Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Tudor Gate Surgery,

Aneurin Bevan 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 Tudor Gate Surgery, Tudor St, Abergavenny NP7 5DL, within Aneurin Bevan University Health Board on 7 October 2019.

Our team, for the inspection comprised of a HIW inspection manager (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 evidence that Tudor Gate Surgery provided safe and effective care. The practice provided a modern, clean and accessible environment for patients. Patients reported a very positive experience in the practice and we found they were treated with dignity and respect. We saw the practice had good management and governance processes in place.

We found evidence that the practice was not fully compliant with all Health and Care Standards in all areas. This included concerns regarding information governance and some areas of patient record keeping.

We had immediate concerns for the delivery of safe and effective care. We found the checks on resuscitation equipment had not been completed at the required intervals. Also, we could not be assured that clinical staff had Hepatitis B immunity, GPs had completed the relevant level of safeguarding training, and all necessary staff had completed an enhanced DBS check.

This is what we found the service did well:

- Wide range of appointment times for patients
- Good range of literature and patient information
- Process in place to identify specific groups of patients
- Modern practice building that was very well maintained
- Safeguarding arrangements for children and vulnerable adults
- Wide range of policies and procedures that were clearly accessible
- Processes for staff induction and appraisals
- System to record and monitor staff training information.

This is what we recommend the service could improve:

- Promotion of the Welsh language and delivery of a bilingual service
- System to capture patient feedback and views
- Some aspects of fire safety including the need for a new external fire risk assessment
- Secure storage of patient identifiable information in line with GDPR
- Clear information for patients regarding the use of CCTV
- Some aspects of clinical record keeping
- Updating training information for all staff.

We had an immediate concern about patient safety that was dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. This was in relation to an aspect for the delivery of safe and effective patient care.

Details of the immediate improvement we identified are provided in Appendix B.

3. What we found

Background of the service

Tudor Gate Surgery currently provides services to approximately 8,700 patients in the Abergavenny area. The practice forms part of GP services provided within the area served by Aneurin Bevan University Health Board.

The practice employs a staff team which includes four GP partners, one salaried GP, one trainee GP, four nurses, two health care support workers, three pharmacy dispensers, three prescription clerks, a practice manager, an assistant practice manager and a team of reception and administrative staff.

Tudor Gate Surgery is a training practice.

The practice provides a range of services, including:

- General medical services
- Minor surgery
- Family planning
- Cervical smear tests
- Chronic disease management
- Travel clinic and vaccination service
- Antenatal clinic
- Health visitor clinic
- Dispenses medication for rural registered patients.

Healthcare Inspectorate Wales last inspected Tudor Gate Surgery on 10 August 2017. Key areas of improvement that we identified during the last inspection included the following:

- Formalising systems in place for patients to provide feedback on services
- Several aspects within the practice required improvement to ensure patients' privacy and confidentiality was suitably maintained
- Records and documents relating to infection control required implementation/updating
- Staff awareness of, and the practice's compliance with, health and safety law and policy required improvements. In light of the upcoming refurbishment work several health and safety aspects required immediate action
- Staff training in some areas required updating, for example, child and adult safeguarding. The current system of organising staff training made it difficult to monitor ongoing training compliance and identify training needs.

Since the previous inspection, the practice has undergone an extensive refurbishment and has a new practice management team in place. Therefore, during this inspection, we explored all areas of the Health and Care Standards (2015).

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.

Patients told us they were very happy with their care and were treated with dignity, respect and kindness by the practice team. We found that the practice placed an emphasis on providing a positive patient experience.

The practice provided good access to appointments with extended opening hours on two days a week. Appointments could be made in person, on the phone or online. We found some patients raised concerns with the ability to book appointments.

A good range of literature was available on third sector organisations, health promotion material and information for carers. However, there was a lack of practice information available in Welsh.

Arrangements were in place to provide dignified care that included a dedicated area for confidential discussions.

The practice provided good access to help promote patients independence. A process was in place to identify specific groups of patients.

We found the practice needs to introduce a system to capture patient views and 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. On the day of the inspection, the inspection team also spoke with patients to find out about their experiences at the practice.

In total, we received 41 completed questionnaires. The vast majority of the patients who completed a questionnaire were long term patients at the practice (those that had been a patient for more than two years).

