NHS
Leicester City
Clinical Commissioning Group

NURSING AND QUALITY TEAM

Title of the report:	Outcomes of CQC inspections in GP practices
Author:	Manjit Singh, Quality Officer
Presenter:	Manjit Singh, Quality Officer
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1. Purpose of Report

1.1 The purpose of this report is to summarise the outcomes of CQC inspection of GP services between September 2013 to the end of March 2014, so that the reasons for aspects being identified as good practice and reasons why other aspects were deemed not to be compliant with key standards can be used to support continuous professional development and service improvements.

1.2 This report covers the areas and standards inspected by the CQC, the outcome of inspections completed between September 2013 and the end of March 2014, summary bullet points by standard of the aspects identified as good practice and those found to be non-compliant, and two annexes providing detail of good practice and non-compliance from the inspection reports. Individual GP practices are not identified.

2. Background

2.1 General Practitioner (GP) services are usually the first point of contact for a patient seeking healthcare; they treat patients; and they refer them on for further care or treatment. They play a vital role in making sure that people's care is properly organised when more than one type of care service is involved, eg, when people leave hospital and are visited in their own home by a district nurse. Practices are often at the centre of a network of local community-based services, working closely with both NHS and social care providers.

2.2 Because of their vital role, a poor quality GP practice can have serious consequences for the health and wellbeing of a large number of people. To address this the Care Quality Commission (CQC) monitors, inspects and regulates GP services to make sure they meet fundamental standards of quality and safety, so that people have access to health provision that is safe, effective, compassionate, high quality and improving. The CQC's approach is to focus on identifying non-compliance against key national standards, although where there is compliance it is described to provide a balanced view when the CQC reports its findings and judgements. The CQC's first 1,000 inspections of GP surgeries across England have demonstrated that there are a minority of practices providing unacceptable care that need to improve, as well as some good and outstanding practices.

2.3 Inspections take place against sixteen key standards in five areas. The five areas are:

1. Standards of treating people with respect and involving them in their care
2. Standards of providing care, treatment and support that meets people's needs
3. Standards of caring for people safely and protecting them from harm
4. Standards of staffing
5. Standards of quality and management

2.4 The sixteen standards are:

Area 1:	**Standards of treating people with respect and involving them in their care**
St 1	**Respecting and involving people who use services -** People should be treated with respect, involved in discussions about their treatment and able to influence how the service is run
St 2	**Consent to care and treatment** - Before people are given any examination, care, treatment or support, they should be asked if they agree to it
Area 2:	**Standards of providing care, treatment and support that meets people's needs**
St 4	**Care and welfare of people who use services** - People should get safe and appropriate care that meets their needs and supports their rights
St 5	**Meeting nutritional needs** - Food and drink should meet people's individual dietary needs
St 6	**Co-operating with other providers** - People should get safe and coordinated care when they move between different services
Area 3:	**Standards of caring for people safely and protecting them from harm**
St 7	**Safeguarding people who use services from abuse** - People should be protected from abuse and staff should respect

	their human rights
St 8	**Cleanliness and infection control** - People should be cared for in a clean environment and protected from the risk of infection
St 9	**Management of medicines** - People should be given the medicines they need when they need them, and in a safe way
St 10	**Safety and suitability of premises** - People should be cared for in safe and accessible surroundings that support their health and welfare
St 11	**Safety, availability and suitability of equipment** - People should be safe from harm from unsafe or unsuitable equipment
Area 4:	**Standards of staffing**
St 12	**Requirements relating to workers** - People should be cared for by staff who are properly qualified to do their job
St 13	**Staffing** - There should be enough members of staff to keep people safe and meet their health and welfare needs
St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills
Area 5:	**Standards of quality and suitability of management**
St 16	**Assessing and monitoring the quality of service provision** - The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
St 17	**Complaints** - People should have their complaints listened to and acted on properly
St 21	**Records** - People's personal records, including medical records should be accurate and kept safe and confidential

3. Position

3.1 Between the months of September 2013 and the end of March 2014 the CQC have undertaken thirteen inspections and published reports of GP practices located in the Leicester City CCG area.

3.2 In five of these inspections all standards across the five areas that were inspected against were met. Good practices was identified in nine standards across these five inspections. The details are as below:

1. **Standards of treating people with respect and involving them in their care**
   St 1 Respecting and involving people who use services **x 4**
2. **Standards of providing care, treatment and support that meets people's needs**
   St 4 Care and welfare of people who use services **x 5**
3. **Standards of caring for people safely and protecting them from harm**
   St 7 Safeguarding people who use services from abuse **x 3**
   St 8 Cleanliness and infection control **x 2**
   St 9 Management of medicines **x 2**
4. **Standards of staffing**
   St 12 Requirements relating to workers **x5**
   St 14 Supporting workers **x 1**
5. **Standards of quality and management**
   St 16 Assessing and monitoring the quality of service provision **x 4**
   St 21 Records **x 1**

3.3 In each of the remaining eight inspections between one and six standards were not met across the five areas. In these eight inspections ten standards did not meet the required outcomes a total of 26 times. The details are as below:

1. **Standards of treating people with respect and involving them in their care**
   St 1 Respecting and involving people who use services **x 1**
   St 2 Consent to care and treatment **x 1**
2. **Standards of providing care, treatment and support that meets people's needs**
   St 4 Care and welfare of people who use services **x 3**
3. **Standards of caring for people safely and protecting them from harm**
   St 7 Safeguarding people who use services from abuse **x 3**
   St 8 Cleanliness and infection control **x 4**
   St 10 Safety and suitability of premises **x 3**
4. **Standards of staffing**
   St 12 Requirements relating to workers **x5**

St 14 Supporting workers **x 1**

5. **Standards of quality and management**

St 16 Assessing and monitoring the quality of service provision **x 4**

St 17 Complaints **x 1**

4. Aspects identified as good practice, and the reasons

Area 1	**St 1**	**Respecting and involving people who use services** - People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
		• a range of methods used to gain the views of patients, eg, quarterly questionnaires, PPGs involved in decision making, comments box in waiting area; • displays of information for patients include photographs and names of staff, patient charter, Freedom of Information Act information, hygiene advice, baby changing information, use of chaperone details, fire alarm info, complaints information, home visiting arrangements, and emergency evacuation; • support to gain access to the building, modifications for wheelchair users, pictorial explanations for people with LD, hearing loops, interpreter services • respecting patient dignity and privacy, ensuring confidentiality at reception, use of chaperones for sensitive examinations; • a comprehensive system for managing complaints, accidents and incidents, and subsequent learning.
Area 2	**St 4**	**Care and welfare of people who use services** - People should get safe and appropriate care that meets their needs and supports their rights.
		• patient needs are assessed, and care and treatment is planned and delivered in line with individual care plans, with patients informed of and involved in decisions about their care; • emergency appointments are provided on the day of contact, vulnerable patients are given priority appointments, patients see the same GP, telephone appointments have been introduced; average waiting times are monitored daily; • the delivery of care and treatment aims to ensure patient safety and welfare; • a range of timetabled audits and quality assurance tools are used to check quality and safety, necessary action is recorded in an electronic diary system to remind staff of targets for action, audit results and records of discussions are stored centrally so that all staff can access them; • actions have been taken to improve health outcomes for particular groups, eg, Polish women; • there are good arrangements for foreseeable emergencies: emergency and continuity plans exist with info for each staff role; also available are defibrillators, oxygen, emergency medication, staff training in first aid and cardiopulmonary resuscitation, and emergency procedures posted on walls for patients; • patients with a terminal illness are allocated a named and deputy doctor to ensure continuity of care, systems are in place to ensure the patient is seen by their named doctor, multidisciplinary team meetings are convened to review care, appropriate agencies are informed of care needs.
Area 3	**St 7**	**Safeguarding people who use services from abuse** - People should be protected from abuse and staff should respect their human rights.
		• there are policies for safeguarding children, vulnerable adults, and whistle blowing; staff are aware of the content and where to locate the policies, and who to go to if they needed to report any safeguarding concerns; • alerts exist in the electronic record system to inform staff if there are safeguarding concerns; systems are in place to share information with the local authority; monthly staff meetings discuss child protection; • chaperones are available for patients who require a sensitive examination by a doctor; • attendance for childhood vaccinations is monitored; • a list of people caring for vulnerable people is maintained to offer them regular health care assessments; • patients with learning difficulties are invited to attend an annual health check.
	St 8	**Cleanliness and infection control** - People should be cared for in a clean environment and protected from the risk of infection.
		• consultation and treatment rooms were always clean and regularly monitored by the practice manager; • personal protective equipment, eg, gloves and aprons were readily available, and sanitizing hand gel available for staff and patients throughout the practice; • staff were aware of the infection control policy and received infection control training which was updated regularly • the cleaning schedule covered all areas in the practice and was monitored by the practice manager and practice nurse; staff using treatment rooms were trained in aseptic procedures and cleaned all surfaces and equipment used between patients; • systems were in place for the appropriate disposal of clinical waste, including needles and blades; • staff received relevant immunisations to help protect from infection risks.
	St 9	**Management of medicines** - People should be given the medicines they need when they need them, and in a safe way

		• the practice had developed a formulary for medicines prescribed by their GPs, which included information about the purpose and dose of medicines; the practice manager regularly audited prescribing and addressed any issues formally with individual GPs • the service was signed up to a Prescribing Quality Scheme with the CCG • prescription pads were kept in lockable cupboards and drawers; • the storage of medicines and the emergency drug box dressing, sharps and swabs appropriate and in date, with a system for checking medicines that was regularly reviewed by the practice manager; • nurses and administration staff monitored the vaccines fridge on a daily basis; all medicines were in date and in stock order • medicines were disposed of appropriately, with a pharmacist regularly collecting for disposal any out of date medicines and unused medicines brought in by patients.
Area 4	**St 12**	**Requirements relating to workers** - People should be cared for by staff who are properly qualified and able to do their job.
		• appropriate checks were undertaken before staff began work; a new policy introduced by the practice manager ensured all relevant checks were done before staff were employed, and all existing and prospective staff were checked with the Disclosure and Barring Service (DBS) and to repeat checks every three years; any declared convictions would be risk assessed in relation to risks to patients and staff; • all relevant checks had been done for the GPs including their registration with the General Medical Council • effective recruitment and selection practice was in place and a specialist human resources company was used for advice and to ensure compliance with employment legislation
	St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
		• The senior GP had already been through the GP revalidation scheme; all the GPs undertook training that contributed to their continuous professional development; • Records confirmed training received by staff and when it needed to be updated; • Staff received induction training and shadowed other staff if appropriate, the regular practice meeting often had a training element, eg, learning from incidents; • Staff received supervision and annual appraisal where they could identify training and development needs; • Staff enjoyed working at the practice and felt supported and valued by the manager and GPs, and that colleagues were helpful
Area 5	**St 16**	**Assessing and monitoring the quality of service provision -** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
		• The provider regularly monitored the quality of its service through surveys for patient' views, through regular meetings and feedback from their PPG, and a comments box in the waiting area; any issues identified were addressed through action plans; the PPG felt that the practice listened to their feedback and acted upon it; • The practice had an effective system to identify, assess and manage risks, eg, through audits of aspects such as infection control, clinical waste management and medicines management, as well as ad-hoc audits such as immunisation uptake; all audits were evaluated and action plans to improve quality put in place where needed; • A business continuity plan was in place • The project manager audited some aspects through regular spot checks to ensure cleanliness and safety, eg, maintenance and cleaning , electrical equipment, air-conditioning units, monthly fire alarm testing, and water and heating system tests for Legionnaire's disease; • Staff received training which was updated as required; there were regular staff meetings, staff supervision, and opportunities for staff to identify their training and development needs; • Appropriate changes were implemented as a result of learning from incidents and complaints; • There were systems in place to share learning from complaints and significant events with all staff; discussions at practice meetings were not about blame but for ideas about how something could have been done differently not about blame but for ideas about how something could have been done differently the complaints procedure was available in the waiting area and on the practice website.
	St 21	**Complaints -** People should have their complaints listened to and acted on properly.
		• Records were kept securely and can be located promptly when needed; all staff had signed confidentiality statements and had a good understanding of how to protect patient confidentiality and keep written records secure; • Medical records were accurate and fit for purpose; patient information was on the SystemOne computerised system; quality audits included checks of medical records; • Staff records and other records relevant to the management were stored electronically and could only be accessed by appropriate staff; • All staff knew how to access shared management records, as well as staff and PPG meeting minutes

5. Aspects identified as non-compliant, with the reasons presented as suggestions for improvement

Area 1	**St 1**	**Respecting and involving people who use services -** People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
		• take patient views into account in the way the service and care for patients is delivered; • ensure formal mechanisms for people with decision making responsibility to be able to listen to patient views; • ensure access to information in an appropriate format, including systems for translation and interpretation.
	St 2	**Consent to care and treatment -** Before people are given any examination, care, treatment or support, they should be asked if they agree to it.
		• where patients do not have the capacity to consent the practice must ensure it can demonstrate it has acted in accordance with legal requirements; • be able to evidence before patients receive any care or treatment they are asked for their consent and the provision acts in accordance with their wishes; • be able to demonstrate that mental capacity assessments are carried out in accordance with the Mental Capacity Act (2005). The Act states every adult has the right to make their own decisions if they have the capacity to do so and that any act done for, or any decision made on behalf of, someone who lacks the capacity must be in their best interests; • ensure staff have a full understanding of gaining and documenting consent or assessing people's mental capacity.
Area 2	**St 4**	**Care and welfare of people who use services -** People should get safe and appropriate care that meets their needs and supports their rights.
		• ensure there is appropriate and sufficient emergency medical equipment and medication at the practice for both adults and children, including oxygen and defibrillator; • ensure patients using the service can receive appropriate care, treatment and support should a foreseeable emergency occur; • ensure care and treatment is planned and delivered in a way that intends to ensure people's safety and welfare; • always consider and respect patient's equality and diversity by providing signage, leaflets and interpretation services in relevant languages; • ensure all emergency drugs and single use equipment, eg syringes, are in date; • ensure all other medication is in date and stored correctly; • ensure that all relevant staff have received training in medical emergencies, that it is up to date, and training records are available.
Area 3	**St 7**	**Safeguarding people who use services from abuse -** People should be protected from abuse and staff should respect their human rights.
		Ensure patients are protected from the risk of abuse by identifying the possibility of abuse and preventing the abuse from happening by: • having systems that identify and respond to risks to children and vulnerable adults; • ensuring all staff have up to date safeguarding training to the correct level and that records are available; • ensuring there are clear internal policies, protocols and procedures for helping staff to identify and protect vulnerable adults and children from abuse.
	St 8	**Cleanliness and infection control -** People should be cared for in a clean environment and protected from the risk of infection.
		• ensure the cleaning schedules available for inspection and that staff are aware of the details and extent of the cleaning regime; • in treatment rooms ensure there are no piles of debris on the floor under treatment couches, dust on top of cupboards, around door frames, picture frames, a build-up of dust around the skirting boards, dust on blinds or dity curtains, etc, and that patient's accessible toilets are clean; • ensure practice cleaning records which confirm the cleaning standards are always maintained and that arrangements for assuring cleanliness of the premises are in place; • adequate arrangements must be in place for the safe disposal of clinical waste and sharps, such as needles and blades; • staff must have access to spill kits to deal with bodily spillages; • the information in the infection control policies and procedures must be up to date and accurate; • there needs to be an infection prevention and control lead and regular infection control checks undertaken; • staff should be trained in infection prevention and control practice and evidence of recent staff training needs to be kept available; • maintain a record of the latest infection control audit, an infection control policy and a copy of the 'Code of Practice on the prevention and control of infections and related guidance' that is available for staff information; • cleaning equipment and cleaning materials need to be safely stored with designated colour coded cleaning buckets or mops so that cleaning staff cannot be confused over what equipment should be used in any area, so as to remove the possibilities of cross contamination or cross infection; • ensure systems and checks are in place to prevent risks associated with Legionella from the water supply.
	St 10	

		Safety and suitability of premises - People should be cared for in safe and accessible surroundings that support their health and welfare.
		• where treatment rooms are on the first floor ensure access for people in a wheel chair; • ensure that the reception area and reception desk height is designed to be suitable for people in a wheel chair so that they have appropriate access to the reception desk or staff; • ensure that the reception area is kept clean and free of debris as part of a cleaning regime aimed at reducing the possibilities of cross infection; • there should be firefighting equipment throughout the building which has been serviced and in date; • there should be evidence of staff fire training or emergency evacuation drills, and nominated fire marshals; • the latest fire certificate for the premises must be available as well as a risk assessment for Legionella testing of the water supply; • the hot water temperature must be adequately maintained, and must be available in all the toilets; • the recent health and safety risk assessments and a copy of the electrical tests for the building must be kept available.
Area 4	**St 12**	**Requirements relating to workers -** People should be cared for by staff who are properly qualified and able to do their job.
		• all practice staff, temporary or permanent, must be subject to full recruitment checks that are currently in place; • effective recruitment checks include documented CRB/DBS checks, written personal references, fully completed application forms with a full employment history, explanations for gaps in employment, relevant experience, skills or training relevant to the job applied for, qualification checks, proofs of identification or photographs, etc, in order to assess staff suitability before they can start work within the practice; • the practice manager must be able to clearly describe the recruitment and selection process in place; • there should be a written recruitment policy or procedure to explain how the process must be operated to ensure that it is operated consistently and securely; • the provider must have a system in place to check and record that GPs and nurses remain registered with their professional body, and hold copies of these documents.
	St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
		• patients must be cared for by staff who are supported to deliver care and treatment safely and to an appropriate standard • there should be evidence of completed induction programmes to demonstrate that new members of staff completed an induction programme or relevant mandatory training. • staff should receive formal opportunities to discuss their performance and needs, such as supervision sessions, and annual appraisals must be completed; • staff should receive relevant training to prepare them for their role • staff performing delegated tasks should receive appropriate supervision or competency assessments so that they appropriately trained.
Area 5	**St 16**	**Assessing and monitoring the quality of service provision -** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
		• an infection control lead needs to maintain oversight that infection prevention and control checks have been undertaken and recorded; • regular and robust checks need to be undertaken of the cleanliness of the building; • systems for checking and maintaining equipment need to be in place; • the practice manager should be able to confirm that no out of date equipment has been left in storage on the premises, including items that should have been destroyed once opened; • there must be checks in place to ensure a thorough recruitment process has been undertaken; • the practice should have a Patient Participation Group; • there needs to be records on the practice nurses' qualifications, professional development and pin number; • there must be formal processes in place for reviewing and monitoring the quality of care and service provided; • there must be evidence of audits or reviews for areas such as record keeping, documentation, infection and control practices, buildings' maintenance and clinical practices, the storage and availability of emergency medicines, so that regular monitoring and review of care and services can ensure that patients receive quality care in a safe environment; • there must be an up to date documented risk assessment for the premises and regular Legionella checks carried out • any action points recommended from a fire risk assessment should be promptly implemented; • fire doors should not have ventilation holes cut out of the door as this prevents the door being fire resistant. • learning from serious incidents and investigations needs to be evidenced and documented and appropriate changes implemented; • serious incidents must be reported to the Care Quality Commission as is required by law, and processes need to be in place to report and deal with less serious incidents, for example slip trips and falls or staff accidents.
	St 17	**Complaints -** People should have their complaints listened to and acted on properly.
		• comments and complaints patients make must be responded to appropriately and outcomes recorded;

		• patients should know how to complain as a result providers making their procedure available; • patients who do not speak or read English should not experience any difficulty using it • complaints from patients should not be recorded on their medical records As this would place them at risk of discrimination; • there should be documented reviews of complaints that include analysis and evidence that complaints have been used for learning and service improvement.

Annexe A

Detail of Areas & Standards of good practice identified through Inspection

Area 1: Standards of treating people with respect and involving them in their care

St 1 – Respecting and involving people who use services

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- The provider used a range of methods to gain the views of patients and there was good evidence of patients' views were taken into account. A questionnaire had been developed which was used quarterly to capture the views of patients. The results of the questionnaires were collated and shared in meetings where staff were involved in deciding what action to take as a result. The Patient Participation Group's (PPG's) was also involved in decision making about action from the questionnaire. Information about the PPG's work was displayed in the waiting area and there was a visible comments box for all patients to submit written comments if they wished.
- On entering the building there was a variety of displays and information for patients including photographs and names of staff, a patient charter, Freedom of Information Act information, hygiene advice, baby changing information, use of chaperone, fire alarm, complaints information, home visiting arrangements and emergency evacuation.
- The provider was continuously reviewing advice from a variety of sources and made and reviewed decisions with staff and patient representatives.
- The building had parking spaces reserved for people with disabilities. The provider had talked to patients and provided a bell and sign at the front door advising wheelchair users and other people with restricted mobility to ring the bell if they needed any assistance getting through the door. The reception desk had a dropped area so that people who used a wheelchair could easily talk to the receptionist and all public areas and consulting rooms were on the ground floor, including a toilet suitable for patients with restricted mobility.
- The provider had also introduced information with pictorial explanations to support people with a learning disability to understand how to make appointments and what would happen during an appointment.
- Hearing loops and interpreter services were made available to patients and the practice had made considerable efforts to ensure information and support was available to patients in different formats. A summary of the services in Polish had been developed to reflect patients registered at the service. A number of languages were spoken by receptionists including Hindi and Gujarati. The provider had also developed a guide to common vaccinations for the nursing staff in Polish, Lithuanian and German.
- Staff spoke with people in a friendly and courteous manner both on the telephone and when they attended the surgery. Patients found staff helpful and friendly. The practice was also able to arrange interpreters for patients. There was information about this in the waiting area. The practice tried to ensure that all its patients were able to understand and consider diagnoses and treatment options.
- Conversations at reception could not be overheard. Reception staff had been trained not to talk loudly and to avoid repeating patient's names to help preserve their privacy.
- At another practice where conversations at reception could sometimes be overheard by other people in the waiting area, reception staff were able to speak privately with a patient in the lobby near reception or in the treatment room when this was required. This option was offered on a notice in the waiting area.
- Patient's dignity and privacy were respected. Consultations took place in private rooms behind closed doors. There were privacy curtains around the examination couches. Patients confirmed these were used during examinations. There was information about chaperones being available in the waiting area and on the doors of the consulting rooms. Staff explained that chaperones were offered when performing sensitive examinations. Reception staff were trained to undertake this role. Staff told us that some patients preferred to have a family member act as a chaperone and the practice allowed this.
- There was a comprehensive system for managing complaints, accidents and incidents. All reported issues were investigated with a root cause analysis. This is a detailed investigation to identify why something has gone wrong. These investigations were analysed for any themes and the results shared with all staff, to ensure there was learning from any untoward incidents.

Area 2: Standards of providing care, treatment and support that meets people's needs

St 4 – Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

- Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Plans were in place to manage their care and treatment. Patients told us they were informed of and involved in the decisions about their care.
- Patients confirmed that they got an emergency appointment on the day they contacted the practice. This meant that the provider had a system in place to ensure that vulnerable patients were given priority appointments. Most patients we spoke with told us that the doctors and nurses gave them all the time they needed to discuss their concerns, and most patients could see the same GP.
- The practice had also introduced a system of telephone appointments. Reception staff were trained to identify situations when this might be suitable. The GPs had several appointments which they could offer later that day if they felt the patient needed to be seen. A patient who had used this process found it to be very helpful. The GPs indicated that it was useful for patients to be able to seek advice about matters such as viral illnesses, sickness certificates or to follow up a previous consultation.
- Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. Patients confirmed they found it easy to book an appointment. Appointment booking was regularly monitored through the patient questionnaire. Average waiting times to be seen were also monitored on a daily basis during clinical sessions. There were never more than two patients waiting at any one time. This was because appointments with both GPs were running on time, so patients were not waiting long periods.
- The practice manager used a range of audits and quality assurance tools to check the quality and safety of care and treatment. Audits were timetabled and any necessary action was also recorded in an electronic diary system so staff were reminded of targets for action. Results from the audits and minutes of discussions were stored in a central place on the computer system so all staff could access them. Staff stated they attended all meetings, even if they were not supposed to be working. This was because they found the meetings useful for their work.
- There was evidence of action taken to improve health outcomes for particular groups. For example, a recent demography search on those women who had not taken up cervical screening service revealed a high percentage of Polish nationality. The service translated an information leaflet about cervical screening into Polish and sent it to every eligible Polish woman registered with the service. This showed how the provider used quality assurance information to ensure the health and welfare of patients.
- There were arrangements in place to deal with foreseeable emergencies. The service had an emergency and continuity plan which included information for each member of staff role in case of emergency. Plans included the role of the sister service in sharing resources and premises in case of premises or service delivery emergency. Staff had access to defibrillators, oxygen, and emergency drugs. Staff had received training in first aid and also in cardiopulmonary resuscitation and demonstrated a good knowledge of what they would do in the event of a medical emergency. There were systems in place to ensure that the emergency drugs and oxygen were in date. Emergency procedures were posted on walls so patients and staff could see what to do if there were an emergency and they needed to provide cardio-pulmonary resuscitation (CPR) or if there was a fire.
- All patients with a terminal illness were allocated a named and deputy doctor. The receptionists used systems to ensure patients were seen by their named doctor. Multi-disciplinary team meetings were held between the practice staff, the community nursing team and palliative care nurses to review the care of patients with a terminal illness. This meant that these patients received continuity of care because appropriate agencies were informed of their care needs.

Area 3: Standards of caring for people safely and protecting them from harm

St 7 – Safeguarding people who use services from abuse

People should be protected from abuse and staff should respect their human rights

- The provider had policies in place for the safeguarding of children, the safeguarding of vulnerable adults and whistle blowing. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Staff were aware of the information

contained in the policies and where to locate them. This meant that staff were supported in their decision making about the safe protection of patients because they had guidelines to refer to.

- There was a GP safeguarding lead at the practice who had completed the higher level three safeguarding training for children and vulnerable adults. The GP safeguarding lead demonstrated a good knowledge of their role and responsibilities in protecting children and vulnerable adults from the risk of abuse. This meant that patients were protected from the risk of abuse because the GP had updated their safeguarding knowledge to reflect current guidelines. All the practice staff we spoke with knew who to go to within the practice if they needed to report safeguarding concerns.
- The training records confirmed that staff had received safeguarding training at a level appropriate for their role. Staff were aware of the various types of abuse and the appropriate agencies to refer safeguarding concerns to ensure that patients were kept safe from harm. Staff were aware of the importance of reporting all bruising in babies less than six months of age.
- Alerts within the electronic record system informed staff if there were safeguarding concerns about a child or vulnerable adult. There were systems in place for the provider to share information with the local authority if a child had a child protection plan in place. Monthly face to face meetings took place between practice staff and the practice's designated Health Visitor to discuss child protection concerns. This meant that there were effective systems in place to share information of concern and protect patients at risk from abuse.
- There was a chaperoning policy in place for patients who require a sensitive examination by a doctor. There were posters displayed throughout the practice informing patients of their right to be accompanied by a chaperone if they required a sensitive examination. Staff demonstrated a good knowledge of their responsibilities and were able to describe what they would do if they had any concerns regarding an examination.
- The practice monitored attendance for childhood vaccinations and raised any concerns appropriately.
- The practice also kept a list of people they knew to be caring for vulnerable people primarily in order to offer them regular health care assessments. Patients with learning difficulties were also invited to attend for an annual health check.

St 8 – Cleanliness and infection control

People should be cared for in a clean environment and protected from the risk of infection

- There were effective systems in place to reduce the risk and spread of infection.
- Patients said that the consultation and treatment rooms were always clean. The practice manager regularly monitored the cleanliness of the practice.
- There were effective systems in place to reduce the risk of infection. Personal protective equipment such as gloves and aprons were readily available. Patients confirmed that staff wore protective equipment and washed their hands and wore gloves during any procedure. Sanitizing hand gel was available for staff and patients throughout the practice. The practice had an infection control policy which all staff were aware of.
- Staff responsible for infection control received training which was updated on a regular basis. This meant the service kept up to date with current infection control methods. There was a cleaning schedule which covered all areas in the practice. This was monitored by the practice manager and practice nurse.
- There were systems in place for the appropriate disposal of any clinical waste, including needles and blades. Staff using treatment rooms were trained in aseptic procedures and cleaned all surfaces and equipment used between patients.
- Staff had also received relevant immunisations to help protect them from infection risks. This meant the provider had taken appropriate steps to protect patients, staff, and visitors to the surgery from healthcare associated infections.

St 9 – Management of medicines

People should be given the medicines they need when they need them, and in a safe way

- Medicines were prescribed and given to patients appropriately. The provider had developed a formulary for medicines prescribed by GPs at the service. This provided information about the purpose and dose of medicines as well as providing standard information for patients on labels printed at the pharmacy. The formulary also linked to national guidance on medicines in the British National Formulary (BNF). The practice manager regularly audited prescribing and addressed any issues formally with individual GPs. The service had also signed up to a Prescribing Quality Scheme with their Clinical Commissioning Group (CCG). This involved auditing prescribing of specific drug types and taking action to improve

- Medicines were kept safely. Prescription pads were kept in lockable cupboards and drawers. The provider had recently identified that they needed a clear policy for use of scripts on home visits. This showed the provider was continuously assessing risks identified with medicines and taking action to reduce risks.
- In the storage of medicines and the emergency drug box the dressings, sharps and swabs were found in date and a number were labelled for use by individual patients. There was a system for checking medicines in the emergency drug box and was regularly reviewed by the practice manager.
- The vaccines fridge was temperature monitored daily both by the nurses and the administration team. All medicines were in-date, and in stock order.
- Medicines were disposed of appropriately. A pharmacist regularly (usually daily) collected any medicines for disposal. This included medicines brought in by patients and any out of date medicines held by the service as emergency medicines or for use by the practice nurse. There were effective systems for recording medicines brought to the surgery by patients for disposal.

Area 4: Standards of staffing

St 12 – Requirements relating to workers

People should be cared for by staff who are properly qualified and able to do their job

- Appropriate checks were undertaken before staff began work. The practice manager had introduced new recruitment procedures to ensure all relevant checks were done before staff were employed. The provider had introduced a policy to check all existing and prospective staff with the Disclosure and Barring Service (DBS) and to repeat checks every three years.
- The practice confirmed that they would risk assess any declared convictions and decide whether someone could be employed on the basis of the risk to patients and staff.
- Employment records for the GPs employed at the service confirmed all relevant checks had been done, including their registration with the General Medical Council (GMC), inclusion on the local 'performers' list, a list of GPs held by the local commissioning organisation approving GPs to work in the area, and appropriate professional indemnity.
- There were effective recruitment and selection processes in place. The provider used a specialist human resources company to support the practice manager with recruitment and selection. They provided advice to ensure the provider was meeting the requirements of employment legislation, and ensured that staff were recruited in accordance with the provider's policies.

St 14 – Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

- All staff had received appropriate training. The senior GP confirmed that they had already been through the GP revalidation scheme by which doctors are required to demonstrate every five years that their skills and knowledge are up to date and they are fit to practise. The GP was also doing further training related to diabetes. All the GPs working at the practice undertook training which contributed to their continuing professional development, for example online training about child protection.
- Records were available to confirm the training staff had received and when it needed to be updated. Staff indicated that they had received induction training and shadowed other staff if appropriate. There were regular practice meetings which often had a training element, for example, looking at learning from incidents. Staff received supervision and an annual appraisal where they could identify any training and development needs.
- Several staff indicated they enjoyed working at the practice, that colleagues were helpful, and felt supported and valued by the manager and GPs. One associate GP also told us that they had been supported and enabled to learn a great deal about the practice and how it operated which was contributing to their professional development.

Area 5: Standards of quality and suitability of management

St 16 – Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

- The provider regularly monitored the quality of its service. This included the use of surveys to gather views of patients who used the service. Systems were in place for the provider to analyse the results of the survey for information so that any issues identified were addressed. A four point action plan had been put in place to address patient concerns. The changes had been carried out in line with the action plan such as how patients book appointments and telephone access to the practice. Patients were encouraged to provide feedback about the practice and the care they received through the comments box in the reception area. There were systems in place for this feedback to be reviewed and action plans were put in place where a need was identified.
- The practice had an established PPG that encouraged patients to share their views and highlight areas for improvement at the practice. A PPG representative indicated that they held regular meetings and the practice listened to their feedback and acted upon it. For example, after feedback the practice introduced the facility to book appointments online by their website.
- The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service, eg, audits had been conducted, such as infection control, clinical waste management and medicines management. The information technology manager had carried out adhoc audits in areas such as immunisation uptake. All audits were evaluated and action plans to improve quality were put in place where needed.
- There was a business continuity plan in place which meant that in the event of the failure of domestic services or information technology, patients would continue to receive a service that met their needs.
- The practice manager monitored and audited a number of aspects of the service through regular spot-checks to ensure the surgery was kept clean and safe, eg, the maintenance and cleaning of the premises , which included electrical equipment and air-conditioning units, monthly fire alarm testing, and the water and heating systems were tested to ensure they were free from Legionnaire's disease.
- A training matrix showed staff had received training which was updated as required. Records also showed that there were regular staff meetings, staff supervision, and opportunities for staff to identify their training and development needs. Learning from incidents and complaints took place and appropriate changes were implemented. There were systems in place for the practice to share learning from complaints and significant events with all staff. These were discussed at practice meetings and the discussions were not about blame but for ideas about how something could have been done better or differently. The practice kept copies of its complaints procedure in the waiting area and on its website. The provider completed the Quality and Outcomes Framework (QOF). This is a government initiative concerned with chronic disease management (for example, diabetes). There are financial incentives for practices meeting set targets.

St 21 – Records

People's personal records, including medical records, should be accurate and kept safe and confidential

- Records were kept securely and can be located promptly when needed. All staff had signed confidentiality statements. Staff members had a good understanding of how to protect patient confidentiality and how to keep written records secure.
- Patients' personal records including medical records were accurate and fit for purpose. All new records for patients were recorded and stored on the SystemOne computerised system. Medical records recorded all important information. The service's quality audits included checks of medical records. Staff records and other records relevant to the management of the services were accurate and fit for purpose. Staff records and other management records were all stored electronically and could only be accessed by appropriate staff. All staff knew how to access shared management records including minutes from staff meetings and Patient Participation Group meetings. All of the records were accurate and fit for purpose.

Annexe B

Detail of Areas & Standards Failing at Inspection and Requiring Improvement to achieve Compliance

Area 1: Standards of treating people with respect and involving them in their care

St 1 – People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients' views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care (moderate impact).

- The three PPG members spoken to could not describe any formal mechanism for ensuring that people with decision-making responsibility listened to their views. Patients did not have access to information in an appropriate format because the provider did not have effective systems to access translation and interpretation.

St 2 – Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Before people received any care or treatment they were not asked for written consent and the provider was unable to demonstrate they acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider was unable to demonstrate they acted in accordance with legal requirements (moderate impact).

- From what we saw and heard we were unable to evidence before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
  We were also unable to locate evidence to demonstrate that mental capacity assessments were carried out in accordance with the Mental Capacity Act (2005). The Act states every adult has the right to make their own decisions if they have the capacity to do so and that any act done for, or any decision made on behalf of, someone who lacks the capacity must be in their best interests. We also reviewed the provider's MCA policy, which stated that consideration must be given to assuring patients understood, are able to retain and access information and are able to communicate their decision.
  We asked to see evidence that the two stage question test or the assessment of capacity checklist detailed in the provider's policy had been carried out for people who were suspected of lacking capacity. Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements because the provider had not acted in accordance with their own policy or the MCA (2005).
  We spoke to the provider and manager who explained to us that mental capacity assessments were not carried out but patients were referred to the memory clinic at the local hospital. The provider was unable to demonstrate how they were ensuring that care was planned with the consent of people using the service or their representative. We saw no evidence that any best interest meetings had been held for any of the people using the service who had been deemed to lack capacity.
  We spoke with a number of staff during our inspection and asked them to describe their approach to ensuring people were involved and understood their care and treatment. Their responses indicated that the staff were respectful of people's wishes but all had very little understanding of gaining and documenting consent or assessing people's mental capacity.

Area 2: Standards of providing care, treatment and support that meets people's needs

St 4 – People should get safe and appropriate care that meets their needs and supports their rights

People did not always experience care, treatment and support that met their needs and protected their rights as arrangements were not in place to deal with foreseeable emergencies (minor impact).

- We saw that there was some emergency medical equipment and medication at the practice for both adults and children. However there was no oxygen or defibrillator available. A defibrillator is a lifesaving machine that gives the heart an electric shock in some cases of cardiac arrest or irregular heart rhythm. The provider told us that this was not required as they would call an emergency ambulance. This meant that people using the

service were at risk of not receiving appropriate care, treatment and support should an emergency occur. These are required to be available as part of the arrangements in place to deal with foreseeable emergencies.

People did not always experience care, treatment and support that met their needs and protected their rights as arrangements were not in place to deal with foreseeable emergencies (minor impact).

- We saw that there was some emergency medical equipment and medication at the practice for both adults and children. However there was no oxygen or defibrillator available. A defibrillator is a lifesaving machine that gives the heart an electric shock in some cases of cardiac arrest or irregular heart rhythm. The provider told us that this was not required as they would call an emergency ambulance. This meant that people using the service were at risk of not receiving appropriate care, treatment and support should an emergency occur. These are required to be available as part of the arrangements in place to deal with foreseeable emergencies.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare (minor impact).

- People's equality and diversity was not always considered and respected because we found that all the signage and leaflets available were all written in English. The manager explained to us the surgery provided health care to a varied and diverse community. We asked if information was available in different languages or whether staff accessed interpreting services. We were told that services were available but staff were reluctant to use them, preferring to use relatives as interpreters and they did not provide leaflets in other languages.
  We reviewed the emergency drugs and saw they were in date, however some of the single use equipment, such as syringes, were out of date. We also reviewed all other medication which were in date and stored correctly. However, there was no lock on the cupboard, the fridge or the door to the store room. This demonstrated to us that medication was not stored safety and securely.
  We asked to see the training records for all staff who had received the appropriate training in medical emergencies and cardio – pulmonary resuscitation. Some staff had received basic life support training within the last three years, whilst others were out of date or had not received the training at all.

Area 3: Standards of caring for people safely and protecting them from harm

St 7 – People should be protected from abuse and staff should respect their human rights

Patients were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent the abuse from happening (moderate impact).

- The provider's systems were not appropriate for identifying and responding to risks to children and vulnerable adults. We saw safeguarding training records for only seven staff of a team of more than 20. The provider's child protection protocol stated that clinicians should be trained in child protection every year and other staff every three years. The protocol did not state what level of training each staff role should complete. The provider did not keep any records of the training expected of each staff role and training completed. There were no internal policies or procedures for protecting vulnerable adults from abuse. Vulnerable adults were not protected from the risk of abuse because the provider had no internal guidance for staff and some staff had not been trained to respond to concerns about vulnerable adults. There was no system for identifying vulnerable adults at risk of abuse.

Patients were not protected due to some staff being untrained and unaware of child and adult protection protocols (minor impact).

- We spoke with reception staff about the safeguarding of children and vulnerable adults. The staff we spoke with did not demonstrate a good knowledge of these vulnerable groups. Staff told us they had not been trained about the types of abuse and prompts to look out for. This meant that important safeguarding information could be missed due to some staff not being trained or aware what safeguarding prompts to look for.

Patients were not protected from the risk of abuse due to a inadequately trained and poorly managed staff group (minor impact).

- We saw where staff had regular discussions about peoples' safety, as this was recorded in minutes of meetings. We were told by the practice manager that staff have been trained to recognise where people may

be vulnerable and at risk. However, the reception staff were not familiar with what they should be observing for or the terminology around safeguarding and protection. This means children and vulnerable adults may be placed at risk from staff who are not well informed or adequately trained.

St 8 – People should be cared for in a clean environment and protected from the risk of infection

Patients were not protected from the risk of infection because an effective system was not in place for the appropriate disposal of clinical waste, an absence of appropriate equipment to deal with bodily spillages and lack of detailed information around the cleaning of the building (minor impact).

- We saw that all areas of the practice were clean and organised. We saw that patients and staff had good access to hand washing facilities and to antibacterial gels. However, the staff had no copies of the cleaning schedules available for inspection. This meant that staff were unaware of the details and extent of the cleaning regime, so patients could be placed in danger from an unclean or unhygienic environment. There were adequate arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. However, we saw that staff did not have access to cytotoxic sharps bin, which must be used for the disposal of cytotoxic and cytostatic medicines. These medications include most hormonal preparations, some anti-viral drugs and some antibiotics. We also noted that staff did not have access to spill kits. This meant that patients and staff were not fully protected from risks of harm.

The provider does not have an effective system in place to regularly assess and monitor infection prevention and control practices and cleanliness of the premises (moderate impact).

