Bere Regis Surgery

Quality Report

Manor Farm Road, Bere Regis,
Wareham,
Dorset
BH20 7HB
Tel: 01929 417268
Website: www.bereregissurgery.nhs.uk

Date of inspection visit: 3 June 2014
Date of publication: 13/08/2014

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

Contents

Summary of findings

Overall summary

The Bere Regis Surgery is a GP practice that offers general medical care to approximately 3500 patients in the Bere Regis and the surrounding rural area.

We visited the practice, which is based at Manor Farm Road, Bere Regis, Dorset on 3 June 2014 to carry out our inspection.

Patients provided feedback (before and during our inspection) and told us they were happy with the care and treatment they received and they felt safe. They told us staff treated them respectfully and were helpful and added that their treatment was clearly explained to them and they were able to make choices.

Staff spoke politely to patients and consultations were carried out in private treatment rooms. Information was available for patients which included health promotion, access to support services and information about the practice and the services it provided.

We found that there were some systems in place to manage risk to patients but were not always monitored. These included recruitment and disclosure and barring service (DBS) checking procedures. We also found that a number of risk assessments had not been carried out. These included health and safety and fire safety. Improvements were needed in these areas to protect patients from harm.

During our inspection we looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups we reviewed were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

We found the practice provided a responsive service for some patients within each population group.

Bere Regis Surgery

Manor Farm Road

Bere Regis

Dorset

BH20 7HB

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall, improvements were needed to make the practice safe.

The practice had systems in place to safeguard vulnerable children from the risk of harm. However, although there was written information available for staff to follow if they had a concern about a vulnerable adult the practice did not have a policy for this. Also staff had not received vulnerable adults safeguarding training.

Some risk management procedures were in place for example controlled drugs, but there were none available for health and safety including a fire risk assessment. This meant that the risks to patients, staff and visitors to the practice were not assessed and measures were not put in place to prevent harm.

The practice had policies and procedures for the dispensing of medicines. The repeat prescribing system was set up in a way that would not generate a repeat prescription if a patients medication review was overdue which meant that overprescribing did not happen.

Medicines and forms associated with medicines were stored securely but measures to control risks were not always followed. For example, medicines were stored in the dispensary which had a min/max thermometer but the temperatures were not monitored which meant that medicines could be stored outside recommended temperature ranges and may not be effective. Also, we found one medicine in use which was out of date.

All areas of the practice were seen to be visibly clean and well maintained. Staff had received infection control training and demonstrated their understanding of the importance of following control procedures. However, records of checks made by the infection control lead of the standard of cleaning carried out by clinical and non-clinical staff where not kept.

Are services effective?

Overall the practice was effective.

Care and treatment was delivered in line with best practice guidelines. Clinicians were able to prioritise patients and make use of available resources.

Staff had annual appraisals and told us that their training needs were supported by senior staff. However, staff skills portfolios were only partially completed which meant that it would be difficult to identify when refresher training was required.

Summary of findings

The practice provided its patients with a wide range of information about health promotion in its waiting area and on its website.

Are services caring?

Overall the practice was caring.

We spoke with six patients who all told us they were always treated respectfully by the staff and their individual needs were considered. This was further evidenced during our observation of staff and patient interactions and discussion with members of staff about the way they provided practice to their patients.

We saw evidence of patient surveys carried out by the Patient Participant Group in January and February 2014. The results were positive which showed a positive patient attitude towards the practice and the service they provided.

While the area had a very low percentage of people whose first language was not English there was access to telephone interpreter services.

Are services responsive to people's needs?

Overall the practice was responsive to patients needs.

There was an open culture within the organisation and a comprehensive complaints policy. Complaints we looked at were investigated to a satisfactory conclusion for the patient.

Significant events were taken seriously and were responded to in a timely manner.

We saw patient and staff suggestions for making improvements had been acted on.

The practice was accessible for people with limited mobility and all areas of the premises were free of clutter. We did find however that the fire escape to the rear of the building had a step which may be a barrier for a wheelchair user in an emergency situation.

Are services well-led?

Overall, improvements were needed to make the practice well-led.

There was a structure in place to ensure that key members of staff had designated responsibility for areas such as safeguarding and infection control. Staff knew who their line managers were and told us they felt the team worked well together and that GPs were approachable.

Some clinical and non-clinical audits took place but there was no overarching audit plan to engage the team and ensure that quality was being measured, reviewed and improved to benefit patients.

Summary of findings

Not all the required risk management procedures were in place, for example fire risk assessment and health and safety.

An appraisal system was in place and followed in a timely way to ensure that all members of staff had received a current appraisal.

The practice was able to demonstrate that they used feedback from their Patient Participant Group and complaints to improve the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice held a monthly meeting of palliative care nurses, district nurses, community matrons where they discussed end of life care services for patients. The GP reviewed care needs annually with each patient who resided in a care home. This meant that older people's needs were met by the practice

People with long-term conditions

Staff offered help with referral booking to patients who needed support, such as those patients who had learning disabilities, were blind or deaf or those with dementia. This meant they could make their appointment at a time and place that suited them.

Annual reviews were carried out for patients with long term conditions which included diabetic checks. These checks covered their care plan and education on signs and symptoms of low or high blood sugar levels and routine blood sugar levels monitoring.

Mothers, babies, children and young people

The practice provided regular baby clinics which offered baby checks and immunisations.

Mothers with young children or babies were offered appointments at or the near end of the surgeries so that they didn't have to wait long.

Young patients had the option to see the nurse or of their preferred gender choice of GPs. The practice followed the Gillick competence guidance when treating young people. Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge.

The working-age population and those recently retired

The practice provided extended hours (outside office hours) to cater for the working population although other times were available.

Flu vaccines were also offered by GPs to these patients during the extended hours.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care Patients living in gypsy and traveller communities did not have to make appointments if they were not registered with the surgery. This meant they could walk in and an appointment was given	
People experiencing poor mental health The practice used instant Improved Access to Psychological Therapies (IAPT) for patients experiencing conditions, for example depression or anxiety. A patient could refer themselves and offered a choice of location in which to attend (this could be another surgery). The practice offered their counsellor to other local surgeries and patents were able to be seen at a different location from their surgery	

Summary of findings

What people who use the service say

We received 38 patient comments about the Bere Regis Surgery before and during our inspection of which 34 were favourable. Patients commented about the staff being very comforting towards them and welcoming. They also commented about how they liked having the facility to order repeat prescriptions online.

Of the 38 people who provided feedback one said their waiting time to see a GP was sometimes longer than expected. Two other patients expressed difficulty in getting appointments. Another patient spoke about overhearing the receptionist speaking to a patient on the phone which identified them and their medical need.

We looked at the results of a national patient survey held in 2013. The results were favourable and showed a positive patient attitude towards the service Bere Regis Surgery provided, 86% of patients surveyed said they would recommend their GP and 87.2% of patients rated the practice as either good or very good.

We also looked at the results of a survey carried out by the Patient Participant Group (PPG) in February 2014. Of 247 patients who responded 240 (97%) said they were satisfied with range of appointments offered and 237 (96%) said they were satisfied with the practice premises. The PPG was made up of volunteer patients who fed back patient views and suggestions for improving, changing & developing services at the practice.

Areas for improvement

Action the service COULD take to improve

- Adult safeguarding training was not carried out by any staff
- Room temperatures where medicines were stored were not monitored to ensure they remained effective for use by staying below 25 degrees Celsius.
- Expiry dates of medicines in the dispensary were not monitored effectively to ensure they were in date.
- Identification and management of risks to the practice, patients and staff were not effective. For example fire risk assessments.

Good practice

Our inspection team highlighted the following areas of good practice:

- Patients from gypsy and traveller communities were offered immediate (on the day) appointments.
- Regular community based services such as Social Services clinics and Citizen Advice Bureau sessions were held at the surgery.

Bere Regis Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team of six was led by a CQC lead inspector and a GP. The team included two further CQC inspectors, one of which was a pharmacist specialist, and a variety of specialists that included an expert by experience (an expert by experience is a person who has experience of receiving services specific to our inspection) and a health professional.

Background to Bere Regis Surgery

Bere Regis practice is situated in Manor Farm Road, Bere Regis and covers the town of Bere Regis and the surrounding rural areas. The practice has been operating since 1984 and has its own pharmacy dispensary. The practice is responsible for providing primary care to approximately 3500 patients between 8.30am and 6.30pm from Monday to Friday.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

This was the first time the service had been inspected since it was registered with the Care Quality Commission in 2013.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health condition.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the practice. These organisations included Local Healthwatch, NHS England and the Clinical Commissioning Group.

We carried out an announced visit on 3 June 2014. During our visit we conducted a tour of the premises and spoke with a range of staff which included GPs, receptionists, secretaries, dispensary staff and practice nurses. We also spoke with six patients who used the practice and the chairperson of the practice Patient Participation Group (PPG).

Detailed findings

We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

We reviewed information that had been provided by the practice and looked at the surgery's policies, procedures and some audits. We reviewed other information that was available in the public domain.

Are services safe?

Summary of findings

Overall, improvements were needed to make the practice safe.

The practice had systems in place to safeguard vulnerable children from the risk of harm. However, although there was written information available for staff to follow if they had a concern about a vulnerable adult the practice did not have a policy for this. Also staff had not received vulnerable adults safeguarding training.

Some risk management procedures were in place for example controlled drugs, but there were none available for health and safety including a fire risk assessment. This meant that the risks to patients, staff and visitors to the practice were not assessed and measures were not put in place to prevent harm.

The practice had policies and procedures for the dispensing of medicines. The repeat prescribing system was set up in a way that would not generate a repeat prescription if a patients medication review was overdue which meant that overprescribing did not happen.

Medicines and forms associated with medicines were stored securely but measures to control risks were not always followed. For example, medicines were stored in the dispensary which had a min/max thermometer but the temperatures were not monitored which meant that medicines could be stored outside recommended temperature ranges and may not be effective. Also, we found one medicine in use which was out of date.

All areas of the practice were seen to be visibly clean and well maintained. Staff had received infection control training and demonstrated their understanding of the importance of following control procedures. However, records of checks made by the infection control lead of the standard of cleaning carried out by clinical and non-clinical staff where not kept.

Our findings

Safe patient care

We spoke with six patients who used the practice who all told us they felt safe and had confidence in the GPs and nurses. We saw the provider's recruitment policy and procedure they followed when employing new staff. Appropriate checks were carried out for GPs and nursing staff and they all had current registrations in place with their professional bodies. These registrations being with the General Medical Council (GMC) for GPs and Nursing and Midwifery Council (NMC) for nurses. This meant that patients were cared for by competent staff.

There were records of significant events and incidents. Staff had followed the procedures and risk assessed the three incidents recorded in the last 12 months. Meeting minutes we looked at recorded the investigation of an incident clearly and improvements were made. This meant that the practice learnt from adverse events.

Learning from incidents

There was a robust approach to investigating incidents and the analysis which followed the practice policy 'toolkit'. The actions taken had been recorded and they were reviewed at the next practice meeting. Other agencies had been contacted to help prevent similar events or incidents happening again. An example of where incidents investigated affected change was that community matrons now visited patients unable to come into the practice for their annual health review. This meant that patients care was delivered in way to meet their needs.

Safeguarding

The practice had a policy in place for the protection of children, but there was no policy for vulnerable adults. This meant that staff had written information to refer to should they have a concern regarding the safety of a child. However whilst the practice did not have a policy for safeguarding vulnerable adults it did have information on display in the reception which was a flow chart that gave clear instructions how to report a concern and to whom. For example, the local authority and police. We were told that a GP was the safeguarding lead for the practice. We spoke with them and were told that they gave a safeguarding talk, after their training, to staff in the practice and records confirmed this. Another GP and nurse we both spoke with also confirmed they had received training in safeguarding children. Reception/administration staff

confirmed they had a talk from the GP and they carried out online training for safeguarding children. We saw a training schedule that had been produced by practice manager which also confirmed this. All the staff we spoke with told us they were aware of their responsibilities. Two members of staff gave us separate examples of when they had used the protocols. However, staff had not received any vulnerable adult safeguarding training but a nurse confirmed that this was happening later in the month. This was confirmed by the practice manager who told us that previously arranged training had been cancelled at the last minute.

The practice had a whistle blowing policy and procedure for staff to follow. The policy included contact details of external organisations. We spoke to three members of staff who demonstrated their understanding of it and gave examples of when it should be used. This meant the practice supported its staff.

Monitoring safety and responding to risk

We saw evidence that learning from incidents took place and appropriate changes were implemented. We were shown records of significant event analysis meetings which included both clinical and non-clinical incidents and learning outcomes. Where incidents involving medicines were identified the practice would log and investigate the incidents. We saw records which confirmed this. This meant that investigations looked at how processes could be changed to minimise the risk of the incident occurring again.

Medicines management

We saw that the practice had policies and procedures covering the supply of medicines which we observed being followed by staff. Medicines were purchased from approved suppliers. Medicines requiring refrigeration were store in specific refrigerators for medicines. The minimum and maximum temperatures of these refrigerators was monitored which meant that should the temperature go above eight or below five degrees Celsius it would be highlighted and actions taken which may include the disposing of the medicines affected. The practice was unable to tell us if the rooms were medicines were stored were kept within recommended temperature ranges. This meant that the storage of medicines appeared to not follow the standard for medicines management guidelines issued by The Royal Pharmaceutical Society.

The practice monitored the frequency repeat prescription requests were made by patients and escalated any resulting concerns to the GP. The repeat prescribing system would not allow the issuing of repeat prescriptions if a medication review was overdue. The practice had identified that a few patients would forget whether they had collected their medicines. We saw that the practice undertook additional monitoring of these patients, by way of a log, which meant their medicines were managed safely.

Cleanliness and infection control

We saw that all areas of the practice were visibly cleaned, odourless and well maintained. Patients we spoke with told us the practice was clean. We looked at three consulting rooms and found them to be clean. We were told that all nursing staff received annual infection control training in November 2013. Records we looked at confirmed this. A practice nurse was the designated infection control lead.

We saw hand cleansing gels were located close to the sinks. There was written and pictorial information about hand washing displayed above sinks. This promoted good hand hygiene. Records confirmed that staff had received hand hygiene training.

There were sufficient quantities of personal protective equipment (PPE), including gloves and aprons and the consulting couches had paper rolls protecting them. There were appropriate procedures in place to protect staff and patients from dangers associated with sharps, such as needles. Sharps bins were secured to walls and out of the reach of children. We saw a contract for clinical waste removal and records of when this waste was collected. This meant contaminated waste was safely removed from the premises.

We saw the practice infection control policies. These covered areas such as hand hygiene, cleaning protocols for clinical staff's uniforms, sharps, waste, cleaning and safe handling of samples. We asked to see the surgery's annual infection control statement but were told, by the infection control lead, that this was not available as it had not been written. This indicated that the guidance as detailed in the Health and Social Care Act 2008 - Code of practice on the Prevention and Control of Infections was not being followed. The code of practice states that the annual

Are services safe?

statement should provide a short summary of known infection transmission events, audits undertaken, risk assessments undertaken, staff training and reviews of policies and procedures.

We were shown an infection control audit that had been carried out three working days before our visit. The infection control lead told us the audit had not been collated by the time of our visit.

The practice manager told us that a cleaner was employed to clean all the areas of the practice. We saw an environmental cleaning policy and checklist which was followed by the cleaner. This cleaning took place out of practice hours. We saw that there was a cleaning checklist in place. Information about the colour coding of cleaning equipment to be used for various areas of the practice was on display in the cleaning cupboard. We saw that some cleaning equipment that did not follow the guidelines set out in the Health Technical Memorandum 01-05 (HTM01-05).

We were told that clinical staff were provided with a cleaning plan for each treatment room. We saw this plan present in each treatment room and this was laminated which meant that staff did not have a way to record that they had carried out the tasks on the plan. The infection control lead told us they carried out visual checks on the standards of cleaning by both the clinical staff and cleaner but did not record these but would implement this immediately following our visit. This meant infection prevention and control guidance was not fully followed and could place patients at risk.

Staffing and recruitment

We looked at the recruitment record for one non-clinical member of staff who started working at the practice in June 2013. Satisfactory checks had been made on this persons identity, place of residence and conduct in previous employment. We also saw a completed and signed induction record. There was no record to confirm that a Disclosure and Barring Service (DBS) check for criminal records had been carried out for staff other than GPs. The criminal records checking policy was reviewed in May 2014 and stated that the practice would carry out checks for all staff every three years for all staff. This meant that the provider was not following its own policy to ensure patients were cared for by staff who were appropriately checked.

Dealing with Emergencies

Staff working at the practice had received emergency first aid training. Emergency medicines were available, within their 'use by' date and stored securely. The practice was unable to tell us if the rooms, where emergency medicines were stored, were kept within their recommended temperature ranges. This meant that emergency medicines may not be effective to a patient experiencing a medical emergency.

There were procedures to ensure that reception staff knew how to respond to medical emergencies both in the practice and on the telephone if a patient called the practice with a medical issue. A member of staff told us how they would alert the duty GP in the practice and call an ambulance to assist a patient who telephoned. The staff member had received life support training that included defibrillator training in the 12 months prior to our visit.

There were plans available to ensure continuity of the care at the practice in the event of emergencies. The plans were reviewed annually and contained a flow chart of contact organisations. Mutual arrangements with other surgeries were recorded and the contact details for the Care Commissioning Group emergency planning officer. This meant that the practice could continue to offer a service should an emergency happen.

A fire risk assessment for the practice had not been carried out. We were told that following informal external advice it was not deemed necessary to do this. This meant the provider appeared to not follow the Regulatory Reform (Fire Safety) Order 2005 which states that a fire-risk assessment must be carried out to identify any possible dangers and risks.

Equipment

We were told that equipment checks had been regularly carried out in line with manufacturer recommendations but records of these checks were not seen during our inspection.

Are services effective?

(for example, treatment is effective)

Summary of findings

Care and treatment was delivered in line with best practice guidelines. Clinicians were able to prioritise patients and make use of available resources.

Staff had annual appraisals and told us that their training needs were supported by senior staff. However, staff skills portfolios were only partially completed which meant that it would be difficult to identify when refresher training was required.

The practice provided its patients with a wide range of information about health promotion in its waiting area and on its website.

Our findings

Promoting best practice

Two GPs in the practice both confirmed that they follow the National Institute for Clinical Excellence (NICE) guidelines and other guidance by the relevant professional bodies. NICE guidelines are recommendations on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales. One GP told us that following an audit of dermatology referrals in the locality they adopted a practice based referral protocol for dermatology referrals. Records seen on the practice computer system confirmed this. We saw adequate seating in the waiting room and relevant health promotion leaflets available in the waiting area and consultation rooms. This meant patients were supported to make informed decisions about the management of their health care and treatment. The senior GP partner spoke to us about the Mental Capacity Act 2005 (MCA) and gave an example of how a mental capacity issue was dealt in the practice recently. This meant that patients could be confident that their human rights were respected and taken into account.

We were told that patients that required end of life care and support were discussed in the practice multi-disciplinary team meetings (MDT) meetings. Meeting minutes confirmed this. We saw consent forms for patient injections. We were told that patients who gave verbal consent to treatment, was recorded on the practice computer system. This meant that systems were in place to record patient consent. However, we were told by a GP that some intimate examinations were not always documented in the patients notes.

Management, monitoring and improving outcomes for people

The senior partner showed us the prescription data pack and explained how the areas for improvement were identified and action taken. Records confirmed this. We saw that Quality Outcomes Framework (QOF) data, Clinical Commissioning Group (CCG) feedback, and audits were taken into consideration to improve practices. We were shown audits carried out by the surgery. For example, a patient testosterone level checking audit. Significant events were recorded and investigated. Minutes of staff

Are services effective?

(for example, treatment is effective)

meeting confirmed that these events were discussed with staff. We were told by two GPs that informal patient case discussion between took place almost every day. This meant that patients were provided with safe quality care.

Staffing

All the patients we spoke with during our visit spoke favourably about the staff at the surgery. We saw that staff had received appraisals during the last 12 months, objectives were set and some training/development identified. Staff confirmed they had appraisals annually and they were due again within next few months. We saw a list of staff and when they had their appraisal which confirmed this. However, appraisal forms had not been signed by the person being appraised or appraiser. Staff also confirmed that additional training had been offered to them; for example, customer care and medical terminology and as requested by them additional computer training, as well as mandatory requirements. The training schedule that the practice produced showed that some mandatory training had taken place on infection control, Cardiopulmonary resuscitation (CPR), health and safety and safeguarding children. This meant staff were supported to provide care and treatment to patients. However, we saw that not all the 'Staff Skills' portfolios were completed. For example, four members of staff had no records of their qualifications or courses they had attended written in their portfolios instead we found a blank sheet of paper with only their name and the headings which meant it was difficult to identify when refresher training was required.

Working with other services

The practice held regular multi-disciplinary team meetings which district nurses, health visitors, palliative care nurses, practice nurses and GPs attended. Minutes of these meeting confirmed this. We were told by three staff that a person from the local authority was available at the practice on pre-arranged days to provide patients the opportunity to discuss their social care needs. We saw that information about this practice was displayed in the waiting area. We saw information about a weekly Citizens Advice Bureau service held at the surgery. This was advertised in the waiting room and on the practice website. Message books for the district nurses, community matron and health visitors were seen with up to date messages in them. Information was shared between the out of hours (OOH) services and the surgery. We were told that this information was seen by GPs the next morning and action taken as appropriate. We were shown an example of the message template used. This meant that patients received coordinated care and support where more than one provider is involved or they are moved between services.

Health, promotion and prevention

We saw a number of health related information guides in the waiting area. These were in leaflet form which meant patients could take them away from the practice and read at home. This meant that patients were encouraged to take an interest in their health and take action to improve it. The practice offered a broad range of additional services to patients which focused on health promotion and disease prevention. For example smoking cessation and weight control. The practice website had information for patients which included information about how to book for clinics such as chiropody and midwifery. This meant that the patients were able to access services in their local area.

Are services caring?

Summary of findings

Overall the practice was caring.

We spoke with six patients who all told us they were always treated respectfully by the staff and their individual needs were considered. This was further evidenced during our observation of staff and patient interactions and discussion with members of staff about the way they provided a service to their patients. We saw evidence of patient surveys carried out by the Patient Participant Group in January and February 2014. The results were positive and showed a positive patient attitude towards the provider and the practice they provided. While the area has a very low percentage of people whose first language was not English there was access to telephone interpreter services.

Our findings

Respect, dignity, compassion and empathy

We spoke with patients who used the practice and they told us the staff were kind and caring. They gave examples of situations when the staff demonstrated compassion and respect. Feedback from the 31 completed comment cards indicated that all the patients were happy with the standard of care provided by the practice. All the patients we spoke with confirmed that they felt cared for. We observed receptionists speaking with patients in a kind and respectful manner. This meant that patients were made to feel well cared for and supported. Patients we spoke with told us they felt they were treated with dignity and respect. We observed that patients privacy was maintained even though the receptionist was located in the main area of the entrance to the surgery. We spoke with the receptionists who told us there was always a private room available for patients should they wish to discuss anything in private so other people could not hear. We saw staff speak in a quiet way to patients which indicated they were aware of the need to preserve confidentiality. We saw the patient waiting area was comfortable with sufficient seating. Consultations took place in clean consulting rooms which had a consulting couch for examinations and suitable curtains which offered protection for patients privacy and dignity. We were told by staff that patients could ask for a chaperone if they required one to be present at the examination but the practice did not promote this in consulting rooms. However this was rectified by staff who printed off signs and displayed them in the treatment rooms during our visit. This meant that patients were informed about the opportunity to request someone to support them during their appointment with the GP or nurse. This meant that patients had their privacy, dignity and independence respected by staff.

Involvement in decisions and consent

We were told that information was given to patients in the form of leaflets. A variety of health related leaflets were seen in the consultation rooms. This meant that patients had information to enable them to make informed decisions about their care.

We also saw information available for carers in the waiting area. This included the invitation for carers to take part in planning of care for a family member if they requested this or lacked the ability to make their own decisions about

Are services caring?

their care and treatment. We were told by a GP that when patients, relatives or carers contact the practice for advice or any issues, they phoned them back and discussed the matter with them. We were shown this in operation where a request to contact a patient was recorded as an action for the GP. This meant that patients were involved in their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the practice was responsive to patients needs.

There was an open culture within the organisation and a comprehensive complaints policy. Complaints we looked at were investigated to a satisfactory conclusion for the patient. Significant events were taken seriously and were responded to in a timely manner. We saw patient and staff suggestions for making improvements had been acted on.

The practice was accessible for people with limited mobility and all areas of the premises were free of clutter. We did find however that the fire escape to the rear of the building had a step which may be a barrier for a wheelchair user in an emergency situation.

Our findings

Responding to and meeting people's needs

Staff described how they took account of patient preferences, faith, and culture. They gave an example of a patient who was a Jehovah witness and it was entered on their notes that they did not want blood transfusions. Two members of staff spoke about patients who were of this faith as examples. A GP confirmed they would take into account people's views preferences as a natural part of consultation when it arose up and would note this on their system if appropriate. This meant that patients cultural needs were met in a way that protected their human rights.

Patients were offered 'choose and book' (choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Patients can book their own appointment through this system and the practice will offer help to the older patients or those having difficulty doing it themselves. This meant patients were able to make decisions about their treatment. We found that the practice had a satisfactory system for dealing with patient test results. We were shown the process the GP followed when they received these results. The process included actions the reception staff would take as a result of the GPs review. This could include making a follow up appointment for the patient or arranging further tests. Staff confirmed this process when asked.

We saw the practice 'Confidentiality (teenagers) Policy'. Staff we spoke with were aware of need to see young people and mentioned Gillick competence when asked about treating teenage patients. Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge. Staff confirmed they would make an appointment for someone under 16 if the patient had the ability to give informed consent to treatment. We were told that patients discharged from hospital, who required care, were contacted by the practice (when the practice received a patient discharge summary) and were visited by a Health Care Assistant (HCA) who is trained to take blood if needed. Practice nurses confirmed that they may go out to

Are services responsive to people's needs?

(for example, to feedback?)

complete diabetes check if a patient needed this. Also a district nurse may be involved if patient was housebound. This meant that the practice assessed the needs of patients and acted accordingly.