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

> *"Nursing and reception staff are always helpful and pleasant. I am happy to see nursing staff instead of doctors as care from them has always been excellent"*
>
> *"Reception staff very friendly and nothing is too much for them very lucky to have such a great GP practice"*
>
> *"The doctors, nurses and healthcare staff are all amazing, friendly and always treat you with respect"*

Patients were asked in the questionnaires how the GP practice could improve the service it provides. Comments suggested for improvement included:

> *"More appointments on line"*
>
> *"Make it easier to book appointments in advance for working people"*
>
> *"Easier to make an appointment"*

Staying healthy

We saw there was a good range of information leaflets available for patients to read, in the reception of the practice. This included leaflets on wall mounted holders and on the reception desk, for the Meningitis Trust, Be Breast Aware, smoking cessation, cervical screening, and Macmillan Cancer Support.

We found a good range of information was displayed to promote the flu vaccination programme. This included a large banner on the outside of the practice, bunting on the windows and reception desk, and posters on consulting room doors.

A television screen in the waiting area provided a series of rolling adverts on health promotion and patient information. This included adverts for eating

disorders, and the Eatwell guide[1] which showed the quantity and type of food needed to achieve a healthy, balanced diet.

Advice and information for carers was clearly displayed and well presented on a designated noticeboard in the waiting room. This provided a comprehensive range of information, which included identifying the carers champion in the practice, information for young carers, signposting carers to collect a carer's identification and referral form from reception, and a poster for the outreach service provided by Hafal[2] to carers and those affected by mental illness.

Dignified care

Every patient who completed a questionnaire felt that they had been treated with dignity and respect by staff at the practice. All of the patients we spoke with told us they were treated with dignity and respect, and staff were kind and very approachable. Throughout the inspection we witnessed staff speaking with patients in a professional and friendly manner.

The practice had redesigned the waiting area to create a new room next to the main reception, specifically for confidential discussions with patients. The reception staff we spoke with told us the room was well used by patients. We were advised the facility was advertised on the television screen in the waiting area and in the patient newsletter. However, we did not see any signs showing this facility was available. The practice should consider installing signage in reception to ensure all patients are aware of the room to use for confidential discussions.

We saw there was a self check-in touch screen system near the main reception desk. The self check-in helped to enhance patient privacy by reducing potential queues, and stopped the need for patients to verbally confirm their details at reception.

[1] Eatwell Guide

[2] Hafal is a Welsh mental health charity supporting those affected by serious mental illness in Wales. Hafal helps people recover from serious mental illness.

We saw there was railing placed near the reception desk for patients to queue behind. A sign was displayed informing patients to wait behind the railing until they were called to the reception desk. We also saw information was displayed on the television screen in the waiting area. This informed patients there was a queuing system in place to enable patients to communicate with the receptionist discretely.

We did not see any information displayed in the reception, informing patients that they could take a chaperone into an appointment. However, we were advised it was included as one of the rolling adverts on the television screen. We found there were a number of staff trained to provide a chaperone service for patients, which aims to protect patients and healthcare staff when intimate examinations of patients are performed.

Improvement needed

The practice must ensure information is permanently displayed in the reception area, to inform patients a chaperone facility is available.

Patient information

We found the practice had a very informative and professional website that was easy to navigate. The website provided clear information across a range of areas including the practice team, opening hours, prescriptions and online services. The practice website promoted My Health Online[3]. This can assist patients to make appointments and request repeat prescriptions online. We were informed approximately 2,500 patients were registered for this service.

A patient information booklet was available for patients to take home. It included information on members of staff, opening times for the reception and dispensary, the process for making appointments, My Health Online and out of hours contact information. The majority of the patients who completed a questionnaire told us that they would know how to access the out of hours GP service.

[3] https://www.myhealthonline-emisweb.wales.nhs.uk/languages?returnurl=/

We saw a patient newsletter was available on the reception desk, and we were advised it was also provided on the website. The newsletter included an update on new staff in the practice, information for carers, information on Bowel Screening Wales and signposting to an activity organised by the Alzheimer's Society in the community.

The NHS Wales Putting Things Right[4] poster was displayed on several notice boards in reception, however we did not find any Putting Things Right leaflets available for patients to read and take away. The practice complaints procedure was printed on a leaflet, and was available in a wall mounted holder near the reception desk. The leaflet clearly identified the complaints lead as the practice manager, and the timescales and process for making a complaint. It also included sources of advocacy if a patient was dissatisfied with the outcome of a complaint. The sources of advocacy included the Public Health Services Ombudsman and Community Health Council. It did not include contact details for Healthcare Inspectorate Wales.

Improvement needed

The practice must:

- Ensure Putting Things Right leaflets are available for patients to take away in reception
- Ensure the complaints policy includes Healthcare Inspectorate Wales as a source of advocacy.

Communicating effectively

The majority of the patients who completed a questionnaire told us that they were always able to speak to staff in their preferred language. Every patient who completed a questionnaire felt that things are always explained to them during their appointment in a way that they can understand, and also told us

[4] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed “Concerns”. This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

that they are involved as much as they wanted to be in decisions made about their care.