- We looked at the infection control policies and procedures needed review as the information was not accurate. The manager informed us that no infection control checks were undertaken and there was no identified infection control lead. We asked whether staff had been trained in infection prevention and control practice and found no evidence of recent staff training. We saw dust around the metal base of the treatment couch and a pile of debris on the floor underneath in one treatment room. We found the treatment couch was not in a good state of repair and had been taped up as part of the surface area had split. We found dust on top of a cupboard. In another treatment room we found a build-up of dust around the skirting boards, and underneath the treatment couch on the metal base we found dust. We saw the patient's accessible toilet was dirty. This means that areas in the practice which patient's would access were not cleaned to an appropriate standard. We saw a practice cleaning record which confirmed the cleaning standards were not always maintained. We found that the arrangements for assuring cleanliness of the premises were not in place.

Patients were not protected from the risk of infection because cleaning schedules, Legionella risk assessment and infection control policy and procedure were not in place; treatment rooms did not meet infection control requirements, and cleaning equipment and chemicals were not stored or used correctly (moderate impact).

- We looked around the practice in treatment rooms and in the surgeries where patients saw their doctor. We looked to see if the staff had access to, and knowledge about spill kits for bodily fluids. There were none in any of the treatment rooms. We looked at the examination couches in the treatment rooms, these had disposable paper covers in use. We noted that in one treatment room that there was a cloth cover under the disposable paper which was marked and soiled. We also noted there was a portable screen in another treatment area. Though this had a wipe clean surface, this was again marked. That meant that patients were placed at risk of cross infection or cross contamination due to areas not being cleaned regularly or appropriately.
  We asked to look at the cleaning schedules to see how often areas were cleaned. We were told there were no cleaning schedules in place, and cleaning staff knew what and how often they had to clean. That meant that there was no staff guidance in place to ensure areas were cleaned regularly enough to protect patients from the risk of infection.
  We asked to see the latest infection control audit, but were told there had not been one done recently, and staff were unsure when the last audit was undertaken. There was no infection control policy in place and no copy of the 'Code of Practice on the prevention and control of infections and related guidance' was available for staff information. That meant that there was no overall quality assurance around infection control which placed patients at risk.
  We looked at where the cleaning equipment and cleaning materials were being stored. We noted that there were no designated colour coded cleaning buckets or mops. This meant that cleaning staff could be confused over what equipment should be used in any area. That meant that patients were open to the possibilities of cross contamination or cross infection whilst visiting the health centre.
  We asked about systems in place to prevent risks associated with Legionella. There was no risk assessment to protect patients from the possibilities of contracting Legionella.

People were not protected from the risk of infection because appropriate guidance was not followed (moderate impact).

- The main areas and the treatment rooms were not clean. We found that the door frames, picture frames and cupboards were dusty throughout the surgery. We examined the treatment couches in the consultation rooms. We found there was a build-up of dust and other debris under the couches and in the joints and hinges. This meant the provider could not be sure that all cleaning tasks were undertaken to prevent the spread of infection through the build-up of dust.
  We asked to see a cleaning schedule which detailed what should be cleaned and how often. We saw a schedule of daily and weekly cleaning tasks. However, there were no documented checks on the cleanliness of the surgery.
  We spoke with the lead for infection prevention and control and asked them to show us their schedule for reviewing and monitoring the quality of cleaning and infection prevention. We were told that no such quality checks were undertaken. We asked whether staff had been trained in infection prevention and control practices. We asked to see the training records but were told that the training had not taken place.

St 10 – People should be cared for in safe and accessible surroundings that support their health and welfare

Patients, staff and visitors were not protected against the risks of unsafe or unsuitable premises due to a poor cleaning regime and missing health and safety information (minor impact).

- Most of the treatment rooms are situated on the ground floor; those on the first floor were accessible only by a flight of stairs. The reception area had a glazed front which was not designed to be accessible for people in a wheel chair. This meant that people using wheelchairs or of restricted height would not have suitable access to the reception desk or staff.
  The reception area had seats which could be wiped clean. However the floor was dirty and had debris on it. Though there was evidence of cleaning schedules in place, the premises were only visited by a cleaner twice a week. This was not adequate to ensure a suitable environment for patients and staff. This meant the provider had not taken steps to provide an environment that was adequately cleaned to reduce the possibilities of cross infection. We saw that the wallpaper was coming away and patches of bare walls were exposed. This meant that the provider had not taken steps to provide an environment that was adequately maintained to reduce the possibilities of cross infection.
  We saw there was firefighting equipment throughout the building; this had been serviced and was in date. The manager was not able to provide any evidence of staff fire training or emergency evacuation drills. This showed us that the provider had not taken the necessary steps to ensure people using the service, staff and visitors were protected from an unsafe environment.
  The practice manager could not produce the latest fire certificate for the premises and was unable to produce a risk assessment for legionella testing of the water supply. This showed us that the provider had not taken steps to ensure safety procedures and precautions were in place to protect patients and staff against the risks associated with unsafe or unsuitable premises.

Patients were not protected from the possibilities of a poorly maintained environment (minor impact).

- The practice manager told us that the hot water temperature was recognised as being too hot, but no accurate temperature had been taken. The practice manager said they were looking at reducing the hot water temperature. We also found that there was not hot water available in the men's toilets. That meant there was a health and safety risk to patients from the hot water system.

Patients who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises due to missing health and safety information and checks (minor impact).

- We saw there was firefighting equipment throughout the building; this had been serviced and was in date. The manager was not able to provide any evidence of staff fire training or emergency evacuation drills. Staff told us there were no nominated fire marshals. This showed us that the provider had not taken the necessary steps to ensure people using the service, staff and visitors were protected from an unsafe environment.
  The practice manager could not produce the latest fire certificate for the premises and was unable to produce a risk assessment for Legionella testing of the water supply. The manager was also able to provide us with recent health and safety risk assessments and a copy of the electrical tests for the building. This showed us the provider had not taken steps to ensure safety procedures and precautions were in place to protect patients and staff against the risks associated with unsafe or unsuitable premises.

Area 4: Standards of staffing

St 12 – People should be cared for by staff who are properly qualified and able to do their job

People were not protected because the provider had not carried out an effective recruitment process (minor impact).

- A number of practice staff have been employed for many years, and were not subject to the recruitment checks that are currently in place. The provider had carried out some CRB checks on the newer member of staff to assess their suitability with work within the practice.
  When we looked at a member of staff recruited recently there were no CRB or DBS checks in place, nor were there any personal references taken up by the provider. The practice manager had not attempted to follow up references for the person. This means that people are not adequately protected by the appropriate recruitment checks being in place.
  The practice manager was unable to clearly describe the recruitment and selection process in place. There was no written recruitment policy or procedure to explain how the process should be operated. This means that there was nothing to back up the recruitment process to ensure that it was operated consistently and securely.
  The provider told us that he had a system in place to check that GPs and nurses remained registered with their professional body. The practice manager told us that the registration status of staff was checked when they are employed and then on an on-going basis. However the practice did not hold copies of these documents, and were not able to produce all of these even being given time to do so following the inspection visit.

People were not protected because the provider had not carried out an effective recruitment process (minor impact).

- The majority of practice staff have been employed for many years, and were not subject to the recruitment checks that are currently in place. The provider had carried out some CRB checks on the newer member of staff to assess their suitability with work within the practice.
  When we looked at the staff that had been recruited recently, there were no CRB or DBS checks in place, nor were there any personal referee details provided by the applicant. The practice manager had not attempted to follow up references for the person. This means that people are not adequately protected by the appropriate recruitment checks being in place.
  The practice manager was unable to clearly describe the recruitment and selection process in place. There was no written recruitment policy or procedure to explain how the process should be operated. This means that there was nothing to back up the recruitment process to ensure that it was operated consistently and securely.

The provider did not follow effective recruitment and selection checks (minor impact).

- We found in one staff record the applicant had supplied the provider a curriculum vitae (CV), the names of two referees, and their qualifications. The manager told us that verbal references were sought but had not obtained the required two references. A new check had not been obtained for the applicant with the Disclosures and Barring Service (DBS), before they started work at the practice.

Patients were placed at risk by a lack of clear guidance on the recruitment and selection procedures (minor impact).

- A group of staff we looked at, who did not have 'hands on' activity with patients did not have any checks in place. We looked at the recruitment files of staff and noted there were no proofs of identification or photographs, though there were references in place. The practice manager was unable to clearly describe the recruitment and selection process in place. There is no written recruitment process to support this. That meant that patients are not protected by a secure and detailed recruitment process.

*The provider did not carry out the relevant recruitment checks to assure themselves that patients were cared for, or supported by, suitably qualified, skilled and experienced staff (*moderate impact).

- We looked at three staff files to see if there were effective recruitment and selection processes in place, and whether appropriate checks were undertaken before staff began work. We found that one staff member did not have appropriate checks in place.
  The file did not contain a completed application form giving a full employment history, relevant experience, skills or training for the job they had applied for. The provider did not ask for satisfactory references or ask staff to explain gaps in their employment history prior to them commencing their employment at the surgery. They did not feel it was necessary to complete a full recruitment and selection process when staff were temporarily employed. All staff, whether temporary or permanent, must have the appropriate checks

undertaken before they can begin work, ensuring staff who were employed to work at the surgery were suitable and of a good character.
The provider did not have a process for checking and recording professional registration.

St 14 – staff should be properly trained and supervised, and have the chance to develop and improve their skills
The provider did not ensure there were suitable arrangements for staff to receive appropriate training, development and supervision. Patients were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard (moderate impact).

- We asked to see evidence of a completed induction programme. The manager was unable to demonstrate that new members of staff completed an induction programme or relevant mandatory training.
  We found that staff did not always receive formal opportunities to discuss their performance and needs, such as supervision sessions. We were told no formal supervision took place although we found annual appraisals were completed.
  We spoke to staff and asked them to describe what training they had received to prepare them for their role. We received mixed responses; two members of staff told us they had received no training in the last twelve months. One member of staff told us they had attended training when employed with another provider and another member of staff described a variety of clinical training sessions. We found that staff who performed delegated tasks had not received appropriate supervision or competency assessments. The provider did not ensure delegated tasks were undertaken by appropriately trained staff.

Area 5: Standards of quality and suitability of management

St 16 – The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The provider does not have an effective system in place to regularly assess and monitor infection prevention and control practices, cleanliness of premises, and the storage of clinical equipment (minor impact).

- The infection control lead informed us that no infection control checks were undertaken. Senior staff told us they carried out regular checks with the cleaning service that cleaned the practice. In one room used for patients we found the vertical window blinds were dirty and a dirty white curtain. We found systems for maintaining equipment were not in place: and arrangements for assuring cleanliness of the premises were not robust. We found out of date equipment in the locked treatment store room. They included items which should have been destroyed once opened and not left in storage. We found items had been opened from their packaging and left in cupboards. The practice manager was not aware out of date equipment was stored in this area.

The provider does not have an effective system in place to regularly identify, assess and manage risks to the health, welfare and safety of people who may be at risk from the carrying on of the regulated activity (minor impact).

- We saw evidence of some internal audits undertaken by staff which covered a number of clinical areas and the storage and availability of emergency medicines. However a number of these have not been recorded to provide an on-going audit trail of information. For example we looked at staff recruitment files and training records. We noted there were no checks in place to ensure a thorough recruitment process had been undertaken. We noted a number of training services had been undertaken and completed, but the information was not readily available to the practice manager. This means there is an absence of monitoring systems to ensure patients health and safety whilst visiting the practice.

Patients, staff and visitors were not protected against the risks of unsafe or unsuitable treatment or support because the provider did not have an appropriate system for gathering recording and evaluating information about quality and safety of care, treatment and support (minor impact).

- The practice did not have a Patient Participation Group. We saw evidence of some internal audits undertaken by staff which covered a number of clinical areas and the storage and availability of emergency medicines. However a number of these have not been recorded to provide an on-going audit trail of information. For example we looked at staff recruitment files and training records. We noted there were no checks in place to ensure a thorough recruitment process had been undertaken. We noted a number of training services had been undertaken and completed, but the information was not readily available to the practice manager. We also noted that there were no records on the practice nurses' qualifications, professional development and pin

number. A pin number is a recognised system to identify individual nurses and if they are still qualified to work in this country. This meant there was an absence of monitoring systems to ensure patients health and safety whilst visiting the practice.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. There were no processes in place to identify, assess and manage the risks to the health, safety and welfare of people who use the service and others (moderate impact).

- We were told there were no formal processes for reviewing and monitoring the quality of care and service provided. We saw no evidence of audits or reviews for areas such as record keeping, documentation, infection and control practices, buildings' maintenance or clinical practices. Regular monitoring and review of care and services ensures that patients receive quality care in a safe environment.
  There were no risk assessment for the premises and no Legionella checks had been carried out. The provider was unable to show us that the premises and water supply were safe for patients use.
  A fire risk assessment had been undertaken in November 2010 and was due for review in November 2011. The review was not undertaken. The level of risk from the 2010 review was normal however there was 11 action points recommended. We saw that only three recommendations were completed. During our visit we raised our concern that the electrical cupboard was extremely hot. The risk assessment carried out in 2010 had recommended a fire door be fitted. We were told by the provider that the door was fire resistant. However, there was a ventilation hole cut out of the door, approximately four by five inches wide, thus preventing the door being fire resistant.
  There was evidence that learning from serious incidents and investigations took place and appropriate changes were implemented. We saw they were shared with the CCG and appropriate actions taken. However, these serious incidents had not been reported to the Care Quality Commission as is required by law. Staff told us there were no processes in place to report less serious incidents, for example slip trips and falls or staff accidents.

St 17 – People should have their complaints listened to and acted on properly

There was not an effective complaints system available. Comments and complaints patients made were not responded to appropriately (minor impact).

- Patients knew how to complain because the provider made their procedure available, although patients who did not speak or read English might have difficulty using it. Complaints from a patient were recorded on their medical records. Not all staff were aware of the provider's complaints procedure which meant patients were at risk of discrimination because their complaints were kept on the personal medical records. We saw a review of complaints from 2012. The review lacked any analysis or evidence that complaints were used for learning and service improvement. Some had no outcome recorded.