inspection we found that these were difficult to find and navigate. When we did review policies, many were out of date. We recommended that appropriate governance arrangements are put in place to ensure that staff are able to easily access up to date policies and procedures at all times. We found that when policies were updated or amended, staff were made aware of these changes, and on occasion, were asked to confirm they had read the most recent version following team meetings. We advised that this was good practice and should take place for all policy updates and changes.

Improvement needed

The practice should ensure that policies and procedures are easily accessible to staff at all times and are up to date.

Staff and resources

Workforce

There was a well-established staff team in place, with many staff members being employed for a number of years. Staff were able to describe their roles and responsibilities, and demonstrated a good understanding of the practice processes.

We looked at staff training records, and found them to be disorganised and difficult to navigate. The practice did not maintain an overall record of completed training, neither did they have a record of when training was overdue or in need of refreshing. The practice did not hold a record of what essential and mandatory training staff were required to complete. Therefore, we could not be assured that staff had received all training relevant to their roles. Our concerns regarding the above were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Staff we spoke with told us that they have access to in-house and online training, and felt supported by the practice to do this. We were also told that staff received annual appraisals of their work.

We found that there were limited processes in place to support the safe recruitment of staff. As with staff training, we were unable to view a comprehensive sample of staff records on the day of the inspection. It was unclear through discussions with the practice manager whether newly appointed and existing staff had received all the appropriate checks, to support safe recruitment and ongoing employment.

We were unable to review the pre-employment records of any clinical staff on the day of the inspection. As such, we could not be assured that the relevant safety checks had been carried out. This included a Disclosure and Barring Service (DBS) check relevant to particular roles, professional registration checks, hepatitis B immunisation checks for clinical staff, and relevant qualifications and training records.

A review of other staff files and discussion with the practice manager confirmed that staff who had been employed for long periods of time had not had a DBS check, and some members of clinical staff were missing hepatitis B checks. Our concerns regarding the above were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

In light of the above issues with regards to recruitment, the practice must ensure that they have a robust process in place for any recruitment and appointment of staff in the future. This must include carrying out the relevant pre and post appointment checks.

Clinical staff are required to register with their professional body, such as the General Medical Council (GMC)[6] or the Nursing and Midwifery Council (NMC)[7]. They must also revalidate their registration with evidence of practice and training at defined intervals. Whilst it is an individual's responsibility to ensure their registration is maintained, the practice did not have a clear process in place to monitor this, to ensure that staff remained registered with their professional body.

[6] https://www.gmc-uk.org/

[7] https://www.nmc.org.uk/

Improvement needed

The practice must ensure there is a process in place to ensure evidence is obtained and filed for clinical staff's professional registrations.

4. What next?

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 when and how the findings identified will be addressed, including timescales
- 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.

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.

5. How we inspect GP practices

GP inspections are usually announced. GP practices will receive up to 12 weeks notice of an inspection. This is so that arrangements can be made to ensure that the practice is running as normal, and that the inspection causes as little disruption to patients as possible.

Feedback is made available to practice representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how GP practices are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within GP practices.

Further detail about how HIW inspects the GP practices and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries 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: Greenhill Medical Centre