We saw the self check-in screen had language options for English, Welsh, Polish and Chinese. We also saw some information was available bilingually for leaflets that were produced by the health board. However, we found there was not any surgery specific information available for patients in Welsh. We raised this with the practice as the need to provide patient information in English and Welsh was identified at the inspection in 2017. We were informed the practice had not progressed this, and would need to seek support from the health board as there were no expertise within the practice.

We found the practice had a hearing loop system installed to assist patients with hearing aids. A notice advertising this facility was clearly displayed on the reception counter and main entrance door. We were also advised that one member of the reception team had received training to be able to communicate with patients using sign language.

The staff we spoke with confirmed they could access a translation service if they needed to communicate with patients who did not speak English. We did not see a notice advertising the translation service in reception.

We found that all messages for the doctor, nurse or other health professional were recorded electronically on the clinical system and were linked to patient notes. We were advised nothing was completed on paper except prescription queries from patients, which may be written.

We saw there was a system in place to ensure all incoming clinical information was reviewed by a GP. We were informed that most of the clinical letters were scanned on the same day and read coded[5] at this point, and then distributed to the appropriate clinicians. We found that staff doing read coding were trained but there was no written protocol in place.

We found there were robust procedures in place to track and manage patient test results and medical investigations, when patients come into the surgery or received results via the reception staff.

[5] Read Codes are a coded thesaurus of clinical terms.

We found that the practice could remotely access the GP out of hours system, to enter patient information. This was completed by designated team members, and back up staff were available to provide cover during annual leave and sick leave. The use of remote access also enabled clinicians to review results and write up home visits at home if not attending practice the following day.

Improvement needed

The practice must:

- Ensure important practice information is available bilingually
- Ensure there is a written protocol in place for read coding clinical letters and correspondence.

Timely care

Nearly all patients who completed a questionnaire told us that they were very satisfied or fairly satisfied with the hours that the practice was open. The majority of the patients described their experience of making an appointment as very good or good, however, a quarter of the patients said it was not very easy or not at all easy to get an appointment.

We found that patients were able to book appointments in person, via telephone and online. The practice provided appointments from 08:00am to 6:00pm three days a week, with extended opening hours until 7:00pm on a Monday and opening on a Tuesday at 7:30am. The appointment system allowed patients to book morning appointments on the day, and pre bookable appointments in the afternoon.

Nearly all of the patients we spoke with, raised concerns with the appointments system however, they did state they could eventually get an appointment on the same day. Issues raised included not being able to get through on the phone, waiting a long time and waiting until midnight to book an appointment via My Health Online.

Individual care

Planning care to promote independence

All of the patients who completed a questionnaire felt that it was very easy or fairly easy to get into the building. The consulting and treatment rooms were all on the first floor of the building. Wheelchair users and people with pushchairs could easily access the practice via a dropped curb and ramp near the

entrance. We saw the reception desk and pharmacy desk incorporated low level areas that were accessible for wheelchair users. A spare wheelchair was available in the practice that we witnessed being used on several occasions.

We were informed of the process to identify patients with additional needs, by means of a flag system on the electronic patient record. This would alert practice staff, for example by identifying patients that were hard of hearing and / or visually impaired. We also found that patients with learning disabilities had an annual review by a GP that was recorded on the patient record.

We found the surgery was in the process of identifying specific groups of patients, which included ex-service people, Welsh speakers, and victims of domestic abuse. This was advertised on an advert on the television screen in the waiting area, which asked for patients to identify themselves. This information was then recorded in the patient records.

We found that currently, new patients were not asked about disability or any mobility issues as part of registration process. The practice should consider including this as part of the new patient registration process.

People's rights

We found that peoples' rights were promoted within the practice and saw staff treating patients with dignity, respect and kindness. Patients could be accompanied by relatives or carers during a consultation or treatment.

Listening and learning from feedback

We found there was limited options available for patients to submit comments and feedback. We saw a small notice on the patient newsletter which asked for feedback however, there was no suggestion box in the reception area. When we discussed this with some of the staff they felt a patient suggestion box in the reception waiting area would be a useful way to capture patient's views and suggestions.

We saw there was a Have your Say button available on the practice website. This led to a question on how likely patients are to recommend the GP practice to friends and family. The results online showed only ten responses had been received, of which seven stated a response as extremely unlikely.

The need for the practice to ensure there are systems in place that empower patients to provide feedback, was highlighted in our last inspection in 2017, however it had not been progressed.

Improvement needed

The practice must ensure there is a facility available to allow patients to provide feedback on the services provided.

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 building provided a very modern and clean environment to provide patient care. We found risk assessments were in place, however, we identified a number of improvements to fire safety.

