Catherine House Surgery

Quality Report

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Date of inspection visit: 9 July 2014
Date of publication: 21/11/2014

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.

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Summary of findings

Overall summary

Catherine House Surgery is a GP practice providing primary care services for people in and around Totnes, Devon. It provides services from Catherine House Surgery, The Plains, Totnes, Devon TQ9 5HA where we carried out an announced inspection on 8 July 2014. It also has a branch surgery held at St Peters Church, Harbertonford Devon TQ9 7TA, this is offered one day a week and by appointment only.

When the practice is closed patients are advised to contact the Out of Hours service, which is operated by a different provider.

As part of our inspection we spoke with five patients after their appointments and a member of the patient participation group (PPG). This group acts a voice for patients at the practice. We received seven comments cards completed by patients. Both verbal and written comments were all very positive about the practice and the care and treatment patients received from the GPs and nursing team. We also spoke with the senior partner who was also the registered manager of the practice, three other GPs, two practice nurses, a healthcare assistant, the practice manager and reception and administration staff.

Catherine House Surgery provided safe clinical care for its patients. Staff knew how to safeguard vulnerable patients and children, and how to monitor and manage risk for patients. The practice was effective in meeting the wide range of patients' needs and it supported the continuity of patient care through established working relationships with other agencies and services such as social services. Patients experienced person-centred and holistic care and treatment. Staff were caring and compassionate towards their patients treating them with dignity and respect, giving them time and making them feel they were being heard.

Catherine House Surgery was not meeting the requirements relating to staff recruitment. Full and relevant checks were not always completed for all staff prior to employment at the practice.

There were areas at the practice that needed improvement to ensure administrative processes and procedures were up to date and safe:

Infection control practice did not always follow the practice policy and procedure.

Records of staff registrations, insurance and training information were not kept up to date

Audits cycles were not always dated, full and complete with actions for outcomes.

Roles and lines of accountability were not well-defined.

The nurses and GPs were trained in providing care and treatment for medical conditions affecting older people. The practice recalled patients with long term health conditions for annual health checks to provide a more holistic approach to care and treatment and to avoid patients with more than one long term condition being called separately for each condition. The nursing team provided annual checks and health action plans for patients with learning disabilities. Effective systems were in place for GPs to seek advice and support if they had concerns about a child or a vulnerable adult and to raise a safeguarding alert if they felt the child or vulnerable adult was in danger of significant harm.

The practice offered longer opening hours one evening a week to accommodate working patients' needs and an open access service for two hours every morning for all patients. The open access was particularly popular with parents of young children, patients with mental ill health, and patients in vulnerable circumstances who may have poor access to primary care.

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 the practice was safe but some improvement was needed.

Catherine House Surgery provided safe clinical care for patients. Staff knew how to safeguard vulnerable patients and children, and how to monitor and manage risk for patients.

There were safe storage facilities for vaccines, emergency medicines and controlled medicines. All medicines were logged and accounted for properly.

There were areas needing improvement to ensure administrative processes and procedures were up to date and safe. These included staffing and registration checks, chaperone and infection control procedures and training.

Are services effective?

The practice was effective.

The practice was effective in meeting the wide range of patients' needs. There was a system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times. Information about individual patients was shared with other healthcare providers such as the Out of Hours service, midwives and community nursing teams, and palliative care services. Patients were provided with information leaflets about their health needs to support them in making decisions about treatment. They were also signposted to relevant agencies and services. This supported the continuity of the patient's care.

There were clinical governance systems in place. The quality of care and treatment was monitored by significant events' learning, practice meetings and patient feedback. There was a commitment to review and improve the effectiveness of treatment however audits and monitoring processes needed improvement to ensure they were complete and up to date.

Are services caring?

The practice was caring.

Patients experienced compassionate care and staff put significant effort in to providing care that took account of each patient's physical support needs and individual preferences.

Patients were involved in planning their care and making decisions about their treatment and were given sufficient time to speak with the GP or nurse.

Summary of findings

Patients were referred appropriately to other support and treatment services. The Out of Hours service was notified of any pertinent information about individual patients in the event it was contacted by, or about, the patient.

There were opportunities for people to provide feedback about the care and treatment they had received.

Patient confidentiality was respected and maintained.

Are services responsive to people's needs?

The practice was responsive.

The practice was responsive to patient's individual needs and these were met without avoidable delay.

Staff were aware of arrangements in place for responding to medical emergencies that may arise.

There was an open culture within the practice with a clear complaints and feedback system in place.

The practice involved patients, their representatives and external agencies in planning its services, and learned from patient's experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Overall the practice was well-led but some areas needed improvement.

The practice offered a service that was clinically safe with 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.

Administrative processes were incomplete and could compromise patient safety because clinical governance was not robust and lines of accountability and responsibility were not clear or well-defined.

