Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Riverside Surgery, Primary Care Resource Centre, Swansea Bay University Health Board

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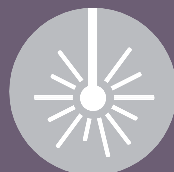

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

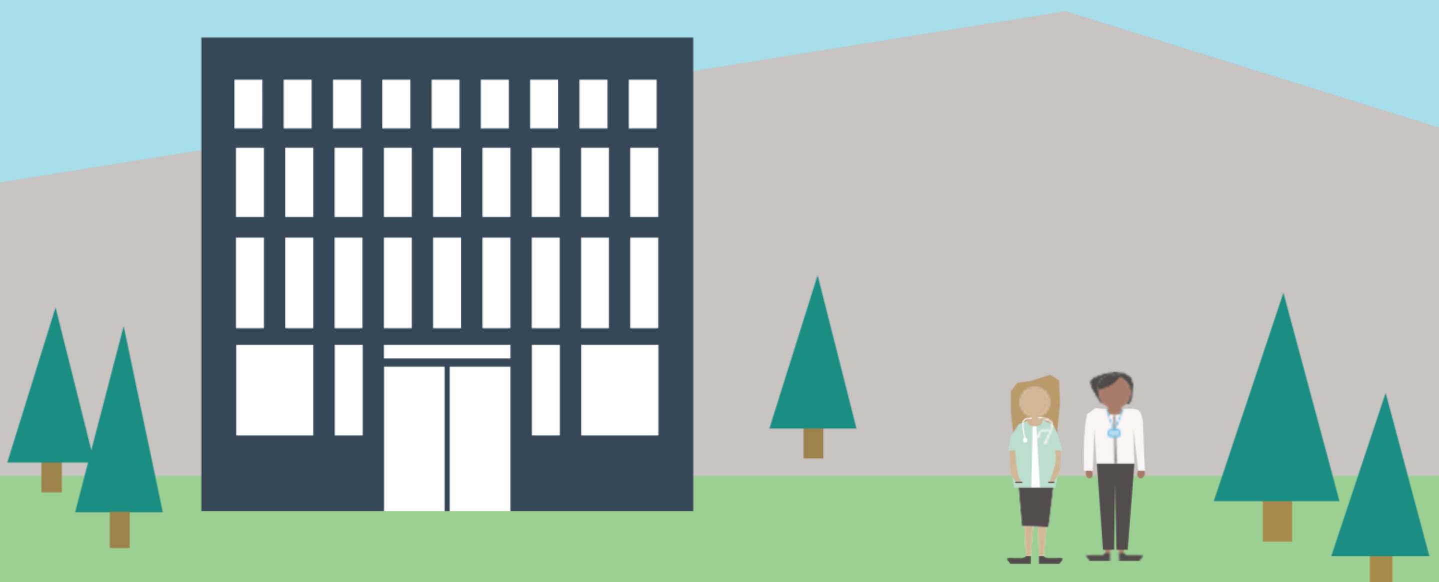
- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Riverside Surgery, Swansea Bay University Health Board on 1 August 2023.

Our team for the inspection comprised of one HIW Senior Healthcare Inspectors, a clinical peer reviewer and a practice manager peer reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 13 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patient responses received through HIW questionnaires were generally positive, with respondents rating the service as 'good' or 'very good'.

There was a good supply of health promotion information available and on display to patients. There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. The waiting room was spacious and the treatment areas were all situated on the ground floor. There was also a children and toddler area in the waiting room.

The practice had put a process in place to attempt to reduce the waiting times for patients calling the practice by telephone.

Whilst the reception and waiting area were calm, the reception desk was within the waiting room and there was potential for conversations to be overheard.

The process surrounding the offer of chaperones could be improved.

This is what we recommend the service can improve:

- Displaying and recording the offer of a chaperone
- Providing further privacy for patients at the reception desk.

This is what the service did well:

- Supply of health promotion information to patients
- Installing a new telephony system
- Level access for patients to the practice.

Delivery of Safe and Effective Care

Overall summary:
Overall, we found practice staff to be dedicated and committed to providing patients with safe and effective care. The practice was clean, well maintained and clutter free. All treatment rooms were well equipped and of a good size.

