Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Tenby Surgery, Hywel Dda University Health Board

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Tenby Surgery as part of its programme of assurance work. The surgery is a health board managed GP practice, providing primary care to the residents of Tenby and surrounding areas, local care homes, and more recently the Penally refugee camp.

HIW's quality checks form part of a new tailored 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 are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the practice manager, lead GP and the Head of General Medical Service - Sustainability for the Health Board on 08 June 2021 who provided us with information and evidence about their service. We used the following key lines of enquiry:

1. 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?

2. How effectively is the service able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?

3. What changes have been made in light of COVID-19 to ensure infection prevention and control standards are maintained?

4. How is the service ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely in terms of the practice environment and access appointments.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The COVID-19 pandemic assessment of clinical areas
- Cleaning schedules for the toilets
- Health Board cleaning policy

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told that at the beginning of the pandemic a number of key changes were made to adapt the environment to allow for social distancing and effective infection control. These included creating a one way system around the practice, limiting the number of patients that could be accepted in to the waiting room by asking patients not to arrive earlier than their appointment time, and arrangements to wipe down surfaces after use by patients. We were told that clinical staff collected patients when they were ready to be seen, and escorted them to the clinical rooms.

The practice manager told us that they monitored the environment on a daily basis.

We saw evidence that signage was placed around the practice and hand sanitising stations could be found on the entrances to rooms that we were sent images of.

We saw evidence that cleaning logs were being kept for both the staff and patient toilet, and we were told that all staff had been briefed on how to adequately clean the bathroom after each use.

We were told that the practice has remained open throughout the COVID-19 pandemic. Patients could request a consultation via eConsult[1] or over the phone. Should there be a clinical need, the patient would be invited to attend an appointment in the practice. We were told that if a patient was unable to use the eConsult of telephone system, the practice could accommodate requests for appointments by patients in person, but this was discouraged unless on a needs basis.

[1] eConsult is a medical app developed to allow GPs to offer online consultations to their patients

We were told that staff completed individual COVID-19 risk assessments[2] on a six monthly basis, unless a change in their health triggered a review.

The following areas for improvement were identified:

We were told that the practice does not keep cleaning logs for rooms other than the toilets. This was due to the burden this would place on staff. As a result we were unable to gather assurance that appropriate cleaning was taking place in all areas within the practice. This was dealt with through our immediate assurance process. We were assured by the practice and health board response to this issue, which included the introduction of checks and a house keeping review.

We were told that the practice could still undertake visits to care homes and patients homes when the need arose. However, we were told risk assessments had not been completed for clinicians specifically to undertake clinical duties away from the practice premises. Visits to care homes, patients homes and the Penally refugee camp were or had been undertaken, without a record of the assessment process undertaken. We were assured by the practice and health board response to this issue, which included assurance that visits and individual staff members were risk assessed as required.

We saw from the COVID-19 risk assessment of clinical areas that the practice had a dedicated "red" area[3] room, to isolate patients who were showing symptoms of COVID-19. However, we noted that the room was also used every morning for phlebotomy services and also for most clinical examinations by GPs in the afternoon for consultations. If a red room is identified in a practice, this room should be kept available as far as possible to minimise the risk a patient would need to be isolated elsewhere if this room was in use. This was dealt with under our immediate assurance process. We were assured by the practice and health board response to this issue, which included assurance that a suitable room was identified as a 'red room'. This room is now kept for this purpose only.

[2] The All Wales COVID-19 Workforce Risk Assessment Tool has been developed to help people working in the NHS and Social Care in Wales to see if they are at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus. The tool aims to help staff understand whether they may be at greater risk, and to help them and their line manager choose the right actions based on the level of risk.
[3] Red areas refers to dedicated areas or patient pathways with proven or suspected COVID-19.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Training data for staff (not inclusive of GPs) in infection prevention and control
- Cleaning schedules for toilets
- Health Board cleaning policy
- Staff temperature checks log

The following positive evidence was received:

We were told that the practice followed the Health Board policy for the prevention and control of infection. The policy has been amended to reflect the management of COVID-19.

The following areas for improvement were identified:

We were provided with information relating to infection control training which showed completion for some staff, however we did not receive evidence of GP training or up to date training for all staff. We were told that non-clinical staff had not received formal training on donning[4] and doffing[5] personal protective equipment (PPE)[6]. As these staff had the potential to be public facing, it is important that staff are adequately trained to ensure they protect themselves and patients. The practice must ensure that all training is easily accessible for all staff, and all staff undertaken regular training in infection prevention and control.