Access to the service

Bere Regis Surgery is situated in a purpose built building and was accessible to patients with mobility impairments. The consulting rooms were spacious and laid out in a way to provide easy access for patients with limited mobility. However, we found that the front door to the practice was heavy and saw two older people struggling to open it. This meant that this was a barrier to these patients who could not open the door without assistance. Patients spoke favourably about improvements that had been made to the waiting area of the surgery. We saw a selection of chairs available; some with arms and some higher than other chairs. There was a washroom available for patients and this was signed as being accessible to patients who were wheelchair users. We found this washroom did not have grab rails or emergency pull cord which could prevent staff being alerted to a patient in an emergency situation who may be unable to call for help. Access into the building was adequate we found the emergency exit, at the opposite end of the building from the front door, was stepped. This meant that a wheelchair user may find it difficult to exit the building in an emergency should this be their only way out. Patients we spoke with indicated that the phone in appointment system and the introduction of an evening surgery, for those who worked, was well received. The online repeat prescription ordering service was also highlighted as good practice.

Concerns and complaints

The practice had a complaints policy and we saw their complaints procedure displayed on the notice board in the waiting room. There were also leaflets which were available for patients to take away with them. Patients we spoke with confirmed they knew how to complain and two spoke about a notice in the waiting area. Another patient we spoke with told us that complaints information was included in the booklet they were given when they registered as a new patient. This meant the practice had a system in place to enable patients to make a complaint.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Overall, improvements were needed to make the practice well-led.

There was a structure in place to ensure that key members of staff had designated responsibility for areas such as safeguarding and infection control. Staff knew who their line managers were and told us they felt the team worked well together and that GPs were approachable.

Some clinical and non-clinical audits took place but there was no overarching audit plan to engage the team and ensure that quality was being measured, reviewed and improved to benefit patients.

Not all the required risk management procedures were in place, for example fire risk assessment and health and safety.

An appraisal system was in place and followed in a timely way to ensure that all members of staff had received a current appraisal.

The practice was able to demonstrate that they used feedback from their Patient Participant Group and complaints to improve the practice.

Our findings

Leadership and culture

Staff we spoke with described how they were aware of the vision of surgery. One spoke about one of the GPs desire to become a trainer and the practice having a GP registrar in the future. A second nurse confirmed this and said they understood the future direction the surgery. They told us they were involved in discussions about the recent building work and changes to the computer and telephone system. Practice meeting minutes confirmed this. All the staff we spoke with confirmed there was good team working ethic and that they helped each other out. One commented on how much better it was with the change of doctors, who they said were, bringing in new ideas and keeping them better informed of what was going on. All the staff we spoke with confirmed that they felt comfortable about raising issues and concerns. They said they could add items to agendas for meeting. One member of staff told us how they were treated compassionately with the practice being very flexible and understanding. This meant staff were included in decisions about how the practice was run and their views were regarded favourably.

Governance arrangements

We identified that not all senior staff had received governance training (governance is the establishment of policies, and continuous monitoring). We found that staff and clinicians were not clear about who had responsibility for governance. They were not aware of who the Caldicott Guardian was and mentioned a receptionist in the first instance as being the guardian (a Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing). When we asked other staff they were unsure. A receptionist went to ask the GP who it was and they were not sure and going to ring the practice manager. In the meantime going through the policies we found on the data protection policy that the practice manager was listed as the Caldicott Guardian. This meant that the practice may not apply its data protection policy effectively.

Systems to monitor and improve quality and improvement

We saw a Metal Capacity Act (MCA) 2005 policy which had been updated in February 2013. Staff we spoke with told us they would try and explain things clearly to these patients and would remind them of appointment. We were told by

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

two staff that a note would be put on a patients screen if they had a particular condition which could prevent them accessing the practice. An example of this was a person with dementia.

A GP told us about a request they had from a patient wishing to have a testimonial saying they had mental capacity (mental capacity means a patients ability to make their own choices and decisions). The GP said they researched the Mental Capacity Act 2005 and had contacted their Medical Defence Union for advice. This GP told us that when the doctors meet on a Monday they talk about patient concerns and issues and also significant events where they would reflect on these. Another GP we spoke with confirmed this. We were also told that significant events were discussed at three monthly practice meetings and another GP confirmed that they discussed the learning from these practice minutes confirmed that significant events were discussed. Administration staff also confirmed that significant events were discussed at practice meetings and confirmed that they learnt from these. This meant that the practice improved by learning from events.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG). The PPG ensured that their notice board in the waiting room informed patients about the various groups they could join to help maintain their health and wellbeing. We spoke with the lead from the PPG. They told us the practice was open and supportive. A doctor had attended their regular meetings and two members of the PPG attended the practice meetings. The PPG patients survey results were followed up with action from the surgery. Information about the survey results and action taken had been on the practice web site, in the parish magazine and in the waiting room. Patients had been listened to. The practice had more treatment room space and medicines were delivered to older patients that could not get to the surgery. A confidentiality concern raised by patients had been addressed. Notices were put up in the practice about confidentiality and staff had received additional confidentiality training. Staff we spoke with were aware of the concerns of patient confidentiality and described how they had reduced the risk of being overheard. They told us they would provide a private room to talk to patients when asked. This meant that patients comments and complaints were listed to and acted on.