Whilst areas of good practice were noted, we did identify a small number of issues including linking medication to diagnosis. We also found an issue in relation to the regular checks of emergency drugs and equipment. This issue was dealt with under HIW's Immediate Assurance process.

Medical records reviewed were found to be generally of a good standard.

Immediate assurance:

- The emergency equipment and drugs had not been evidenced as checked between 23 December 2022 and 4 April 2023. Whilst the checking document stated that these checks should be carried out on the first of each month, this was not in accordance with the Resuscitation Council (UK) requirement to check these items weekly.

This is what we recommend the service can improve:

- Link medication to specific diagnoses.

This is what the service did well:

- Ensure all the areas within the practice were clean, well maintained and clutter free
- A clear flow of information within the practice from partners and to partners and management
- Well controlled medicines management.

Quality of Management and Leadership

Overall summary:
We noted that the practice had good leadership and clear lines of accountability. The staff team worked very well together and were committed to providing a high standard of care for their patients.

There was evidence of a comprehensive induction process, with good compliance to staff recruitment procedures. However, there were gaps present in mandatory training compliance.

The practice had comprehensive and up to date policies and procedures.

Team meetings were taking place with the relevant team leads.

This is what we recommend the service can improve:

- Staff compliance with mandatory training
- Advertising the complaints and feedback process and the results of the feedback.

This is what the service did well:

- Clear management of the practice
- Up to date policies and procedures

- Staff recruitment well managed.

Details of the concerns for patient’s safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

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. In total, we received 13 responses from patients at this practice.

Responses received through HIW questionnaires were generally positive, with all rating the service as 'very good' or 'good'. Most of the patients who answered were able to arrange a same-day appointment when they needed to see a general practitioner (GP) urgently, around half of the patients who answered said they could book routine appointments when they need them. All of the patients who answered were offered the option to choose the type of appointment they preferred and said that they were treated with dignity and respect. Most of the patients who answered said measures were taken to protect their privacy (9/11).

We received 4 comments about the service, and how it could improve. Some are below:

> *"The team are exceptional - a glowing team an asset not only to the practice but the NHS. Top class service and always has been."*
>
> *"More afternoon late appointments needed for workers long wait to get through to practice."*
>
> *"The phone system is like a lottery. The available telephone queue fills up in micro-seconds, the message says you are in a queue, but the receptionist is not actually answering the phones! It would be better to be honest and admit that or deal with the queue."*
>
> *"Always happy with my doctor, sometimes can't get to see him."*

Person centred

Health Promotion

Patients who used the service were able to access information to empower people to improve their health and lead a healthy lifestyle. Written information was

displayed in the resource centre advising patients of the other services they could access for health advice or treatment, such as their local pharmacy, NHS 111 and the minor injuries unit.

The practice engaged with patients to ensure that the information was available to the right patients through the self-help section on the practice website. This was maintained by the practice manager and the advanced nurse practitioner (ANP) who also maintained social media resources and the waiting room information television screen. We noted there was comprehensive information on the website that was easily navigable.

There were also a number of leaflets at the resource centre including information for carers and information on how patients could maintain a healthy lifestyle including stopping smoking. Some of this information was available bilingually in English and Welsh. The practice shared the resource centre premises with three other practices, district nurses, the mental health cluster lead, phlebotomy, audiology and physiotherapy, amongst others. There were shared appointment calendars regarding the minor illness scheme with local pharmacies, allowing the direct booking of patients. With regard to mental health promotion initiatives, there was a mental health community psychiatric nurse (CPN) available at the centre that the practice had access to. The practice had also started to plan for the winter flu programme.

The practice worked closely within the cluster, with allied professionals who also worked out of the same resource centre and other agencies. Patient attendance would be reviewed and contact made in cases of patients who repeatedly did not attend (DNA). We were told that DNAs were not a major problem at the practice.

All patients in the questionnaire agreed that there was health promotion and patient information material on display.

Dignified and respectful care

We saw during our inspection that staff at the practice treated patients and their representatives with respect and kindness. Doors to clinical rooms were closed when patients were being seen by general practitioners (GPs) or other healthcare staff. Clinical rooms had privacy curtains that could be used to provide additional privacy when patients were being examined. Clinical rooms were located away from the reception and waiting room, which helped prevent conversations from being overheard by people in the waiting room. There was also a children and toddler area in the waiting room. Additionally, telephone conversations were taken in the rear of the reception area and could not be heard from the reception desk.