Good arrangements were in place for infection control, however the practice must ensure the infection control policy is updated and reviewed annually.

Good arrangements were in place for the safeguarding of children and young people and the protection of vulnerable adults.

We found significant events were being discussed by the practice management team, so lessons can be learnt.

The practice had policies in place for GDPR, however we identified a risk where patient identifiable information may be compromised. Also, the use of CCTV on the premises should be clearly advertised.

Patient records were an acceptable standard, however we identified a number of improvements in this area.

We had a number of immediate concerns relating to patient safety that were dealt with under our immediate assurance process. This included more regular checking of resuscitation equipment, a lack of staff records confirming Hepatitis B immunity and no record of safeguarding training for GPs.

Safe care

Managing risk and promoting health and safety

We found the practice had undergone an extensive refurbishment that was completed in January 2018. The refurbishment was completed to create an improved patient experience, which included creating more space, improved access and enhanced facilities.

We saw that the corridors were clear of any clutter and hazards that may cause a person to trip and fall. We found the practice was very clean and tidy with modern fixtures and furnishings. The practice was very well maintained.

All of the patients who we spoke with agreed the practice provided a nice environment, and was clean and tidy. However, one patient told us they felt the bring lights hurt their eyes. Additionally, nearly all of the patient told us they felt the curved seating area looked modern, however we received several comments that the seats were uncomfortable.

We found a robust business continuity plan was in place, which included arrangements with a neighbouring practice. This ensured the practice is able to continue to deliver essential patient care and services, following a disruptive incident. We were informed the practice manager and GP partners all kept copies of the business continuity plan in their homes.

We saw there was a Health and Safety policy in place, which included the control of substances hazardous to health, a protocol for the use and disposal of sharps, and disposal of medicines and controlled drugs.

We found there were arrangements in place for fire safety that included weekly checks on risks and hazards. This was completed by the assistant practice manager, who was supported by another member of staff. The fire protection policy was clear and included the process for clearing the building during a fire and meeting at the designated fire assembly point.

We reviewed the practice documentation relating to fire safety, and found a record that showed an external fire safety company completed an inspection on all fire equipment in February 2019. This was an annual contract to complete the required servicing on fire safety equipment, which included both the water and carbon dioxide fire extinguishers. We also saw certification that showed the fire alarms had all been tested over a 12 month period.

We found an external fire risk assessment had been completed, and we saw a process was in place for monthly fire safety checks. However, the date of the

fire risk assessment was May 2017, which was before the extensive building refurbishments were completed. In addition, the paper record for completing monthly fire safety checks had not been updated in August or September 2019. We were advised by practice staff that the checks had been completed, however the folder had not been updated.

We could not see evidence of regular fire drills being completed, however some of the staff we spoke with could recall fire drills taking place. We reviewed the staff training information, which showed most members of staff had completed fire safety training. However, the majority of staff had completed mandatory annual fire safety training in June and July 2018, which was therefore now overdue. Training information was not available for the GPs, to evidence if the training had been completed.

Improvement needed

The practice must:

- Commission a new up to date external fire risk assessment
- Schedule regular fire drills for all staff
- Ensure all staff complete annual fire safety training.

Infection prevention and control

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

We saw bottles of hand sanitiser were available at various locations in the reception waiting area. Also sanitiser dispensers were located on several walls within the practice, which included next to the self check-in touch screen. This helped to reduce the risk for cross infection between patients coming into the practice. We saw there were various signs on the walls informing patients to use the hand gel, which included a sign next to the self check-in screen.

The treatment rooms and consulting rooms appeared visibly clean. We saw there was appropriate hand hygiene facilitates, such as hand wash and paper towels with appropriate bins, in the clinical areas.

We found there was a system in place for clinical waste to be securely stored until it could be safely collected and disposed of. The practice had a comprehensive clinical waste management protocol that was reviewed on an

annual basis, and had been reviewed in April 2019. We saw the locked clinical waste bin was kept in the car park. The bin was secured to the wall by a thin metal chain and padlock. The practice should consider replacing the chain with a more heavy duty replacement, to provide improved security for the clinical waste.

We found an infection control policy was in place, which identified the lead for infection control. However, the policy we saw showed it was created in May 2017, with a review date of May 2018. We saw a copy of the infection control audit from January 2019, which was completed on an annual basis.

The infection control policy highlighted that infection control training should take place for all staff on an annual basis, and would include hand decontamination, handwashing procedures, sterilisation procedures, the use of personal protective equipment and the safe use and disposal of sharps. We reviewed the staff training records and found nearly all staff had completed infection control training, however there was some staff that had completed it over 12 months ago. Training information was not available for the GPs to evidence if the training had been completed.