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

Catherine House Surgery held a list of its 300 patients who were over the age of 75 years. The practice had a higher proportion of older patients registered than the national average. They were allocated to the GP who knew the patient best although patients could express a preference. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer patients to local services such as dementia screening clinics and falls assessment clinics.

Patients and their families were encouraged to complete treatment escalation plans to facilitate improved treatment in the event of a medical emergency or rapid decline in health. Multi-disciplinary meetings were held to assess a patient's capacity to give consent and to ensure decisions were made in the patient's best interest. The practice had identified patients (mainly older people) diagnosed with dementia. Monthly multi-disciplinary meetings ensured all these patients were reviewed.

People with long-term conditions

Catherine House Surgery cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. They were also recalled for annual checks in the month of their birthday. This avoided patients with more than one long term condition being called separately for each condition and allowed the clinical staff to treat the patient in a more holistic way.

The practice treated a high prevalence of patients with diabetes (4.5%). One of the practice nurses was the diabetic lead for the practice and able to provide insulin initiation and adjustment for patients with Type 2 Diabetes. This nurse was also the diabetes group education lead for the local health and social care Trust and held a diploma in clinical education. The other practice nurse held diplomas in care of patients with chronic obstructive pulmonary disease (COPD) and asthma.

Mothers, babies, children and young people

Young families were registered as patients with Catherine House Surgery. The open access service (no appointments booked in advance) held daily particularly suited parents with young children. The GPs told us 70% of children were seen during open access service.

Summary of findings

The GPs provided family planning. The practice had a lower proportion of patients less than 18 years of age registered than the CCG and England average so there was not a high percentage of teenagers who were pregnant registered with the practice. There were a large proportion of mothers and women who were pregnant. The practice had its own a midwife who ran a clinic weekly. Health visitors maintained regular contact with the practice via meetings and emails.

The practice had a high screening rate for Chlamydia as young people were able to self-screen (self-testing kits were provided by the practice). GPs were able to refer patients to a local sexual health clinic for advice and support with sexually transmitted diseases.

Effective systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of neglect. GPs and practice nurses monitored these families with escalation to the relevant agencies as needed.

The working-age population and those recently retired

Catherine House Surgery offered longer opening hours one evening a week to accommodate working patients' needs outside working hours. The practice had considered increasing this to two evenings a week however take up of these appointments was less than 50%. Patients were able to request a telephone consultation by a GP which the GPs guaranteed would be on the same day. Patients would be called in to the practice if the GP felt this was more appropriate than a telephone call.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs.

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

Catherine House Surgery had a higher than average number of homeless people, travellers and boat community registered with it. The GPs considered this may be because they offered an open access service each morning as well as the town having a good reputation for people in vulnerable circumstances.

Due to the transient patient population, statistically the practice did not measure well in some areas for patient care and review, for example, the completion of physical health checks for some patients. This was because patients may have been seen and diagnosed but never returned for health screening and monitoring because they had moved away from the practice.

Summary of findings

There were annual check and health action plans for patients living with learning disabilities. These were managed by the nursing team at the practice.

There were few patients who could not communicate in English however the practice had access to translation services. Patients were also asked if they had a family member or friend who could act as a translator for them. Information about who provided translation was recorded on the patient's record. There was a note for staff if there was a particular person the patient wished to be their representative and point of contact for translation purposes. Confirmation of consent to disclose personal health information to the translator was also recorded on the patient's record.

People experiencing poor mental health

Catherine House Surgery had twice the average number of patients with mental health needs. The GPs considered this was because the practice previously provided medical care at a local psychiatric hospital for over 25 years. Also it was due in part to the daily open access service which had no time constraints on consultations, and because the GPs offered longer than average booked consultation periods. The practice did not have a high proportion of missed appointments mainly for these reasons. Afternoon booked appointments were monitored and GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have poor mental health. The GPs considered longer consultations provided an improvement in patient safety.

The practice offered support and treatment for patients of all ages with mental health needs. The GPs told us they were pleased with the current mental health services which were effective and responsive to referrals for adults and children.

Summary of findings

What people who use the service say

Patients told us they were satisfied with their care and treatment. They considered the practice to be efficient and well-organised with polite and respectful staff at all times. Patients said they were given the time they needed to explain their illness or condition, and the GPs and nurses listened to them. Patients were confident about the treatment they received and referrals to secondary care were prompt and appropriate.

Patients told us they could get an appointment when they needed it. They could also attend the open access service held every morning (Monday to Friday) if they wanted to be seen on the same day. The GPs told us they did not operate a duty doctor system because there were enough GPs and they all knew most of the patients. They said they guaranteed a telephone call if a patient requested this and they would call the patient in to the practice if they considered the patient needed to be seen by a GP.

Patients were satisfied with the access to the premises. The GPs and staff told us they tried to accommodate patients with limited mobility by seeing them in the consultation room or treatment room on the ground floor.

Areas for improvement

Action the service MUST take to improve

The recruitment and selection process for staff must include full and relevant checks for all staff prior to commencing work in the practice, and include a risk assessment for roles deemed not to require a criminal record check.

Action the service SHOULD take to improve

The practice should improve the safety of patients and others by ensuring infection control practice follows the practice policy and procedure, keeping staff records of registration and training up to date.

The practice should improve its response to feedback and complaints by maintaining a log of comments and complaints patients make
verbally.

The practice should improve the definition between the roles of the GPs and the practice manager. This would ensure lines of accountability and responsibility were clear and well-defined.

Outstanding practice

The practice covers a very rural location. An average of ten home visits per day were made to ensure patients who were restricted with transport and or disability continue to benefit from routine and emergency appointments. It also provided an open access service (no bookable appointments) for two hours daily with no time constraints on consultations. Standard GP consultations were 15 minutes, and 30 minutes with a trainee GP.

GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have mental ill health. They considered this and longer consultations improved patient safety. The practice had a transient population due to a high percentage of homeless people, travellers and boat community. Patients with no fixed address or living in caravan parks were encouraged to use the practice address as their mailing address. This enabled patients to receive healthcare related information such as hospital letters and clinic appointments. It also enabled other healthcare services and professionals to have a point of contact for these patients.

A GP visited all patients eligible for a flu vaccine in their home or care home to administer the vaccine.

The practice employed a midwife who ran a clinic weekly.

Catherine House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Catherine House Surgery

Catherine House Surgery provides care and treatment to approximately 2,800 patients. It is located in the town centre of Totnes however provides services to patients living across a very rural area. To facilitate access for older and frailer patients less able to travel into the town, the practice offers booked GP appointments one afternoon a week at a local village church. It also provides visits to patients in their own home.

Totnes has a number of people who are homeless and or travellers. There are supportive services for people with mental health illnesses. Both these factors attract a higher than the national average number of vulnerable people to the area. Consequently Catherine House Surgery has a transient patient population and twice the average number of patients registered with mental health illnesses.

The practice has a higher proportion of older patients registered than the national average. It has a lower amount of patients less than 18 years of age registered than the clinical commissioning group (CCG) and England average.

Catherine House Surgery provides services from The Plains, Totnes, Devon TQ9 5HA where we carried out an announced inspection on 8 July 2014. It also provides services one day a week by appointment at its branch surgery held at St Peters Church, Harbertonford Devon TQ9 7TA.

Why we carried out this inspection

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

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 poor mental health.

Detailed findings

Before the inspection site visit we reviewed a range of information that we had about the service. This included information shared with us by other organisations such as the local Healthwatch, NHS England and the clinical commissioning group.

We carried out an announced inspection visit on 8 July 2014 at the provider's registered location, Catherine House Surgery, The Plains, Totnes, Devon TQ9 5HA.

During our visit we spoke with a range of staff, including the registered manager (also the senior partner), the practice manager, three GPs including a trainee GP, two nursing staff, and two reception staff who were working on the day of our visit.

We spoke with patients, other carers and or family members. We looked at the arrangements in place for monitoring presenting symptoms, diagnosis and treatment. We observed how the service handled telephone calls and patients arriving at the practice. We also met with a representative of the patient participation group (PPG). This group acts as a voice for patients at the practice.

We reviewed seven comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Overall the practice was safe, but some improvement was needed.

Catherine House Surgery provided safe clinical care for it patients. Staff knew how to safeguard vulnerable patients and children, and how to monitor and manage risk for patients.

There were safe storage facilities for vaccines, emergency medicines and controlled medicines. All medicines were logged and accounted for properly.

There were areas needing improvement to ensure administrative processes and procedures were up to date and safe. These included staffing and registration checks, chaperone and infection control procedure and training.

Safe patient care

Reception staff, nurses and trainee doctors were able to seek support from the GPs in the event of concern about a patient. There was an emergency alert system for all staff in the event of an emergency or a staff member being concerned for their own safety. If triggered, it alerted all staff and identified where the incident was in the building. There was also an emergency alert system to summon assistance with a clinical emergency.

GPs and nurses had access to good support services locally where they were able to refer patients for appropriate care and treatment, for example, a crisis intervention team for patients with escalating mental ill health, and a rapid access clinic for patients who may need hospital admission.

The nurses' treatment rooms were clean and infection prevention control procedures were in place. There was a risk to patient safety in waiting areas in the event of a patient being unwell because the nursing team dealt with bodily fluid spillages not reception staff. There was the likelihood of a delay before a nurse was available however patients could be moved to wait elsewhere.