Whilst the reception and waiting area were calm, the reception desk was within the waiting room. Therefore, there was potential for conversations to be overheard. We saw a room was available and could be used should patients wish to have private conversations with practice staff. All of the patients who answered felt they were treated with dignity and respect and most of the patients who answered said measures were taken to protect their privacy. However, the majority of patients believed that they could not talk to reception staff without being overheard.

The practice is required to provide HIW with details of the action taken to reduce as far as practicable the likelihood of patients' confidential information being overheard when they talk to reception staff.

We saw an up-to-date policy in place in relation to the use of chaperones. We were told that most of the staff had received chaperone training from the ANP. The newer members of staff would also be trained in the near future. The practice had only one male member of staff who would also be trained in the near future. Although available to all patients, there was no visible offer of this service within the practice, but it was advertised on the website.

A total of five of the six patients who answered the question, said they were offered a chaperone. Additionally, the offer of a chaperone was not documented on one of the six patient medical records checked.

The practice is required to provide HIW with details of the action taken to further make patients aware that they may request a chaperone during intimate examinations or procedures, according to their wishes.

The practice must document the offer of chaperones on patient medical records.

Timely

Timely Care

Care navigators followed a strict emergency policy to direct to an appropriate clinician. Training described as 'red flag' training was carried out which was scenario based and had been provided to all care navigators. A clinician would be informed if advice was given to redirect the patient to an emergency department or hospital. Actions taken were recorded and forwarded to the GP. Both the practice manager and ANP confirmed that all care navigators were given access to an appropriate clinician if they were unsure of any aspects of the process or advice to be given. We also saw the care navigation flow protocol documentation.

Arrangements were in place for more vulnerable groups who needed a face-to-face appointment. There was a hearing loop for those hard of hearing as well as use of language line, including if sign language interpreters were needed. Patient records flagged to the user of any special needs and information on this would be gathered by the care navigators.

Processes were in place to ensure patients could access care via the appropriate channel in a timely way, with the most appropriate person whether this was through a face-to-face appointment, by telephone and where appropriate by letter. The practice had responded to patient feedback (inability to get through on the phone) by purchasing a new phone system which allowed patients to request a callback, this was done automatically, rather than holding on the line for a long period. We were told there had been positive feedback on this from patients. The results of this feedback together with the changes made needs to be publicised to patients.

Where patients required an immediate appointment, but no further appointments were available, the call would be triaged by the on-call doctor as to whether it was safe to leave until the following day or the patient would be seen. Patients under 16 were automatically offered a face-to-face appointment.

The practice also had access to a number of third-party services, including MIND, a mental health charity and Silver Cloud, an online mental health service. These were accessible through the health board's social prescriber or mental health worker.

Regarding access to their GP, all bar one patient said that they were satisfied with the opening hours of this practice. Most of the patients who answered were able to arrange a same-day appointment when they need to see a GP urgently.

All of the patients who answered were offered the option to choose the type of appointment they preferred. All patients stated that they were content with the type of appointment they were offered, almost all of these were an in-person appointment. The majority of patients who said they had an ongoing medical condition, said they could access the regular support needed easily. All bar one patient knew how to access out of hours services if they needed medical advice or an appointment that could not wait until the practice was open. In all, 77% of patients said they were able to contact their GP practice when they needed to.

Equitable

Communication and language

Information was displayed within the waiting room. This included bilingual information together with a notice informing patients that if they wanted to speak to anyone in Welsh to let the practice staff know.

The practice recorded telephone calls and patients were informed of this as part of the introductory message. Calls would be retained on a cloud-based system for up to six months.

We were told that the practice passed messages to the appropriate member of staff via an online application for internal communications. There was a process to ensure read receipts were received for all emails. There were also regular meetings with staff. Communication within the practice team appeared to be well managed and information to patients were provided by various media.

There was a practice protocol in place for home visits, care navigators would follow this protocol and had access to the housebound register. Home visits would be carried out by the on-call doctor of the day.

Incoming mail would be recorded and scanned into the patients' medical summary, so that all clinical staff were aware of any new diagnosis or changes to a patient's condition. These would be summarised and forwarded to the clinician. There was a summarising policy in place which was in date and viewed during the visit.