Staff engagement and involvement

We spoke with a member of staff who told us felt supported by the practice staff and had their training needs met. Another staff member told us about how the GPs were supportive of their training needs and were open to any request to attend study days. They went on to tell us how the GPs listened to their opinions and respected their knowledge and input at meetings. All the staff we spoke with confirmed that they had annual appraisals. One told us they were keen to complete the new computerised 'System 1' recording tool training. This meant patients were cared for by staff who felt supported.

Learning and improvement

We were shown two examples of audits to improve patient care. One example was an annual INR audit (INR is a test of the rate of blood clotting, which is primarily used to monitor warfarin therapy) which they told us they had introduced in 2012 after nurses underwent anticoagulation training. We saw a reduction in patient INR out of target specification. With patient prevalence now at 86.7% which is seen as good. We saw that they followed the National patient safety audit (NPSA) guidelines for INR testing. This is also a rolling audit. One recommendation was to invest in precision software for this testing which they had done. This meant that national guidelines were followed to improve patient care.

Identification and management of risk

There were no records to support the identification and management of risks which included health and safety, fire and equipment. We spoke with the practice manager about this who told us that risk assessments were on their 'to do' list. This meant that risks to patients, staff or visitors were not identified or managed to ensure they were safe and free from harm.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Patients who resided in nursing homes had their medicines audited and were reviewed in person annually by the GP. The practice held a monthly meeting of palliative care nurses, district nurses, community matrons where they discuss their end of life care for patients.

Our findings

Safe

Patients who resided in nursing homes had their medicines audited and were reviewed in person annually by the GP.

Caring

The practice held a monthly meeting of palliative care nurses, district nurses, community matrons where they discuss their end of life care for patients.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Staff offer help with referral booking to people with learning disabilities, blind, deaf or those with dementia so that they can make their appointment at a time and place that suits them. They may not be comfortable with using the system or have limited vocabulary.

Annual health reviews were carried out for people with long term conditions which included diabetes checks. Individual care plan for patients who had diabetes. This included low blood sugar awareness and monitoring.

Our findings

Safe

Staff offered help with referral booking to patients who needed support, such as those patients who had learning disabilities, were blind or deaf or those with dementia. This meant they could make their appointment at a time and place that suited them.

Responsive

Annual reviews were carried out for patients with long term conditions which included diabetic checks. These checks covered their care plan and education on signs and symptoms of low blood sugar levels and routine blood sugar levels monitoring.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice provided regular baby clinics which offered baby checks and immunisations. Mothers with young children or babies are offered appointments at the near end of the surgeries so that they don't have to wait long.

Young people have the option to see the nurse or of their preferred gender choice of GPs. The practice followed the Gillick competence guidance when treating young people (without the knowledge and consent of their parent/guardian).

Our findings

Safe

The practice provided regular baby clinics which offered baby checks and immunisations.

Caring

Young people have the option to see the nurse or of their preferred gender choice of GPs. Mothers with young children or babies are offered appointments at the near end of the surgeries so that they don't have to wait long.

Responsive

The practice follows the Gillick competence guidance when treating young people (without the knowledge and consent of their parent/guardian). Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without parental permission or knowledge.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice provided extended hours (outside office hours) to cater for the working population although other times were available. Flu vaccines were also offered by GPs to these patients during the extended hours.

Our findings

Effective

The practice provided extended hours (Monday 7.30 – 7.45am and Monday, Thursday and Friday 6.30 – 6.45pm) to cater for the working population although other times were available. Flu vaccines were also offered by GPs to these patients during the extended hours.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

People living in gypsy and traveller communities didn't have to make appointments if they are not registered with the surgery. This meant they could walk in and an appointment was given.

Our findings

Caring

People living in gypsy and traveller communities didn't have to make appointments if they are not registered with the surgery. This meant they could walk in and an appointment was given.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice used instant Improved Access to Psychological Therapies (IAPT) for patients experiencing mental health conditions, for example depression or anxiety. A patient could refer themselves and offered a choice of location in which to attend (this could be another surgery). The practice offered their counsellor to other local surgeries and patents were able to be seen at a different location from their surgery.

Our findings

Caring

The practice used instant Improved Access to Psychological Therapies (IAPT) for patients experiencing mental health conditions, for example depression or anxiety. A patient could refer themselves and offered a choice of location in which to attend (this could be another surgery). The practice offered their counsellor to other local surgeries and patents were able to be seen at a different location from their surgery.