Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Rugby Surgery

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Rugby Surgery 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 and the reception manager on 04 November 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 during the pandemic, the practice, where possible, limited the number of patients attending the site for appointments. An email system enabled patients to submit pictures of ailments which were reviewed by clinicians. In addition remote consultations and face to face appointments were available.

Patients who attended face to face appointments were risk assessed to ensure they did not have any COVID -19 symptoms. Patients were also provided with safety instructions for attending the practice.

We saw evidence that all staff had received up to date infection prevention and control (IPC) training, which included sufficient training to ensure appropriate use of Personal Protective Equipment (PPE). We were told the practice had found some problems in sourcing PPE at the beginning of the pandemic as a result of rapidly changing guidance, but the practice manager assured us that this was quickly rectified and there had been no issues since. All staff had access to appropriate PPE in the building, and the practice manager considered there was sufficient reserves.

The practice manager advised that they had reviewed their environmental risk assessment in light of COVID-19, but felt that the current arrangements had allowed them to adhere to the strict IPC arrangements in place. This is covered further in the Environment section of this report.

No improvements were identified.

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 an updated risk safety checklist had been undertaken to identify specific needs in light of the COVID-19 pandemic. We were told that this complimented the health and safety risk assessment held by 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. We were also told that these appointments were extended to allow sufficient time to deal with the patients', adhere to Personal Protective Equipment protocols and clean down the room.

We were advised that there was an alert system in place which identified patients that were shielding, or patients on the chronic disease database who could be vulnerable. This allowed the clinician to consider whether it was safe for patients to attend appointments

when discussing consultation arrangements.

We were told that the practice was still undertaking home visits and visits to care homes when necessary. The practice manager explained that staff had risk assessments to ensure they were safe to undertake visits. We were told that 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.

No improvements were identified.

Infection prevention and control

During this process, we reviewed infection control 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 saw evidence that all staff had received up to date IPC training, alongside additional guidance and information, to support them in delivering safe and effective care to patients. All staff have been briefed on appropriate use of PPE during the pandemic by staff specialised in this process.

We saw evidence of the cleaning contract, and audits by the company to ensure compliance with the contract. In agreement with the contract holder, the cleaning arrangements had been amended to include more regular cleaning of higher traffic areas, including door handles and window sills.

Patients who were suspected of having an infectious illness were escorted through the side entrance to an isolation room to minimise cross-contamination.

No improvements were identified.

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 effectively managed during the pandemic with very minimal disruption to the service. Risk assessments were undertaken on all staff to ensure they were safe within the practice, and staff who were considered at risk were accommodated. This had meant a change in culture to work more flexibly with staff to meet the challenges of family responsibilities and isolation requirements. At the time of the quality check, we were told that there were no members of staff currently taking sick leave. Staff worked from home when they were able to, to minimise the number of people in the practice.

The practice manager told us that staff meetings had continued where possible, but due to the dispersement of staff this had not always been possible. Minutes for these meetings were circulated to staff following each meeting to ensure all staff were kept up to date with the latest guidance and policies.

We were told about the cluster1 arrangements for the practice. The cluster had continued to support practices in the focus campaigns including COVID-19, the opening of the Grange hospital and the flu vaccination programme, and this had worked successfully. The cluster was meeting regularly via remote methods, and was working well together.

We were told that arrangements with secondary care[2] were continuing, and had continued throughout the pandemic despite services being placed under considerable pressure. We were told that although secondary care and mental health referrals were being accepted, secondary case arrangements were still limited and waiting times longer.

No improvements were identified.

[1] A cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally.
[2] Secondary care is provided upon referral by a primary care physician, to a specialist or facility when more specialised knowledge is needed.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan 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.

Improvement plan

Setting: Rugby Surgery

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

Date of activity: 04 November 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	No improvements were identified				
2					
3					
4					

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: Date: