

Quality Check Summary

Waterside Medical Practice

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Waterside Medical Practice (the practice) as part of its programme of assurance work. The practice is one of two practices operating out of Briton Ferry Health Centre and they provide a range of primary care services to the people of Briton Ferry and surrounding areas. The four partners also run two other practices in the local area.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

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

We spoke to the practice manager on 6 May 2021, who was accompanied by one of the partners, who provided us with information and evidence about their service. We used the following key lines of enquiry:

- How has the practice, and the services it provides, adapted during this period of COVID-19? What is the practice road map for returning to pre-COVID-19 levels of services?
- How effectively is the practice able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?
- What changes have the practice implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How is the practice ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely?

Environment

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

The key documents we reviewed included the most recent COVID-19 risk assessments of the environment. We also questioned the service representatives on the changes they had made to make sure patients continued to receive care and treatment according to their needs.

The following positive evidence was received:

The practice manager described the changes that had been made to the environment in light of the pandemic. This included signing up to askmygp¹, an online platform. We were told that this led to an increase in capacity with more clinician appointments available. There was a one way system in operation for the movement of patients within the practice, with two metre markers on the floor to ensure social distancing. Seats were also cordoned off, to limit the number of patients in the practice. Additionally, we were told that a stud wall had also been installed to assist with the one way process and social distancing. Physical access to the practice was also restricted and measures were introduced to reduce footfall, such as sending prescriptions directly to the relevant pharmacy and mailing sick notes.

The practice manager stated that they were able to keep the practice open due to the adherence with social distancing and other measures. These included staff members sitting two meters apart. There were large perspex screens in place between work stations as an extra precaution. Masks were worn at all times while moving around the building and the partners operated a zero tolerance policy of non-compliance from staff. During the height of the pandemic, we were told that all staff were supplied with medical grade scrubs, which they still used. Staff changed into scrubs when they arrived at work and later changed out of the scrubs in a dirty area before departure.

We were told that the practice at Waterside had become a red area, patients with suspected COVID-19 and patients discharged from hospital with COVID-19 were seen here. The building was owned by the health board who also facilitated some of the changes. Consequently, we were told that the health board completed the environmental risk assessment. We were also provided with copies of the COVID-19 risk assessment carried out, using a document provided by the Health and Safety Executive, which included the actions being carried out. Additionally we saw the action plan to rectify any issues.

For patients, where COVID-19 was suspected or there had been symptoms, we were told that

¹ askmyGP is an online consultation and workflow system that helps GPs manage patient caseload through operational change and digital triage. We make it easier for patients to talk to their own doctor and help GPs to prioritise and deliver care through message, phone and video.

two treatment rooms had been allocated with limited items in the room, to make cleaning the room easier. Clinicians asked the patients the relevant COVID-19 questions, prior to allowing the patient into the practice. A blood test was then carried out on the patient with the results being returned in five minutes. Patients then stayed in the car, or outside the practice, until the results were obtained.

The system that was being used for patients to currently access appointments was described. Patients were questioned to decide who would be the most appropriate person to answer the call. There was also a triage system, with a clinician, to decide who needed a phone consultation and who needed face to face treatment. Online methods such as anonymised photographs were also used to help identify ailments.

We were informed that patients who were shielding were not asked to attend the practice, where necessary they were offered home visits, including from a district nurse. We were told that the practice were also concerned where they had not had contact from shielding patients and they had been actively contacting these patients and sent them food parcels.

The practice manager told us that the practice had access to a language line for those who were unable to speak English. There were notations in clinical records where patients had difficulty in communicating.

No areas for improvements were identified.

Infection prevention and control (IPC)

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

The key documents we reviewed included:

- Generic infection control policies and Covid-19 specific policies
- Cleaning schedules
- Training data for staff in infection prevention and control.

The following positive evidence was received:

The process used to ensure there were sufficient supplies of personal protective equipment (PPE) was described. We were told that the health board had difficulty in providing plastic aprons initially. The practice manager stated that they sourced their own PPE as well as purchasing scrubs², a washing machine and wash bags. The washing machine was used by

² Scrubs are the sanitary clothing worn by surgeons, nurses, physicians and other workers involved in patient care in hospitals. Originally designed for use by surgeons and other operating room personnel, who would put

staff, following correct washing procedures. These facilities were still in place, in case there was a further outbreak of COVID-19 locally.

We were told that one of the partners, who had previous anaesthetic experience, made a video to assist staff in being confident and competent at using PPE as well as holding tutorials on the subject. This training followed advice from the British Medical Association³ (BMA). Clinicians used PPE based on guidelines, with administrative staff using scrubs and masks when moving around the practice. The additional that training followed, to support staff to deliver effective care during the pandemic, was described. The general practitioners (GPs) completed self-directed online training and relevant information was sent to staff with read receipts to ensure they had opened the documents. Verbal updates were also given when changes were made to the guidance.

We were provided with the IPC training records that showed that all staff at the practice had completed IPC training. For the clinical staff, the evidence showed that they completed IPC level two training through NHS Wales. Non-clinical staff completed in-house training on hand decontamination, hand washing procedures, sterilisation procedures, the use of PPE and the safe use and disposal of sharps.

The practice manager stated that clinicians who were required to complete home visits were risk assessed before they went on home visits, to reduce the risk of being infected by COVID-19. Additionally, we were told of the precautions that had to be taken at the patients' home before and during the visit. These included other members of the family being in a different rooms and any history was taken over the phone prior to the visit. The visit inside the home only involved the examination of the patient. The result of the consultation would then be discussed over the phone outside the patients' home. Additional PPE was supplied, for the home visit, which included visors and FFP3⁴ masks.

We were told of the changes that were made to the cleaning of the practice. Receptionists were responsible for their own work areas and staff were confined to one desk. Where there had been a patient in the practice with COVID-19, rooms were fogged⁵ to control the spread of COVID-19. The cleaning for the practice (and the wider health centre) was carried out by an outside contractor. We were provided with evidence of the cleaning schedules for the last three months, which showed that the cleaning followed the agreed contractual requirements. We were told that staff had access to disinfectant sprays and wipes as well as hand cleaning gels.

them on when sterilizing themselves, or "scrubbing in", before surgery, they are now worn by many hospital personnel. Their use has been extended outside hospitals as well, to work environments where clothing may come into contact with infectious agents

³ The BMA represents, supports and negotiates on behalf of all UK doctors and medical students.

⁴ The need for FFP3 Mask (oral nasal disposable mask respiratory protection) to be worn is identified through clinical risk assessment. The mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency.

⁵ <https://www.hse.gov.uk/coronavirus/disinfecting-premises-during-coronavirus-outbreak.htm>

The current IPC policy, which was provided as evidence, also referred to the principles outlined in the practice Infection Control (biological substances) Protocol and the Infection Control Inspection Checklist.

We were informed that there had been a small outbreak of COVID-19 in the practice during the pandemic. We were provided with evidence from the health board that stated that there had been very positive feedback from Public Health Wales, on the precautions taken. They were also assured by the IPC and social distancing measures in place across the three practices. Additionally, we saw the COVID-19 risk register that showed the actions being taken depending on the level of risk. These included the risks associated with the increased footfall at the practice for vaccinations and moving high risk staff to a call centre type approach of working remotely, or in one socially distanced location. All staff were risk assessed individually by the practice GPs, to check on any underlying health conditions. We were told that two members of staff had initially taken up the offer of not having to work at the practice, they had both now returned to work at the practice.

No areas for improvements were identified.

Governance / Staffing

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

The key documents we reviewed included:

- Business continuity plans
- Risk assessments undertaken in relation to IPC, environment and staff health and safety.

The following positive evidence was received:

We were told that the health board had informed the practice to stop any enhanced services⁶ or Quality Assurance Improvement Framework (QAIF)⁷ requirements. We were also told that whilst Vitamin B12 injections⁸ were changed to an oral method on prescription, where this was not effective, patients were still given the relevant injection. The practice manager told

⁶ Enhanced services form the third tier of services in the contractual framework and are commissioned and funded by Health Boards in Wales.

⁷ https://gov.wales/sites/default/files/publications/2021-02/directions-to-local-health-boards-as-to-the-statement-of-financial-entitlements-directions-2021_0.pdf

⁸ The treatment for vitamin B12 or folate deficiency anaemia depends on what's causing the condition. Most people can be easily treated with injections or tablets to replace the missing vitamins. Vitamin B12 deficiency anaemia is usually treated with injections of vitamin B12.

us that they continued to provide enhanced services during the pandemic.

We were told that as well as the GP partners, the practice also used three regular locums. In addition the practice multi-disciplinary team included two clinical pharmacists and one muscular skeletal⁹ practitioner. The nursing team included three practice nurses and two healthcare support workers. The practice does not currently have any job vacancies.

The cluster¹⁰ arrangements were described. The practice is part of the Neath Cluster Network. The cluster is made up of eight surgeries in the surrounding area and recently also included a larger network of pharmacy, optometry, dental, district nursing, health visiting and third sector organisations. The evidence provided showed that the cluster had recently employed a cluster development manager who was instrumental in pushing through various projects, including a cluster based paramedic and pharmacist. Other initiatives that the cluster had completed were also described, including working collectively to vaccinate patients in care homes with the COVID-19 vaccine.

We were provided with evidence of the staff team meetings, where the QAIF, prescribing, overtime, staff and issues log as well as any other business was discussed. In addition, we were told that information was passed to staff within the practice through smaller meetings and secure messaging groups.

The practice partner described the arrangements in place to ensure a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)¹¹ discussion and decision making was undertaken appropriately and sensitively. This included GPs having responsibility for the patient and family discussion. This discussion was carried out remotely and the GP would complete and distribute the relevant documentation, for example to the out-of-hours service¹². The Welsh Clinical Portal¹³ was used to ensure that data and information relating to patients, including COVID-19 information, was known and passed on to the relevant parties.

Copies of the practice COVID-19 - Business Continuity Plan were seen. The aim of this document was to provide guidance and advice in preparation for a pandemic such as coronavirus or where the practice felt that it was no longer safe to practice in an outbreak. This brief document provided prompts if there were severe disruptions.

We discussed with the practice manager how effectively the practice and patients were able to access wider primary care professionals and other services such as mental health teams, secondary care and out-of-hours. We were told that there had been minimal contact with

⁹ The human musculoskeletal system is an organ system that gives humans the ability to move using their muscular and skeletal systems. The musculoskeletal system provides form, support, stability, and movement to the body.

¹⁰ A cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally.

¹¹ <https://www.nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/>

¹² The arrangements to provide access to healthcare at times when GP surgeries are closed.

¹³ <https://nwis.nhs.wales/systems-and-services/secondary-care/welsh-clinical-portal/>

secondary care during the pandemic, as very few patients had to be referred to this service. Additionally, we were told that the practice created links with the mental health teams and referrals continued as normal.

Communication and arrangements with out-of-hours services were described as being mainly electronic, but there were delays in receiving information. Whilst the practice were attempting to ensure they received the relevant information, they felt that they were receiving insufficient information from emergency departments at this time. Additionally, we were told that the relevant information relating to patient discharges was not being received in full. Whilst some hospital consultants were proactive in sending information, some discharge summaries were being given to patients and not always received by the practice. This included the practice not being aware of the medication prescribed to patients. We were told that this has been discussed with the local management committee (LMC)¹⁴ and the practice had recorded these issues on Datix, the system used to record incidents.

The following areas for improvement were identified:

We were provided with evidence that showed that the non-clinical staff had completed training that was in date including basic life support, IPC and General Data Protection Regulations (GDPR)¹⁵. However, we also noted that the safeguarding training for non-clinical staff was no longer in date. Whilst we appreciate that factors such as the pandemic, lack of training availability and other pressures may have affected this, we believe that this training should be kept up to date for staff. We were told that the practice has planned for this training in July 2021.

The practice should ensure that a process is put in place to ensure that the training of all staff, once the requirement is identified, should be kept up to date.

¹⁴ LMCs are local representative committees of NHS GPs and represent their interests to the NHS health authorities.

¹⁵ <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/>

What next?

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

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: Waterside Medical Practice

Service: Waterside Medical Practice

Date of activity: 6 May 2021

The table below includes improvements identified during the Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	We were provided with evidence that showed that the non-clinical staff had completed training that was in date including basic life support, IPC and General Data Protection Regulations (GDPR). However, we also noted that the safeguarding training for non-clinical staff was not in date. We were told that the practice have	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk. Standard 7.1 Workforce	Safeguarding training to be completed by all staff - evidence of those completed in LW to be provided in additional documentation supplied. Training now to be undertaken online as to reassure HIW that training has been done training for JULY F2F is dependent on Covid Guidelines,	Roisin Jones	Completed by June 30 th

arranged this training for July.			
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The practice should ensure that a process is put in place to ensure that the training of all staff, once the requirement is identified, should be kept up to date.			
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The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: Roisin Jones

Date: 26/05/2021