Date of inspection: 15 October 2019

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

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of patient experience				
No immediate improvements identified				
Delivery of safe and effective care				
Finding The practice was not able to provide evidence of Hepatitis B immunity for all clinical staff. We saw that records for some staff, but not all. **Improvement needed** The practice must provide HIW with evidence the Hepatitis B immunity status for all clinical	Health and Care Standards (April 2015) 2.4 Infection Prevention and Control (IPC) and	Spreadsheet of clinical staff Hepatitis B immunity status in place. Actions to be taken as appropriate to status / blood test results; and	Practice Manager Practice Nurse	Completed 8/11/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
staff. Where evidence is not available to demonstrate immunity, appropriate action must be taken by the practice to protect staff and patients.	Decontamination	ongoing monitoring.		
Finding We considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within the practice. We noted that the location of equipment including the blood pressure monitor, and height and weight stations were all located within the office behind the reception desk. From here it was possible for patients to see records within the back office, and access the server within the computer room. **Improvement needed** The practice must ensure that measures are in place to ensure the security of all patient information held.	Health and Care Standards (April 2015) 3.4 Information Governance and Communications Technology	All apparatus have been moved from the office behind the reception desk: - Blood Pressure Monitor has been moved to the waiting room; - weighing scales has been moved to the Treatment Room. No patients will be accessing office behind reception desk.	Practice Manager	Completed
Finding On the day of the inspection, some staff	Health and Care Standards			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
members that were interviewed were unaware of the location of the defibrillator. The practice resuscitation equipment was also missing an ambubag, which is essential to assist a patient's breathing where required. **<u>Improvement needed</u>** The practice must ensure that: • All members of staff are aware of the location of the defibrillator and that an appropriate amount of staff are trained in its use. • There is an up to date resuscitation protocol and policy in place, and that all staff are aware of its contents. • All resuscitation equipment is readily available as highlighted within the guidance of the Resuscitation Council UK for primary care settings.	(April 2015)	All staff are now aware of the location of the defibrillator, a notice has been put in the office, locum pack has been updated, signage is in place and staff training has been completed. Devising localised protocol and policy for the practice, to include all aspects of resuscitation equipment; and weekly equipment checks and monthly stock checks. Ambubag ordered, awaiting delivery.	Practice Manager and Practice Nurse Practice Manager and Practice Nurse Practice	Completed 8/11/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Manager 8/11/19	
<u>Findings</u> We considered the arrangements for the safe storage of medications within the practice and found there were a number of areas where medication was not being securely stored, and to prevent unauthorised access, to uphold patient safety. This included: • The vaccines fridge was left unlocked in an area which was accessible to the public • The temperature of the drugs fridge was consistently recorded as 11 degrees, above the recommended maximum of eight degrees. However, no mitigating action had been taken. • Medicines prescribed to patients were kept in unlocked cupboards within the treatment room which was accessible to the public	Health and Care Standards (April 2015) 2.6 Medicines Management			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Prescription medicines within the treatment room cupboard were found with no name labels. **<u>Improvement needed</u>** The practice must ensure that: • Vaccine fridge is kept locked when not in use, or that the fridge is stored in a locked room • Medicines are stored appropriately as recommended by the manufacturer • Medication is stored securely within locked cupboards • All medication is appropriately labelled.		New Fridge ordered and been delivered, which will be kept in a locked room. Original vaccine stock quarantined / disposed of as per Manufacturers' guidelines.	Practice Manager and Practice Nurse	Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A locksmith has been contacted and locks have been ordered for the cupboards in the treatment room. All medication now labelled appropriately in treatment room.	Practice Manager Practice Nurse	1/11/19 Completed
Quality of management and leadership				
<u>Finding</u> We found that there were limited processes in place to support the safe recruitment and training of staff. It was unclear, through discussions with the practice manager and through reviewing staff records, whether newly appointed and existing staff had received all appropriate checks, to support safe recruitment and ongoing employment. We found in the record of one clinical member	Health and Care Standards (April 2015) 7.1 Workforce			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
of staff, that there was no evidence that relevant checks had been undertaken. This included evidence of a Disclosure and Barring Service (DBS) check, professional registration, hepatitis B immunity status, qualifications, training records and indemnity insurance. A review of other staff files and discussion with the practice manager confirmed that staff who had been employed for long periods of time had not had a DBS check. A review of the staff training file could not be fully undertaken as the practice did not hold sufficient records, which meant we were not able to complete this during the course of the inspection. Therefore, we could not be assured that staff had completed all mandatory training. The practice does not hold a matrix of staff training or have guidance in place for requirements of mandatory training for staff. **Improvement needed** The practice must: • Provide evidence to confirm that				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
appropriate employment checks have been carried out for all staff • Ensure all staff (where applicable), have DBS checks completed with a record kept on file, to a level appropriate to their roles • Ensure that all staff have completed all relevant mandatory training applicable to their role, and that a record is kept on file.		All relevant employment checks, including GMC / qualifications certificate checks, now in place for all existing and new staff. DBS database now in place for all staff. Six current certificates on file and a plan is in place, with ongoing support from NWSSP, to process remaining 9 applications over the next	Practice Manager Practice Manager	Completed 8/11/19

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		2 weeks. Staff training matrix now in place, which easily identifies any gaps or training due for renewal. This will be kept up to date and reviewed monthly.	Practice Manager	Completed