The practice provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to the patient's individual needs to enable them to make informed decisions about their care. The practice did not currently have any Welsh speakers although three members of the team were signed up to Welsh classes as a means of addressing this.

Only one patient said that their preferred language was Welsh, but that they were not actively offered the opportunity to speak Welsh during their patient journey. However, they said that healthcare information was available to them in Welsh.

All bar one patient agreed in the questionnaire that the appointment was on time and that their medical details were checked, such as allergies and long-term conditions, before medication was prescribed. They all agreed that their identity was checked, with most patients agreeing that they were given enough time to explain their health needs.

Rights and Equality
The practice had an up-to-date written policy relating to equality and diversity. A training matrix provided to us showed equality and diversity training formed part

of the practice's mandatory training programme. It was also clear that staff understood equality and diversity.

There was level entry to the premises, making it accessible for patients, with free car parking directly outside the premises. This included designated car parking spaces for patients with mobility impairments, to help them access the premises safely. All clinical rooms were located on the ground floor together with the waiting room and toilets (including a wheelchair accessible toilet) with handwashing facilities. The reception desk also had a low-level desk for patients using wheelchairs.

All bar two patients said they could access the right healthcare at the right time, one patient commented "not always". No patients said that they faced discrimination when accessing or using this health service. All patients agreed that:

- The GP explained things well and answered their questions
- They were involved in decisions about their healthcare as much as they wanted to be
- They felt listened too.

All bar one said they were offered healthy lifestyle advice.

We also asked patients in the questionnaire about carer support. Only one said that they were a carer. Whilst they said they had not been offered an assessment of their needs as a carer, they said that the practice had given them details of organisations or support networks that could provide information and support.

Delivery of Safe and Effective Care

Safe

Risk Management

The premises were clean and well maintained both internally and externally, and all areas were free from obvious hazards. There was signage to advise patients and visitors of staff only areas. Suitable designated boxes were used to store medical sharps prior to their disposal. These were seen to be used safely and were located to reduce the risk of injuries.

The practice had a business continuity plan that had been reviewed and updated recently that was held on the shared drive. A copy was also held by the practice manager and ANP offsite. The plan covered the business partnership risk, as well as all clinicians and the practice manager. The practice could also operate from another practice at the resource centre if required.

The practice had a clear process for patient safety alerts. Learning from patient safety incidents would be discussed at practice meetings with the GPs and other clinical staff. Minutes of the significant event analysis (SEA) meetings would be shared amongst the practice.

Locums were provided with a locum induction pack, including a tour of the premises and systems. Locums not familiar with the practice and clinical system would visit the practice prior to the locum session. There was an established formal induction programme for all new staff, this was a two-week programme which included mandatory training.

There were panic buttons in the surgeries that were linked to the front reception. We were told that all clinical and non-clinical staff had been recently trained on where the emergency equipment was stored in addition to cardiopulmonary resuscitation training.

All patients said that the building was accessible and that there were enough seats in the waiting area, with toilet and hand washing facilities that suited their needs. They all agreed that the practice was 'child friendly'.

Infection, Prevention, Control (IPC) and Decontamination

The practice had an in-date policy for IPC, this included the process for needlestick injuries. The policy was held on the shared area where all staff knew where to find the information. Cleaning was managed centrally at the resource centre. The practice used single use instruments and there was appropriate use of

personal protective equipment (PPE) noted. A spill kit was available and locked in the cleaning cupboard. We were told that staff wore personal protective equipment (PPE) where and when appropriate. The PPE was kept in both the consultation rooms and in storerooms.

There was an infection control audit undertaken at the end of July 2023, with no issues identified.

We were told that the practice ensured that staff had received appropriate training in infection control, including mandatory training and brief learning interventions at lunchtimes.

All bar one patient said that there were signs at the setting explaining what to do if they were contagious and they all agreed that hand sanitisers were available and that healthcare staff washed their hands before and after treating them. All patients agreed that the practice was clean.

A series of questions were asked of patients relating to an invasive procedure, this included having bloods taken, injections and minor operations, five patients answered yes to this. They all agreed that staff wore gloves during the procedure, that the syringe, needle or scalpel used was individually packaged or sanitised and that antibacterial wipes were used to clean the patients' skin before the procedure.

