Dr Robert Gardner

Quality Report

218 Saltash Road
Keyham
Plymouth
PL2 2BB
Tel: 01752 562843
Website: www.saltashroadsurgery.co.uk

Date of inspection visit: 11/11/2014
Date of publication: 31/03/2015

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.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Dr Robert Gardner of Saltash Road Surgery was inspected on Tuesday 11th November 2014. This was a comprehensive inspection.

Saltash Road Surgery is a GP practice on the outskirts of Plymouth city centre. The practice supports around 2160 patients and offers general and enhanced services led by the practice GP and practice nurse. The range of services includes health screening, antenatal and postnatal care, minor surgery, immunisations, contraceptive services, asthma and diabetes advice, chronic disease management, mental health care and care of social related illnesses. The GP has a special interest in chronic disease management.

We rated this practice as good

Our key findings were as follows:

The practice had a patient-centred focus. Patients felt they were treated with dignity and respect and in a professional manner that showed kindness and care towards them.

Patients were able to see a GP or have a telephone consultation on the day of requesting an appointment. Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care.

The practice valued feedback from patients and act upon this. Feedback from patients about their care and treatment was consistently positive. We observed a non-discriminatory, person centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patient capacity to make informed choices and decisions and the promotion of good health.

Summary of findings

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Both staff and patients said the practice was well led by Dr Gardner. However, administrative processes were incomplete and could compromise patient safety. All staff had received inductions but not all staff had received regular performance reviews. Staff meetings were ad hoc and infrequent. Staff said they managed well but the lack of managerial support was evident as systems such as recruitment and continual support and development were lacking.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Significant events, complaints and incidents must be investigated and discussed. Learning from these events must be performed and communicated.

Recruitment processes must be improved to include proof of identity, including a recent photograph, references, a full employment history, and a risk assessment to determine the decision regarding carrying out a criminal record check, using the Disclosure and Barring Service (DBS).

Ensure a risk assessment and any necessary actions are taken against the risk of Legionella.

In addition the provider should:

Patients individual notes kept behind the reception desk should only be visible to staff.

Emergency drugs should be kept under review and ensure the necessary checks are undertaken to ensure they are correct.

An updated fire risk assessment should be undertaken.

All staff should have a formal appraisal.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

Administrative processes were incomplete and could compromise patient safety. All staff had received inductions but not all staff had received regular performance reviews. Staff meetings were ad hoc and infrequent. Staff said they managed well but the lack of managerial support was evident as systems such as recruitment and continual support and development were lacking.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity to make informed choices and decisions and promoting good health. Staff had received training that was appropriate to their roles and any further training needs had been identified and planned. Staff worked with and communicated well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 12 Care Quality Commission (CQC) comments cards were received, and discussion with nine patients on the day of inspection all provided positive feedback. A common theme was that the staff were extremely focussed on keeping the care of patients at the centre of their work and patients were always treated with respect and compassion. This was borne out in the way staff engaged with patients with complex communication needs. Staff we spoke with were aware of the importance of providing patients with privacy, and information was available to help patients understand the care available to them.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available on the same day.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had systems in place to provide on-going monitoring and management of risk. The leadership within the organisation held itself to account for the delivery of an effective service. The practice promoted an open and fair culture.

The practice had a leadership structure and although staff felt supported by management there was limited time available for staff to have meaningful meetings and discussion when issues arose. This was partly due to the practice manager only working one day a week.

Governance meetings were held infrequently, every six months. The practice proactively sought feedback from patients when they could, but had difficulty recruiting and maintaining an actual patient participation group (PPG). The practice had a virtual PPG and involved them when required.

All staff said they felt supported by Dr Gardener and were very complimentary about his leadership. The practice manager was employed one day a week .There was a plan in place to employ a full time practice manager in the near future.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their medicine regimes and that their health and care needs were being met. For those people with the most complex needs, Dr Gardner worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were well organised baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening.

The practice had effective relationships with health visitors, midwives and the local school's nursing team. They were able to access support from children's' workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families.