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): Mrs Ranjana Bohra

Role: Practice Manager

Date: 24.10.19

Appendix C – Improvement plan

Service: Greenhill Medical Centre

Date of inspection: 15 October 2019

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.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The practice must provide a range of health promotion information to patients in a variety of formats.	1.1 Health promotion, protection and improvement	We have a QR Pod in the waiting room for patients to access. We are having Television health promotion information installed from Envisage Media on 2.12.19 for our patients. Information leaflets are also left in the waiting room.	Practice Manager	4 weeks
The practice must ensure that information is displayed within the waiting area and consulting rooms, informing patients they can request a chaperone if required.	4.1 Dignified Care	Chaperone Posters have been displayed in each consultation/Treatment rooms and waiting area, informing patients if required they can request a chaperone.	Practice Manager	Done
The practice must ensure that information and	3.2 Communicating	The QR Pod leaflets and our new media	Practice Manager	In process

Improvement needed	Standard	Service action	Responsible officer	Timescale
health promotion material is available in Welsh, and accessible on request, in a variety of languages.	effectively	information are in Welsh and English.		
The practice must ensure that training and an appropriate process is implemented, to ensure that the receptionists are assessed as competent and supported to triage calls for appointments.	5.1 Timely access	Triage Training done.	Practice Manager	Done
The practice must consider undertaking a disability access assessment, and take action where improvements are highlighted.	6.1 Planning Care to promote independence	In discussion within the Surgery	Practice Manager	In the future
The practice must: • Ensure that patients have the opportunity to provide feedback on the services provided • Display contact details for the local Community Health Council • Implement a process to record complaints appropriately, including	6.3 Listening and Learning from feedback	• Suggestion box is in the waiting area which is checked daily. • Community Health Council poster displayed. • Practice Meetings are held to discuss complaints. The information is shared and actioned and we identify the lessons that need to be learnt.	Practice Manager	Done Done Done

Improvement needed	Standard	Service action	Responsible officer	Timescale
demonstrating where actions have been taken, themes and trends identified, lessons learned and information shared with staff where necessary.				
Delivery of safe and effective care				
The practice must ensure that environmental risk assessments are undertaken on a regular basis.	2.1 Managing risk and promoting health and safety	Risk assessment will be undertaken regularly. We have a current Poster for the Health and Safety.	Practice Manager	Immediate
The practice must: • Remove fabric hand towels from all toilets • Ensure that feminine hygiene facilities are available to staff and patients • Ensure the flooring within the treatment room is either repaired or replaced.	2.4 Infection Prevention and Control (IPC) and Decontamination	• All fabric towels have been removed from the toilets. • Feminine hygiene facilities is now available in the patients and staff toilets. • New flooring has been ordered for the treatment room.	Practice Manager	Done Done End of January 2020
The practice must ensure that the medication	2.6 Medicines	New fridge has been delivered with a lock which is being locked when not in	Practice Manager	Done

Improvement needed	Standard	Service action	Responsible officer	Timescale
fridge door is kept locked when not in use.	Management	use		
The practice must ensure that a safeguarding lead is appointed, and this is clearly communicated to all staff.	2.7 Safeguarding children and adults at risk	Dr Bohra is the lead for safeguarding and all staff have been notified.	Practice Manager	Done
The practice must ensure that any staff only areas are highlighted, and are not accessible to patients without escort by staff.	3.4 Information Governance and Communications Technology	No entry signs will be put on all the restricted areas where it is not accessible to patients.	Practice Manager	4 weeks
The practice must ensure that patient records are maintained in line with professional standards for record keeping.	3.5 Record keeping	All staff have been made aware of the standards of record keeping.	Practice Manager	Done
Quality of management and leadership				
The practice should ensure that policies and procedures are easily accessible to staff at all times and are up to date.	Governance, Leadership and Accountability	The Practice will ensure that all policies will be up to date and they are kept in accessible place and all staff will be made aware of where they are kept.	Practice Manager	8 Weeks
The practice must ensure there is a process in place to ensure evidence is obtained and filed for clinical staff's professional registrations.	7.1 Workforce	The Practice has ensured the evidence has been obtained and filed for the Clinical staff professional registrations.	Practice Manager	Done

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): Mrs Ranjana Bohra

Job role: Practice Manager

Date: 28.11.19