Medicines Management

The practice had clear processes in place for medicines management. The practice ensured the safe prescribing of medication and employed a clinical pharmacist. Patients would request repeat medication through my health online or by a written request handed into the practice. These requests were managed by the team at the practice. The prescriptions were generated by the prescribing clerk (including a reminder letter if the reviews were out of date) and these would be signed by the duty doctor. The prescribing clerk would also inform the clinician or pharmacist about those reviews that were overdue.

Medications that were no longer being taken by patients would be removed from the repeat prescribing list. There was an audit of patients not requesting medications for more than 12 months and then the relevant item would be removed where appropriate. Where patients had requested a prescription for medication and had not collected the script, they would be contacted and asked why they had not collected these.

There were two cold chain fridges available in the nurses' rooms that were checked twice a day and the checker signed to evidence this check. Vaccines were stored

correctly and according to guidelines. We were told that the practice followed the national protocol in the event of refrigeration failing.

An examination of the records at the practice in relation to checks of the emergency equipment and drugs showed that they were generally conducted monthly up until 23 December 2022, but then there were three, monthly, gaps until the next check on 4 April 2023. The equipment and drugs had then been recorded as checked in the three months since that date. Whilst the checking document seen stated that the checks should be carried out on the first of each month, this was not in accordance with the Resuscitation Council (UK) requirement to check these items weekly. These were dealt with under our Immediate Assurance process.

There were arrangements in place for the safe storage of drugs at the required temperature, with refrigerated storage where necessary. All drugs were checked and in date. There were no controlled drugs on site. There was a robust system in place for the ordering, monitoring and generating of repeat medications in place. Whilst the dexametasone in the emergency drugs was yet to replaced when it went out of date in April 2023, this was due to issues with the supply of the medication.

The GPs used manual prescription pads for home visits with the relevant controls in place to account for the prescriptions. The prescriptions pads were stored in a locked cupboard. Unused named prescriptions pads would be returned to the health board prescribing team.

Safeguarding of Children and Adults
The policies, procedures and culture at the practice ensured that patients and staff were able to report safeguarding concerns. This included ensuring that safeguarding issues were appropriately investigated and action taken where necessary to protect the welfare of vulnerable children and adults. The practice had a safeguarding protocol in place, with one of the GP partners being the safeguarding lead, taking reasonable attempts to identify and flag vulnerable patients. Members of the wider practice team had received up to date training at the levels required according to their role. All clinicians were up to date with level three safeguarding training, including training in child protection and non-clinical staff had received training at least to level one.

Patients who did not attend the practice for an appointment would have the DNA recorded by a Read code in the patient notes and this meant they could be searched on the system. There was also a process in place to ensure that the practice was informed of emergency department attendance.

The practice had a protocol form to hand over information to the health visiting team which was part of the safeguarding policy that has observed during the inspection. All staff had access to the All-Wales Child Protection Procedures.

Records used by the practice had a clear marker attached to any children at risk. The marker would not be removed until a safeguarding meeting decided that the risk has passed. This process included looked after children.

Management of Medical Devices and Equipment

All clinical staff were responsible for checking medical devices and equipment daily, with electrical equipment having annual portable appliance testing and calibration annually. There were calibration logs and stickers on individual pieces of equipment, with an annual contract in place.

We were told that each GP maintained their own clinical bag for off-site patient visits.

There was an automatic external defibrillator (AED) available with age appropriate and in date pads that was kept by and maintained by the resource centre. Whilst this was not owned by practice, they had access to the equipment.

Effective

Effective Care

The methods used by the practice to keep up to date with best practice, national and professional guidance were explained. This included during annual appraisals, re-validation, e-learning for health, in-house teaching and mandatory training. We were told that staff were encouraged to complete continuing professional development through attendance on courses. There are five days study leave per year to allow for personal development. The ANP organised training both internally and for other practices in the resource centre if relevant or available. The staff notice board, internal memos and email circulation of guidelines were used to circulate information to staff.

Datix was used to report incidents and staff had received recent training sessions on how to use the system.

The process used for referrals was described; urgent referrals would be referred through the Welsh Clinical Communications Gateway (WCCG) and also by telephone directly to the speciality (plus consultant connect). Routine referrals would normally be completed at the end of the day by the referring clinician.