Men, women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. Patients could also be referred to the specialist sexual health clinic in the city for more complex sexual health screening and treatment.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The staff carried out health checks on patients as they attend the practice. This included offering patients referrals to particular groups and clinics for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests including prostate cancer screening and testing cholesterol levels.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of vulnerable people. The practice had a vulnerable patient register. These patients were reviewed monthly at the multidisciplinary team meetings.

Staff told us that there were some patients who had a first language that was not English. Patients with interpretation requirements were known to the practice and staff knew how to access these services.

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant external agencies if they were concerned about possible abuse, in normal working hours and also out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case-management of patients experiencing poor mental health, including those with dementia. In particular, advance care planning had been carried out for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

Summary of findings

organisations. Patients had access to a counsellor and were offered on-going support by the counsellor and GPs. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

There was communication, referral and liaison with a psychiatry specialist who offered advice and support. The GPs could refer patients for mental health assessment and also treatment for older patients who had mental health issues. This included advice and assessments for patients with dementia.

GPs and nurses were aware of the Mental Capacity Act 2005 (MCA) and had received training on this. There was nationally recognised examination tools used for people who were displaying signs of dementia.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 12 comment cards which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they got good treatment. Patients told us that the GP was excellent.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice. Patients commented on the building being old and in need of upgrading but said it was always clean and tidy.

Patients said they felt their privacy and dignity was protected and that they were asked for their consent before any care or treatment took place.

Patients found it easy to get repeat prescriptions and said they thought the website was good.

Areas for improvement

Action the service MUST take to improve

Significant events, complaints and incidents must be investigated and discussed. Learning from these events must be performed and communicated.

Recruitment processes must be improved to include proof of identity, including a recent photograph, references, a full employment history, and a risk assessment to determine the decision regarding carrying out a criminal record check, using the Disclosure and Barring Service (DBS).

Ensure a risk assessment and any necessary actions are taken against the risk of Legionella.

Action the service SHOULD take to improve

Patients individual notes kept behind the reception desk should only be visible to staff.

Emergency drugs should be kept under review and ensure the necessary checks are undertaken to ensure they are correct.

All staff should have a formal appraisal.

Dr Robert Gardner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience.

Background to Dr Robert Gardner

Saltash Road Surgery is a GP practice on the outskirts of Plymouth city centre. The practice supports around 2160 patients and offers general and enhanced services led by the practice GP and practice nurse. The range of services includes health screening, antenatal and postnatal care, minor surgery, immunisations, contraceptive services, asthma and diabetes advice, chronic disease management, mental health care and care of social related illnesses. The GP has a special interest in chronic disease management.

The practice opened from 8am to 6pm three days a week and 7.30am to 6pm on the other two days to accommodate those needs for people who were working. The practice also opened later in the evenings when needs demanded.

The practice has a virtual patient representation group (PPG). This is a group that acts as a voice for patients at the practice.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before conducting our announced inspection of Saltash Road Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

Detailed findings

We carried out our announced visit on Tuesday 11 November 2014. We spoke with nine patients and four staff at the practice during our inspection and collected 12 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, one GP, receptionists/clerical staff and practice nurse. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the surgery and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were not discussed at formal practice meetings. There was no evidence that appropriate learning had taken place and findings had not been disseminated to relevant staff. For example test results were sent to Dr Gardener dating back to March 2014 instead of another GP with the same name in the county. No action had been taken by the practice to push these back to the correct practice. This was not recorded as a significant event and no actions were in place to stop it from happening again.

National patient safety alerts were shared with practice staff and accessible on the practice intranet. Staff told us alerts were discussed at daily meetings between the GP and the nursing team to ensure all were aware of any relevant to the practice, and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The staff team had clear oversight of patients who could be at risk of unplanned admissions to hospital, receiving palliative care or had complex care needs. The team worked in close collaboration with other health and social care professionals to manage and review the risks for vulnerable patients.

Practice training records showed that all staff had received relevant role specific training about safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant external agencies in and out of hours. Contact details were easily accessible on the notice boards in the practice.