We asked to review the records for clinical staff's immunity to Hepatitis B, however, the records were not available. Therefore, we did not see evidence of staff immunity to Hepatitis B, to protect both themselves and patients against infection.

Our concerns regarding this 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:

- Ensure the infection control policy is reviewed and shared with staff on an annual basis
- Ensure all staff complete infection control training on an annual basis.

Medicines management

The practice both prescribed and dispensed medicines. The practice dispensary was for rural registered patients, to ensure they could access medicines without having to travel substantial distances.

The practice was supported by a community pharmacist that had been appointed by the local cluster[6]. They were able to assist the practice by carrying out patient medication reviews, and helping to identify training that is required in relation to prescribing medication. We also found the practice completed annual prescribing audits. Patients could access repeat prescriptions by calling into the surgery in person, and via the My Health Online website.

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[7] stipulate, that healthcare organisations and providers have an obligation to provide a high-quality resuscitation service.

We found that all emergency medicines were all in date, and the medical staff we spoke to knew where they were stored and how to access them.

We reviewed arrangements for the checking of resuscitation equipment, and saw records to evidence that monthly checks had been completed by staff. The Resuscitation Council defines the minimum frequency of checks for resuscitation equipment, as at least weekly. The lack of regular checks meant there was a risk to patient safety, because the resuscitation trolley may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency.

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

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

[7] Resuscitation Council UK Quality Standards for Resuscitation

We were able to see that cardiopulmonary resuscitation (CPR) training had been carried out for all staff in 2019 and was therefore up to date.

Safeguarding children and adults at risk

We found a GP partner was appointed as the safeguarding lead. This meant that staff had a local contact available, to report and discuss any safeguarding concerns. The staff that we spoke with were all aware who the named safeguarding lead was in the practice.

We saw the practice had policies in place for both child protection and the protection of vulnerable adults. The policies provided details on types of neglect and general indicators for safeguarding. We also found a flow chart was available from the health board to direct staff how to make a referral to the safeguarding team, which contained key contacts and telephone numbers.

We found that every month, meetings were held and minuted between the practice staff, GPs, midwives and health visitors. This forum helped to share information and identify any safeguarding concerns. We found there were clear arrangements in place to identify children at risk, which included an alert placed on the child notes.

We reviewed the staff training records for safeguarding. A training matrix showed safeguarding training for both children and vulnerable adults had been completed, or was planned for the majority of staff. However, there was no evidence available that any of the GPs had completed safeguarding training.

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

Effective care

Safe and clinically effective care

The practice had arrangements in place to record patient safety incidents and significant events. Significant events were documented on a comprehensive pro forma, and were regularly reviewed at significant event meetings, which included identifying any learning points that could be disseminated across the teams.

The practice maintained a paper folder to store all significant event reports. The sharing of safety alerts that were received into the practice was managed by the practice manager, who shared them with relevant staff via email.

We were informed the practice used Datix[8] infrequently. We found staff log in details had been arranged, however the use of Datix had not been fully implemented. We suggest the practice embeds the use of Datix for incident reporting and arranges the necessary training for team members.

The staff informed us of the arrangements for keeping the practice team up to date with best practice, and new National Institute for Health and Care Excellence (NICE)[9] professional guidance. This included the practice manager distributing NICE updates via email to GPs and any other relevant staff. We also found the lead nurse shared relevant information during weekly meetings.

Quality improvement, research and innovation

We were advised that the practice is part of the Neighbourhood Care Network (NCN), which is the term used for practice clusters within Aneurin Bevan University Health Board. We were informed that the NCN meetings were used as a forum to generate quality improvement activities and to share good practice.

We found the practice manager and a GP partner attended the cluster meetings, and had actively participated in a number of cluster based initiatives. This included a cluster pharmacist who attends the practice once a week, and a dietician provided by cluster to assist with educating patients and treating obesity at primary care level.

Information governance and communications technology

We found that practice had a number of policies in place regarding the General Data Protection Regulation (GDPR). This included the management of patient information and access to health records. We saw information leaflets were available on the GDPR, for patients to read and take away. We also found there was a dedicated section on the practice website regarding GDPR, which

[8] Datix is a bespoke incident management system that can support practices with recording and analysis of Significant Events.

[9] https://www.nice.org.uk/

included the practice privacy notice. This provided information for patients about how the practice processes patient data.

We identified an area in the practice where patient identifiable information was not stored securely and could potentially be accessed. This was a significant risk for the practice due to the legal requirements under the GDPR and Data Protection Act (2018).