Patient records

We inspected six random sets of patient medical records drawn from the appointment book dated six weeks prior to the inspection. The overall quality of patient medical records was considered to be good. There were comprehensive records with clear recording of history, examinations, investigations and planned treatment, with evidence of the use of diagnostic Read codes. However, we noted that the reasons for starting and stopping medication were not easy to find. Where drugs were linked to conditions, the link was sometimes vague e.g omeprazole – gastroenterology, fluoxetine - Mental Health.

The practice must ensure that medication is linked to specific diagnoses and issues in patient medical records.

There was secure storage and compliance with the Data Protection Act 1998 and General Data Protection Regulations (GDPR). Old paper records were securely stored in a locked room near reception.

Quality of Management and Leadership

Leadership

Governance and leadership

There were clear operational systems and processes in place to support effective governance, leadership and accountability. Senior staff were clear about their roles, responsibilities and reporting lines. An organisational chart with reporting lines was seen at the practice. We were told that partner meetings were held every other week, minutes were seen covering for a sample of two months of these meetings. There were also monthly meetings held by the practice manager with staff. It was clear that the ANP and the practice manager had worked well together to manage the practice since the previous assistant practice manager had left.

The practice policies and procedures were stored online on the shared drive, to which all staff had access. The policies and procedures checked had all been reviewed recently. The review dates for these were held on the online diary system. Any policy or procedure changes would be communicated to staff through emails, online and though face to face as well as online meetings.

There was evidence of staff wellbeing programmes and the practice used an employee assistance provider and all staff were aware of the free and confidential mental health support for NHS and social care staff across Wales called Canopi.

The practice manager believed that the main challenges and pressures being faced by the practice had been sustainability over the past couple of few years. The manager stated that the issue with recruiting clinical staff had now stabilised with salaried GPs and new nursing staff in place. We were also told that representatives of the Royal College of General Practitioners were due to visit, to go over the sustainability model.

There was evidence that designated leads had been appointed for specific practice areas, these included safeguarding, IPC and clinical governance. A list was displayed within the staff areas.

Both partners were responsible for the clinical oversight in the practice. Clinical information was shared through the clinical system, email, meetings and informal discussions. Clinical meetings were held where any lessons learned discussed and information disseminated to staff.

Members of the practice team were also members of cluster sub-groups and they said they regularly attended cluster meetings.

The practice had a full repository of all practice policies and procedures, both clinical and non-clinical policies, which were held centrally on the shared drive. All policies included a date when reviewed, when due review and who was responsible for reviewing the various policies and procedures. The review dates were entered onto a diarised system to ensure they were completed six weeks in advance of the required date. Any changes to policies and procedures would be communicated to staff through emails, team meetings or face to face.

Workforce

Skilled and enabled workforce

We checked a sample of staff personnel files and these showed that references were sought and disclosure barring service checks were completed in advance of employment. Immunisation status of staff was maintained and revalidation and appraisal dates were also recorded. Relevant employment contracts were also held for staff. The central register of the Hepatitis B status of staff and the system for monitoring all relevant clinicians was up to date.

Whilst there was no formal workforce plan in place to ensure there was always appropriate capacity and skill mix of competent staff available when required, the practice manager ensured there was a good skill mix of staff available to work at the practice. We were told that a recent restructuring of the workforce had taken place and this was still under development.

Responsibilities for management, administration, accountability and reporting structures within the team were in place and clearly defined and understood by team members. We were told that there was evidence of workload allocation in accordance with staff members' individual scope of practice. Staff said that the practice listened to the needs of patients and offered services via trained members of the team.

We viewed the records for mandatory training at the practice and noted that the training levels in some areas were low, these included:

- Equality and diversity; 60% completion by non-clinical staff, nil for nurses
- IPC; 40% completion by non-clinical staff, all nurses had completed the training
- Manual handling; 50% completion by non-clinical staff

However, there was good compliance by staff in safeguarding to the required level, data security and fire safety. Additionally, there was also full compliance with basic life support.

The practice needs to inform HIW of the actions they will take to ensure full compliance with mandatory training.

Training was monitored by the practice manager on a training matrix.