Dr Gardner was the dedicated GP as lead in safeguarding vulnerable adults and children who had been trained to level three, to enable fulfilment of this role. All staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information that made staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. An example was discussed with the safeguarding GP lead and lead nurse, both of which demonstrated that the practice worked collaboratively with the safeguarding board, parents and other health and social care professionals to protect the children involved. Staff explained that patient records flagged concerning information and highlighted potential risks for vulnerable adults and children using a coded system. Dr Gardner explained that the practice had identified vulnerable adults and worked closely with other health and social care professionals to protect people.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. The practice policy highlighted that only nurses and healthcare assistants carried out chaperone duties. Chaperone training had been undertaken by all nursing staff, including health care assistants. The staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination of a patient.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

Requires improvement

Are services safe?

The practice must improve the way they manage medicines. Emergency medicines and equipment were available at the practice. Systems were in place to make sure these were checked regularly. However, we found that although the emergency drugs had been checked, staff had not identified that the incorrect type of hydrocortisone for injection was in place.

There was a refrigerator in the treatment room for any items requiring cold-storage, there was monitoring of temperatures to ensure these medicines were stored correctly.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. There were systems to record any errors or incidents occurring, so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. We found that there had been no incidents reported in the last year.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. There were systems in place to ensure that all prescriptions were authorised by the prescriber, and that patient prescriptions were regularly reviewed. The computer system allowed for highlighting high risk medicines and those that required more detailed monitoring, and for checking for allergies and interactions. We discussed the way that patient records were updated following a patient's hospital discharge or a home visit. Systems were in place to make sure that any changes or updates to patient medicines were always made and authorised by the GP.

Vaccines were stored appropriately. There were auditing systems in place to ensure that the cold chain was maintained ensuring that these products would be safe and effective to use with patients. Fridges were not hardwired and there was no system or risk assessment in place to reduce the risk of staff accidently switching off medication fridges.

Other medicines kept at the practice for use by GPs and practice nurses were stored safely and systems were in place to monitor expiry dates. Blank prescription forms for printing were stored securely.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the nurse had received appropriate training to administer vaccines. The nurse had also received appropriate training to administer travel vaccinations and give travel advice.

Cleanliness & Infection Control

Nine patients we spoke with told us the practice was always clean and tidy and this was borne out by our observations.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that nursing staff had carried out monthly audits of treatment areas, providing assurance that deep cleaning of these areas took place.

Policies in place covered areas such as personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this guidance.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However not all wash basins in toilets had paper towels and liquid soap in place.

There was an appropriate system for safely handling, storing and disposing of clinical waste with records to support this. Clinical waste was stored securely in a dedicated secure area within the practice whilst awaiting its weekly collection by a registered waste disposal company. This weekly collection included the sharps bins.

The practice did not carry out Legionella testing. The practice manager confirmed that this required an assessment and if it was necessary, this would be put in place.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations,

assessments and treatments. They told us that all equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment.

Staffing & Recruitment

We looked at the recruitment records of two staff employed within the past year. Both did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, there was no proof of identification, no written references, no risk assessments to determine the decisions re carrying out criminal records checks via the Disclosure and Barring Service (DBS).

There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. The staff group had been less stable over the past year with two members of staff leaving. The practice recruited four new members but only one remained. The practice manager worked only one day a week and worked within pressured time constraints which contributed towards the lack of formal management systems. For example there were infrequent of staff meetings, all staff had not received an annual appraisal and some of the required recruitment processes were incomplete.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to shock a person's heart back in to rhythm in an emergency). All staff asked knew the location of this equipment and records confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. However, not all the medicines were fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken three years ago by the practice manager that included actions required maintaining fire safety. However, there was no updated fire risk assessment in place or records to show that previous actions required had been completed. We saw records that showed staff were up to date with fire training. Fire drills were undertaken which was confirmed by the practice manager.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP told us they lead in specialist clinical areas such as chronic illness, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice was keen to ensure that staff had the skills to meet patient's needs. For example, the nursing team had updated their skills in their lead roles to ensure best practice was being followed in relation to diagnosis, medicines management and care. There were annual check and health action plans for patients living with learning disabilities.

The practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

Effective staffing

The practice employed one registered nurse (RN) and one healthcare assistant. We spoke with one nurse who told us they had updated their clinical skills but had not received a formal appraisal each year. Informal discussions were had between the registered nurse and the GP on a daily basis. The nurse told us they received appropriate support and supervision from their peers and the GP. The nursing team had been working together for several years and covered any leave or sickness themselves where possible. The nursing team said they considered there were enough staff on duty to meet the needs of the patients.

We spoke with administrative staff about appraisal. They all told us they received an annual appraisal. The newest staff member told us she had received a two week induction which covered all aspects of her role as well as including health and safety topics such as fire prevention, however this induction programme was not recorded. We saw annual appraisals were completed for the GPs. An induction programme was run for specialist trainee doctors who spent four months in general practice. These are qualified doctors who are training to become GPs.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were mental health services, health visitors, specialist nurses, hospital consultants and community nursing.

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Communication with the out of hours service was good as the Out of Hours GPs were able to access patient records with their consent, using a local computer system. The practice GPs were informed when patients were discharged from hospital. This prompted a medication review.

The practice were working collaboratively with hospital diabetic specialist which meant patients did not need to visit the hospital but still received advanced specialist care. The GP also benefitted by receiving education on the management patients with complex diabetic needs

Information Sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

All of the staff we met were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. The GP and nurses we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. All patients with learning disability were offered a physical health check each year.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Family planning, contraception and sexual health screening was provided at the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect at Saltash Road Surgery. During our inspection all the staff spoke to patients politely. The nine patients we spoke with confirmed this was the case on every previous occasion too. Due respect was paid to confidentiality. Doors were kept closed during consultations. There were curtains in consultation rooms which provided a screen between the treatment couch and door to maintain privacy and dignity. To ensure against interruption, and promote patient confidence during treatment or examination, the treatment room door could be locked from the inside should the patient wish. Within consultation and treatment rooms, windows were obscured with blinds or curtains to ensure patient's privacy. Patients informed us that when intimate examinations took place staff used screens and a covering to maintain dignity. There were signs in the waiting area and in the consultation and treatment rooms about the chaperone service. These signs explained to patients that they may wish to request another person to be present when they were being examined or treated by the GP or nurse. The sign also explained that sometimes the GP or nurse would require the presence of a chaperone.

The practice had two GP consultation rooms one on the ground floor and one upstairs. The treatment room was on the ground floor. Wheelchair access was available through a side door to the surgery.

Patient's notes were kept behind the desk in the main reception area. Patient's names could clearly be seen on these notes which did not protect peoples' confidentiality.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff. We were given specific examples where the GP and nurses had taken extra time and care to diagnose complex conditions.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice.

Notices in the patient waiting room and patient website sign-posted people to a number of support groups and organisations. The practice's computer system alerted the GP if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted by Dr Gardner. They said the personal list he held helped with this communication. There was a counselling service available for patients to access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Patients told us that the practice responded to their individual health needs well. Nine patients we spoke with consistently commented that their GP had an in depth knowledge about their needs and the needs of their family. Some said that several generations of their family were registered with the practice out of choice because of the friendly and caring approach they experienced. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

Patients said the prescription system was good. Some patients used the on line request service, whilst others called in to collect theirs from the dispensary. All patients said the process took a maximum of three days. The local dispensary was situated just a few doors away and the practice had good relationships with them. The dispensary collected prescriptions twice a day from the practice.

Secondary care referral to hospitals or other health providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system.

Tackling inequity and promoting equality

The practice is an old converted terraced house. The building itself was tired and in need of decorating and modernisation. The practice had ramped access from the main street to the side door of the practice. Inside there was one GP consultation room (this was used primarily) and the treatment room on the ground floor, another consultation room was located on the first floor. There were stairs but no lift. The toilets were located on the ground floor; however the toilet was not big enough to accommodate a wheelchair.

The practice had patients who were unable to communicate in English. For those where this was the case, arrangements were made with the patient's family who, with consent of the patient, had agreed to interpret and translate. The practice also had access to a language service for other languages if a family member or friend was not suitable or available.