We saw there were two doors from the main reception that led into a downstairs hallway, where GP mail drops were attached to the wall. Both of the internal doors had signs on stating no entry, authorised personnel only. However, the doors did not have locks fitted, and therefore meant that someone could potentially enter the area and access patient identifiable information. When we discussed this with practice staff, we were informed the architect who designed the refurbishment advised that the doors could not be locked as it was a fire exit. The fire exit door was positioned at the end of the downstairs hallway. We also found at one point during the inspection this door was left open, which led directly onto the patient car park. This created a significant risk of entry by unauthorised people, however we saw that when a member of staff noticed the door was open it was closed immediately.

We found that on the practice website there was information informing patients that Closed Circuit Television (CCTV) was installed at the practice premises. We found the practice had a CCTV policy and code of practice, however, we did not find any notices clearly displayed in the practice, informing patients on the use of CCTV.

We reviewed the staff training information, which showed most members of staff had completed information governance training. However, the majority of staff had completed annual mandatory training in June and July 2018, which was therefore overdue. Training information was not available for the GPs to evidence if the training had been completed.

Improvement needed

The practice must:

- Ensure the GP mail drop box is stored in a secure area to prevent any unauthorised access to confidential patient information
- Ensure signage is displayed in the practice regarding the use of CCTV
- Ensure all staff complete information governance training on an annual basis.

Record keeping

We looked at a sample of nine electronic patient medical records and found an acceptable standard of record keeping. The records were generally clear and could be easily followed to ensure the continuity of care between clinicians.

We saw the clinical findings were updated in a timely manner with a good narrative recorded of each contact. However, we found one record for an emergency appointment where it was unclear if a home visit had been undertaken or not, as the examination was not documented, and there was no clear management plan in place.

We found one record where a patient presented with flu like symptoms and lower abdominal pain, however there was no record of their temperature or an examination being performed on their abdomen.

We saw that in most cases prescribed medicines were linked to the appropriate conditions. However, we found one instance where diazepam was provided to a patient with alcohol dependency who would have benefited from referral to the Community Drug and Alcohol Team.

We found nearly all patients were provided with information about their condition and management options, so they could understand their own health and illness. However, in one case there was no discussion recorded regarding possible other diagnoses for a condition.

We found evidence that showed GPs had requested patient consent in the two instances where it was required.

We found there were two case records documenting an intimate examination where a chaperone should have been offered. However, there was no record of a chaperone being offered in one of these cases

We found there were designated staff for summarising patient notes and a good summarising protocol was in place. Summarising information helps ensure that GPs and nurses have easy access to a patient's relevant past medical history to help inform care and treatment decisions. We found the summarised notes were not reviewed or audited by a GP in terms of quality, and suggest the practice considers implementing this to ensure good standards are maintained.

Improvement needed

The practice must:

- Ensure home visits are clearly recorded in the patient notes
- Ensure records are fully updated to record all patient examinations that take place
- Ensure all patients are provided with information about their condition and possible alternative diagnosis
- Offer and record the use of a chaperone for intimate examinations.

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.

We found there were clear lines of management and accountability. The management team were enthusiastic and committed to improving the service.

A comprehensive range of policies was in place along with a process to monitor when policies needed to be reviewed. However, we found the paper policy folder required updating.

Good processes were in place for the induction of new staff, and for staff appraisals.

A robust system had been developed to ensure staff training information was up-to-date, and was easily accessible however, training records for GPs had not been updated.

We had an immediate concern relating to patient safety due to a lack of evidence that enhanced DBS checks had been completed for the relevant staff. This was dealt with under our immediate assurance process.

Governance, leadership and accountability

The practice manager was full time and had been in since November 2017. The practice manager was supported by a full time assistant practice manager. We found both members of staff to be very open to identify any areas of improvement and were keen to learn from the inspection.

We saw the practice had a comprehensive range of policies in place that were clearly written. The policies were stored on the local network drive and also printed out and held in folders. We found the assistant practice manager had

created a process to monitor and review the policies on a monthly basis, which identified any policies that were due for review, and if the practice manager had reviewed them. This information was stored on a local spreadsheet. We saw evidence that staff were reminded about the practice policies during appraisals and updates on policies were sent to staff via email.

When we reviewed the policy folder, we found that each policy had a date of creation, date of review and a section for the practice manager to sign to show it had been reviewed. We found that many of the policies had dates of review of 2018, and had not been signed. When we discussed this with the practice staff we were informed that when a policy was reviewed and no changes were made, which was often the case, they were not re-printed. However, the electronic log on the spreadsheet was updated to show the policy had been reviewed. We found this was potentially confusing for staff and therefore suggest the practice ensures all paper policies are updated or signed, to show they have been reviewed in the past 12 months and are therefore up to date.