Culture

People engagement, feedback and learning
Staff we spoke with said that the management and partners at the practice were visible and approachable. They also said that diversity and difference were valued at all levels of the organisation. Care navigators said the practice manager was accessible and answered queries promptly, they also felt that all staff were accessible.

Staff said that they were encouraged to speak up when they had new ideas or concerns. Staff we spoke with said they were proud to work for the service. They believed that the overall culture focussed on the wellbeing and needs of the staff and those using the services.

We viewed the complaints log and noted that there had been three complaints since April 2023, two were dated the end of June and responses were awaited from patients to the letter sent to resolve the complaint.

There was a complaints procedure in place which was in date and included reference to HIW. The procedure also included timescales and reference to the local Llais and Action against Medical Accidents. Sources of support and advocacy were also listed.

Whilst there was a leaflet in reception that was called the complaints process, the document 'Putting Things Right', the NHS complaints process, was not displayed.

The practice needs to ensure that 'Putting Things Right' is displayed in the reception and waiting area.

We were told that the practice had recently undertaken an assessment of patient views, of the access system, which would be repeated on a six-monthly basis. The practice had been interested in forming a patient participation group but this had not been formed at the date of the inspection.

Whilst the setting had reacted on the patient feedback, the results were not made known to patients.

The practice needs to ensure that the results of the feedback are displayed in the practice to inform patients of the results on a 'You said, we did' type board or similar.

Analysis of the questionnaire showed that only five patients were able to confirm that they had been asked by the GP practice about their experience of the service provided, although three could not remember. However, the majority of patients said they knew how to complain about poor service if they wanted to.

There was a policy in place relating to the Duty of Candour, which was in date. Staff were aware of the policy and had received training on the duty.

Information

Information governance and digital technology

Staff we spoke with were aware of the named data protection officer (DPO) and the practice subscribed to the DPO support service through Digital Health and Care Wales.

The practice had an in-date policy in place with a clear process for handling data.

Learning, improvement and research

Quality improvement activities

The practice had engaged in activities to continuously improve, by developing and implementing innovative ways of delivering care, through reviewing practices and continually looking for improvements. These included the diabetic clinic at the practice and work with the health board on a prediabetes project. This project was at its earliest stages, where, the dietician would search using the glycosylated haemoglobin test with HBA1C, to see if patients were slightly elevated and were at risk of developing type 2 diabetes. The dietician would host the appointments at the practice. This work was described as imminent, with letters to be sent out, including a pack to these patients with prediabetes.

There was evidence that clinical and internal audit was used to monitor quality at all levels. This included infection control and waste audits. The practice used an external organisation to undertake health and safety audits.

We were told that the practice received many patient complaints previously about being able to contact the practice by phone. The practice response was to install a

new telephony system which allowed for appropriate call-handling and management from the reception team.

The practiced also undertook significant event analysis for shared learning, the results would be cascaded within the team.

The ANP at the practice had also been awarded the title of Queen's Nurse. This award is given to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice.

Whole system approach

Partnership working and development
The practice was one of the GP practices in the Afan Health Cluster, located in the local health board area. Discussions with the management team indicated the practice worked collaboratively with the other health and care providers within the cluster.

We were told that the practice interacted and engaged with system partners via the cluster involvement and membership of cluster team sub-groups such as improving patient care.

4. Next steps

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 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 inspection.

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.

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: Riverside Surgery

Date of inspection: 1 August 2023

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
The inspection team examined the records at the practice in relation to checks of the emergency equipment and drugs, which were made available to them on the day of the inspection. We saw evidence of recorded checks of emergency equipment and drugs generally being conducted monthly up until 23 December 2022, but then there were three monthly gaps until the next check on 4 April 2023. The equipment and drugs had then been	The practice is to ensure that: • A reliable system of equipment checks and stock replenishment must be in place to ensure that equipment and drugs are always available and in date for use in an emergency situation • This process should be designated to named individuals, with reliable arrangements for cover in case of absence	The Practice has reviewed and updated the Emergency drug and equipment check policy. This policy follows the guidance issued by the Resuscitation Council UK. Named Nurses have been re-trained and issued with the responsibility of checking the emergency drugs and equipment, as per guidance and will be factored into the	Nikky Wallis Nurse Manager	Immediate

recorded as checked in the three months since. Whilst the document seen stated that the checks should be carried out on the first of each month, this was not in accordance with the Resuscitation Council (UK) requirement to check these items weekly. Our findings mean HIW was not assured that evidence of the checks of the emergency equipment and drugs were being conducted, which may result in required equipment not being available for use in the event of an emergency.	• The frequency of checks are at least weekly with regular compliance audits taking place.	Nurses rota with safety netting of Management Team cover if required. This will be checked on a weekly basis. A Resus Trolley checklist has been devised in line with Emergency Drug & equipment checking policy. A Trolley checklist will be completed each week by the responsible Nurse.		