The health board provided us with assurance following the check that all staff were either trained or due to be trained imminently in infection control level 1. They also confirmed that all staff including administrative staff had received training in the donning and doffing of PPE. Further to this the health board also advised that they would be starting audits of PPE donning and doffing.

Aside from the Health Board COVID-19 risk assessment of clinical areas, we were not provided with evidence of any clinical audits as part of this process, including PPE or hand hygiene audits. Practices are required to undertake regular audits to ensure that effective clinical arrangements are in place to protect against the spread of infection. This was dealt with under our immediate assurance process. We were assured by the practice and health board response to this issue, which included the introduction of several audits. These audits covered a number of areas including cleanliness and PPE.

[4] "Donning" is the process of safely putting on personal protective equipment.
[5] "Doffing" is the process of safely removing personal protective equipment.
[6] Personal Protective Equipment is equipment that will protect the user and patient against risks such as the spread of infection.

We were told that cleaning schedules and logs were not completed or in place for all areas. There were logs available for the toilets but there were none available for clinical areas where patient care was delivered. This was not in line with the health board's policy on infection control and prevention. This was dealt with under our immediate assurance process. We were assured by the practice and health board response to this issue, which included the introduction of checks and a house keeping review.

The practice manager was unable to provide any evidence or assurances that staff had agreed to the latest version of the Standard Operating Procedure[7].

The COVID 19 environmental audit undertaken in December 2020 and revisited in April 2021, showed general improvement in many areas. However some remained incomplete or were not checked on the April 2021 audit. For example cleaning schedules not visualised, the isolation room was still being used for other purposes and some areas remained cluttered.

In light of the COVID-19 Pandemic, the need to ensure effective measures are in place should be a priority to ensure that patients are protected from COVID-19, along with other illnesses.

We were assured by the practice and health board response to this issue, which included revisiting the audit and associated action plan to ensure areas of concern were addressed. We will continue to liaise with the practice to monitor their progress in respect of infection control and prevention.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored how the service is working with other primary care teams (or services) and managing risks associated with Covid-19.

We did not review any key documents within this section.

The following positive evidence was received:

We were told that staffing levels had been well managed during the pandemic. Staff had worked on a rota basis where necessary to ensure social distancing could be maintained within the practice, and staff who were required to self-isolate or shield[8] could be protected.

[7] The Standard Operating Procedure (SOP) is a set of step by step instructions compiled by either the Health Board or the practice, to help employees carry out tasks to an agreed standard.
[8] Shielding, in relation to the COVID-19 pandemic, was a means by the Governments to protected the most clinically at risk people by not leaving their homes and minimising all face-to-face contact.

We were told that there was an array of support available via the local cluster[9] to ensure the sustainability of services during the pandemic and beyond. The cluster has actively worked with other services including pharmacies, other healthcare professionals, and secondary care to provide clear and easy to access pathways for advice and support.

The following areas for improvement were identified:

We were told that team meetings were beginning to come back in to the practice. With arrangements during the pandemic being via teams communications and informal discussions when staff were in the practice. However, we did not see evidence of meeting minutes. The practice must ensure team meeting minutes are kept to ensure staff can access the discussions when needed.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements 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 the areas for improvements 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.

[9] A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. **Clusters** are determined by individual NHS **Wales** Local Health Boards (LHB's). GPs in the **Clusters** play a key role in supporting the ongoing work of a Locality Network.

Improvement plan

Setting: Tenby Surgery

Service: GP

Date of activity: 08/06/2021

The table below includes improvements identified during the 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 they keep adequate records of staff agreement to the Standard Operating Procedure.	Health and Care Standards	A Standard Operating Procedure for the cleaning of the premises is being introduced, alongside regular training and supervision. A record of the agreement of the cleaning staff to the SOP will be retained in a file. This record will be shared as evidence.	Hotel Facilities supervisor Practice Manager	30/07/2021
2	The practice must ensure team meeting minutes are kept to ensure staff can access the discussions when needed.	Health and Care Standards	Clinical team meetings take place weekly (chaired by the GP Lead), and admin team meetings are held fortnightly. Minutes/action notes will be documented and made available to staff electronically	Practice Manager	30/07/2021

			and as hard-copy in a file. A sample copy of Minutes/action notes will be shared as evidence.		

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: Anna Swinfield

Date:24/06/2021