We saw the practice had a whistleblowing policy, to provide employees with an avenue to raise concerns internally and receive feedback on any action taken. The whistleblowing policy identified regulatory and investigative bodies, which included contact details for Healthcare Inspectorate Wales and the National Patient Safety Agency.

We found regular meetings took place in the practice, which included team meetings for individual teams such as the nursing, dispensary and administration teams. We found minutes of team meetings were clear, and recorded all attendees and any staff who could not attend. We saw minutes of meetings were printed and clearly organised in folders. We were advised that staff members who cannot attend team meetings are sent the minutes via email or they could review the notes in the paper folders.

We found a comprehensive induction process was in place for new members of staff. This included a checklist that was completed to record that staff had been made aware of important areas, which included practice policies, fire safety, health and safety, information governance, safeguarding and infection control. We also saw there was a section on the staff appraisal pro forma, which recorded if the staff member was aware of where the practice policies were available online and in hard copy.

Staff and resources

Workforce

We found the practice had a recruitment policy in place that included a checklist on pre-employment checks. This included the completion of Disclosure and Barring Service (DBS)[10] checks for staff. We found that in staff folders there was a risk assessment for completing a DBS check, which included factors for if the employee worked alone, worked with vulnerable adults, delivered personal care or was involved in chaperone duties.

During our review of staff files we found the DBS checks were missing in some of the personnel files, which included checks for some clinical staff. This was evident for historic files, where staff members had joined the practice prior to the current practice manager being in post. We were informed that when the current practice manager took over in November 2017 there was a very limited paper trail available for HR information. Therefore, there may be some clinical staff working in the practice who had never completed an enhanced DBS check.

The need for an enhanced DBS check also applies to any administrative staff who have direct patient contact or undertook certain aspects with the role of a chaperone. This is necessary for safeguarding purposes for the protection of children and vulnerable adults.

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.

We found the assistant practice manager had developed a comprehensive log to record and monitor staff training information. This clearly identified all areas of mandatory and non-mandatory training, the date of completion, review period and date of review. We found that with the exception of the GPs, the majority of practice staff had completed all mandatory training, however as previously

[10] The Disclosure and Barring Service helps employers make safer recruitment decisions, by processing and issuing DBS checks. DBS also maintains the adults' and children's Barred Lists, and makes considered decisions as to whether an individual should be included on one or both of these lists and barred from engaging in regulated activity.

highlighted in the report, some of the annual refresher training courses were overdue, for example fire safety and information governance. We were advised that the GPs had likely completed all mandatory training, however, the training records had not been updated. We could not therefore be assured the GPs had completed all necessary training.

Staff were able to describe their roles and responsibilities and indicated they were happy in their roles. Staff told us they had annual appraisals and a sample of staff records supported this. We found appraisal documentation was very comprehensive and included a self-assessment, checks against the current job description and training objectives. The annual appraisal process will help identify any performance issues, and staff training and development needs. It also provides an opportunity for managers to give feedback to staff on their performance.

Improvement needed

The practice must:

- Ensure all staff complete annual refresher training courses for mandatory training
- Ensure staff training information is updated for all staff, which includes the GPs.

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: Tudor Gate Surgery

Date of inspection: 7 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.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action it will take to ensure that: The appropriate checks on the resuscitation equipment trolley will be completed and recorded at least weekly.	3.1 Safe and clinically effective care	Change has been made to ensure weekly checks are carried out on the Resuscitation trolley.	Practice Manager	October 2019
The practice is required to provide HIW with details of the action it will take to ensure that: A record is available to demonstrate the immunity status to Hepatitis B for all clinical staff working within the practice.	2.4 Infection Prevention and Control	Previous Hep B records have been located. Full team will be screened as appropriate over the next month.	Practice Manager	November 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action it will take to ensure that: All GPs working at the practice must complete safeguarding training to the minimum of level two, for children and vulnerable adults. The safeguarding lead is required to complete training to a minimum of level three.	2.7 Safeguarding children and adults at risk	Full review of safeguarding training levels is being carried out; having had a recent meeting where the RCGP safeguarding levels for the team were discussed. Training has been booked by the appropriate staff to attend external training sessions: with links to online training having also been issued. We have a more robust system of recording the training now (and we have found that staff are almost up to date with their training but we had not recorded it efficiently); this is being addressed. Mandatory and Statutory training compliance will be discussed with the individual at the annual appraisal.	Practice Manager and Assistant Practice Manager	Full review October 2019 – with completion by January 2020