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): **Nicola Gilbert**

Job role: **Practice Manager**

Date: **9 August 2023**

Appendix C - Improvement plan

Service: Riverside Surgery

Date of inspection: 1 August 2023

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
There was no visible offer of chaperones within the practice, but it was advertised on the website.	The practice is required to provide HIW with details of the action taken to further make patients aware that they may request a chaperone during intimate examinations or procedures, according to their wishes.	Several notices are displayed within the waiting room (situated in 3 areas) advising patient of the chaperone policy that is used by the Practice. Notices are also displayed in the corridors leading to the consultation rooms, along with the electronic patient information monitor.	Nicola Gilbert Manager	Immediate Completed

The offer of a chaperone was not documented on one of the six patient medical records checked.	The practice must document the offer of chaperones on patient medical records.	All Clinicians have been advised to document the offer to all patients of a chaperone when an intimate examination is required. A 'hotkey' has been installed on the clinical system which allows each Clinician easy and quick access to the relevant Read code for offering and decline of a Chaperone.	Nicola Gilbert Manager	Immediate Completed
In all, two thirds of patients disagreed with the comment that they were able to talk to reception staff without being overheard	The practice is required to provide HIW with details of the action taken to reduce as far as practicable the likelihood of patients' confidential information being overheard when they talk to reception staff.	Notices have been displayed at the main Reception advising patients to respect the privacy of the person in front of them. A second notice has been displayed advising patients that there is a private room where they can speak with staff if they require it. Staff have been made aware of this finding and will ensure their own voices are kept to a	Nicola Gilbert Manager	7 days

		minimum when conversing with patients at the Reception.		
The reasons for starting and stopping medication were not easy to find on patient records, particularly when drugs were linked to conditions, where the link was vague e.g omeprazole - gastroenterology.	The practice must ensure that medication is linked to specific diagnoses and issues in patient medical records.	Discussions with all to advise linking medications to diagnosis . Monthly audit to be undertaken on a small cohort of patients by each Clinicians. Review findings and feedback to Clinical Team.	Nikky Wallis ACP/Nurse Manager	14 days 28 days Quarterly
The records for mandatory training at the practice and noted that the training levels in some areas were low, these included: • Equality and diversity 60% completion by non-clinical staff, nil for nurses	The practice needs to inform HIW of the actions they will take to ensure full compliance with mandatory training.	Practice Team have been advised to complete all mandatory training. To prioritise: Equality & Diversity Manual Handling IPC	Nicola Gilbert	100% compliance by 15th October 2023

• IPC 40% completion by non-clinical staff, all nurses had completed the training • Manual handling 50% completion by non-clinical staff.		Staff will be issued with study time to complete by target date.		
Whilst there was a leaflet in reception that was called the complaints process, the document 'Putting Things Right', the NHS complaints process, was not displayed.	The practice needs to ensure that 'Putting Things Right' is displayed in the reception and waiting area.	A notice detailing the 'Putting things right' process will be placed in the main patient waiting area.	Nicola Gilbert	Immediate Completed
We were told that the practice had recently undertaken an assessment of patient views. Whilst the setting had reacted on the patient feedback, the results were not made known to patients.	The practice needs to ensure that the results of the feedback are displayed in the practice to inform patients of the results on a 'You said, we did' type board or similar.	A patient newsletter to be developed to advise patients of results of 2022/23 annual patient experience survey. This information will be displayed on social media platforms, Practice website and a paper newsletter will be	Nicola Gilbert	October 2023

		displayed in the main reception area. Annual patient survey to take place in November, December & January 23. Results feedback to be advertised to patients in March 2024.		March 2024

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): **Nicola Gilbert**

Job role: **Manager**

Date: **17 September 2023**