Access to the service

The practice opened from 8am to 6pm three days a week and 7.30am to 6pm on the other two days to accommodate those needs for people who were working. The practice also opened later in the evenings when needs demanded. The practice used to close at lunchtime but the practice staff were concerned about the lack of cover during this time and a decision was made to remain open for patients throughout the day. One patient we spoke with said this was really helpful as they were able to get to the GP if needed during their lunch break.

Patients could call after 8am to request a nurse triage consultation. The nurse would then call the patient back to discuss their needs and make an appointment with the GP if required. Pre bookable appointments were also available.

Patients could call after 2pm to request a repeat prescription and for test results. The GP told us this system had evolved in response to patient feedback and staff suggestions. We received very positive feedback from the patients we spoke with who had requested a call-back. They also all confirmed that they knew they would receive a same day call.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients to frail to go into the practice and also to patients who needed to see a GP and who lived in local care homes.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice with a nominated person in their absence. A notice displayed in the waiting area gave advice about how a concern or complaint should be raised. Reception staff were familiar with the complaints procedure. They confirmed that the practice manager was involved if an issue brought to their attention at the reception desk. The nine patients we spoke with felt confident that they could raise any concerns or complaints without fear of victimisation.

We looked at complaints received by the practice over the past 24 months. There had been none received since December 2013. These were handled satisfactorily and in a timely manner.

Are services well-led?

Good

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

Our findings

Vision and strategy

Staff were able to describe the vision, values, strategic and operational aims of the practice. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice.

The practice nurse told about the nurses' forum run locally and of which they were a member. This provided all the practice nurses with clinical updates and gave them an opportunity to meet monthly for peer review and support.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of patients not seen within the past five years was being undertaken. These patients were being contacted and offered an appointment; we saw evidence that confirmed this. Also patients under the age of 40 were being contacted and offered a health check. The practice had arrangements in place for identifying, recording and managing significant events. They were discussed at clinical governance meetings and used as learning for all staff.

The practice had identified its most vulnerable groups of patients and had increased patient access to a GP or practice nurse to improve patient safety. This included offering an appointment on the day service, and longer appointments for booked consultations.

Leadership, openness and transparency

Staff were encouraged to communicate informally. All of the staff we spoke with were happy with the open culture within the practice. They felt they were part of a team and would be listened to and taken seriously if they raised any issues. However, the practice lacked management systems and processes; this was illustrated by the infrequent staff meetings, gaps in staff appraisals and lack of attention to recruitment requirements.

Practice seeks and acts on feedback from its patients, the public and staff

The clearly visible suggestions box in the waiting area was little used. The practice had gathered feedback from patients through GPs undertaking patient suggestions and complaints received. However there were no other formal methods of collecting patient feedback.

The practice had a patient representation group (PRG). The PRG was a virtual group kept together via emails sent from the practice manager.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

A process was in place so that learning and improvement could take place when events occurred or new information was provided. There was informal time set aside for continuous professional development for staff and access to further education and training as needed. For example the registered nurse told us of many courses and seminars attended.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, the computers failed, or if the telephone lines at the practice failed to work.

There were environmental risk assessments for the building. For example, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out. Fire drills were undertaken and staff knew what to do in the event of a fire, however the most recent fire risk assessment had not been updated since it was undertaken over three years ago and there was no evidence to show that the actions previously identified had been completed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users, and others who may be at risk against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to – Identify, assess and manage risks relating to the health welfare and safety of service users and others who may be at risk from the carrying on the regulated activity. Significant events and incidents are not managed in a systematic and standard way to identify, assess and manage risks to the health, welfare and safety of patients and show learning had taken place with the whole team.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must operate effective recruitment procedures. They must ensure that the information specified in schedule 3 is available in respect of a person employed for the person of carrying out a regulated activity, and such other information as appropriate. Recruitment processes must be improved to include proof of identity, including a recent photograph, two references, a full employment history and a risk assessment to determine the decision re carrying out criminal records checks, using the Disclosure and Barring Service (DBS).