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action it will take to ensure that: All clinical staff and any admin staff where applicable to their role e.g. acting as chaperone have completed an enhanced level DBS check.	7.1 Workforce	We have reviewed our HR files and found that most of the team have had the DBS check completed (they were not in the HR files, having been put elsewhere by my predecessor). The system for DBS checks has been reviewed for all staff and a couple who have not had the DBS check will have this processed immediately. Review of this will take place annually at staff appraisal.	Practice Manager	Full review October 2019 – with completion by end of November 2019

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): Sarah Lapping

Job role: Practice Manager

Date: 16 October 2019

Appendix C – Improvement plan

Service: Tudor Gate Surgery

Date of inspection: 7 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 ensure information is permanently displayed in the reception area, to inform patients a chaperone facility is available.	4.1 Dignified Care	A poster has been uploaded to the Waiting Room TV screen to inform pts about the chaperone availability	Practice Manager	Completed October 2019
The practice must: • Ensure Putting Things Right leaflets are available for patients to take away in reception	4.2 Patient Information	These will be printed & put on display in the patient waiting area.	Practice Manager	December 2019
• Ensure the complaints policy includes Healthcare Inspectorate Wales as a source of advocacy.		The complaints policy will be updated to include this contact information	Practice Manager	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must: • Ensure important practice information is available bilingually	3.2 Communicating effectively	The Health Board have a plan to offer a translation service for Welsh Language literature	Practice Manager	April 2020
• Ensure there is a written protocol in place for read coding clinical letters and correspondence.		We will put a protocol together for the read coding process	Practice Manager	December 2019
The practice must ensure there is a facility available to allow patients to provide feedback on the services provided.	6.3 Listening and Learning from feedback	Patient Feedback Forms have been put in the waiting room for patients to collect and complete. A Box has been put alongside to enable pts to put the completed forms themselves. A notice has been put on the waiting room TV screen informing pts of this form	Practice Manager	Completed October 2019
Delivery of safe and effective care				
The practice must: • Commission a new up to date external fire risk assessment	2.1 Managing risk and promoting health and safety	Fire Risk Assessment has been carried out	Practice Manager	Completed 15th October 2019
• Schedule regular fire drills for all staff		Fire Drill carried out (23.10.19) & Fire Drills diarised for 2020	Practice Manager	Completed October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Ensure all staff complete annual fire safety training.		Training schedule updated with deadlines given to the team for their online training. External fire safety training scheduled for Jan/Feb 2020 with fire officer coming to site to carry out the staff training	Practice Manager	Online training to be completed by 31.12.19 – Fire Officer training will be booked Jan/Feb 2020
The practice must: • Ensure the infection control policy is reviewed and shared with staff on an annual basis • Ensure all staff complete infection control training on an annual basis.	2.4 Infection Prevention and Control (IPC) and Decontamination	Policy is due for review January 2020 This training item is down as part of one of their annual mandatory training subjects	Lead Nurse – IPC lead Practice Manager	January 2020 January 2020
The practice must: • Ensure the GP mail drop box is stored in a secure area to prevent any unauthorised access to confidential patient information	3.4 Information Governance and Communications Technology	New fire safe door key pads are being fitted to the two doors which lead to the staff corridor (near the back staff entrance) on 3.12.19 – this will be wired to the fire alarm. This will ensure non-staff are unable to gain access to the upstairs offices or to the GP mail boxes located in this corridor.	Practice Manager	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Ensure signage is displayed in the practice regarding the use of CCTV • Ensure all staff complete information governance training on an annual basis.		Poster to be uploaded to the TV screen in the waiting room informing pts of our CCTV usage Staff training schedule updated with deadlines to complete all mandatory training (incl. IG training)	Practice Manager Practice Manager	December 2019 January 2020
The practice must: • Ensure home visits are clearly recorded in the patient notes • Ensure records are fully updated to record all patient examinations that take place • Ensure all patients are provided with information about their condition and possible alternative diagnosis	3.5 Record keeping	Review of processes at Management meeting, where the 3 items listed will be discussed	Practice Manager	November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Offer and record the use of a chaperone for intimate examinations.		Chaperone notice has been uploaded to the waiting room TV screen, ensuring pts are aware of this service. When a chaperone is used this is recorded by the clinician on the pt record. If a chaperone is offered but declined this is also recorded on the pt notes.	Practice Manager	Completed – October 2019
Quality of management and leadership				
The practice must: • Ensure all staff complete annual refresher training courses for mandatory training • Ensure staff training information is updated for all staff, which includes the GPs.	7.1 Workforce	Training schedule has been updated with each staff member being given a list of their outstanding training, along with deadlines for completion. HR files will be updated with training certification for future reference. GPs to be included in the training records as above	Practice Manager & Assist Practice Manager	December 2019

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): Sarah Lapping

Job role: Practice Manager

Date: 25.11.19