Posters informed patients that a chaperone was available. A chaperone is a person who accompanies a patient during consultation, examination or treatment. Chaperones may also be used during examinations of vulnerable adults and of children. Patients told us they could take someone, for example, a family member or friend, in with them. The practice policy was for a clinician (usually a nurse) to provide the chaperone role. The reception staff were expected to perform this role if a nurse or another GP was not available. Reception staff had not received training about chaperoning and told us they stood outside the curtain which was contrary to the practice policy.

Learning from incidents

The practice used a template for recording significant events and this fulfilled all aspects of significant event reporting. Significant events were included on the agenda of the monthly practice meeting. There had been two significant events in the past twelve months. These were both in the early part of 2014 about the same incident and showed action the practice had taken.

Safeguarding

The practice had a lead person for both children and vulnerable adults safeguarding. The GPs and one practice nurse were trained to level 3 for children's safeguarding. Due to the wide geographical area covered by the practice, the lead person had compiled a safeguarding flow chart combining all the local authorities and health trusts contact details. This facilitated quick access to the relevant agency for all staff and GPs in the event they suspected someone was at risk of significant harm.

Staff knew about the different types of abuse and how to correctly report within the organisation, or externally to local safeguarding teams. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. These details were located where staff could easily find them. The policies included information on external agency contacts, for example the local safeguarding teams. Staff had received training in safeguarding adult and child procedures.

Monitoring safety and responding to risk

Monthly meetings were held with the multi-disciplinary team. This included district nurses, mental health nurses, health visitors and community matron. Vulnerable patients were discussed ensuring a plan of care was arranged.

A GP was responsible for ensuring all the GPs and nurses received any medical alert warnings or notifications about safety, either by email or verbally. Nurses attended required study days to ensure their knowledge was up to date, for example, about care of patients with diabetes. Nurses also accessed national websites for current information, for example, guidelines on travel vaccinations.

Are services safe?

Staff could enter alerts on patient records such as a child at risk or a medical alert advising a patient could be aggressive or violent towards staff. The alert was visible on the front page of the patient record and required the GP or nurse to click out of it in order to access the patient information, thereby ensuring they were aware of the alert.

All staff had access to an alarm in the event of an emergency to alert either all staff or only GPs and nursing staff, depending on the nature of the emergency.

Medicines management

Medicines were managed at the practice by clear systems of receipt, administration and storage of medicines, immunisations, emergency medicines and emergency equipment. However, there was no record of what medicines had been disposed of at the practice.

We looked at the storage facilities for medicines and immunisations. These were organised, clean and not over stocked. The vaccine fridges had a large plastic safety cover over the switch so that it could not accidently be switched off. There was clear system about how vaccines were received at the practice and stored including storage temperatures of vaccines being maintained. This ensured the safe arrival and storage of vaccines.

The practice held a supply of controlled drugs because it covered a very rural area. We saw these were kept in a fixed locked cabinet within a lockable cupboard. The keys to the cabinet and the cupboard were kept in an area only accessible by GPs and nursing staff. We checked the stock of controlled drugs and water for injections. These were all in date. There was a log of monthly checks by the nursing team.

Emergency medicines were available. These were stored correctly and were easily assessable in an emergency. Medicines were in date.

Patients were supplied their medicines with patient information leaflets and also given specific advice should it be required.

The practice had bi-annual meetings with the CCG to review medicines management. The CCG also audited prescribing activities, for example, prescribing of antibiotics, to ensure these were comparable with national guidelines and expectations.

Cleanliness and infection control

Patients said the practice was always very clean. The provider had an infection control policy and a dedicated infection control lead who attended up to date training. There was guidance about infectious diseases for staff to access should such a patient present at the practice. This gave guidance of when staff needed to report infections to relevant agencies.

The packaging and handling of specimens was well managed. A courier called at the practice three times a day to collect for laboratory testing and results were available the following day. Other specimens were disposed of safely.

The treatment and consulting rooms appeared clean, tidy and uncluttered. We saw each room had a dirty/clean sink system to promote good infection control. We saw that staff all knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE). This included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which we saw staff used. This reduced the risk of cross infection between patients. We saw antibacterial gel was available in the reception area for patients to use upon entering the practice.

The practice out-sourced the sterilising of re-usable instruments needed for all clinical examination, tests and minor operations. Some disposable single-use instruments were used as supplements when needed.

There was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area within the practice whilst awaiting its weekly collection by a registered waste disposal company. We found there was no lockable clinical waste bin outside the practice which resulted in clinical waste sometimes being left out on the pavement on the day of collection. This was contrary to the practice protocol and not good infection control practice.

There were cleaning schedules in place and an infection control audit system was in operation. Treatment rooms had hard flooring to simplify the clearance of spillages. Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical

Are services safe?

spillages and had spillage kits available for use. We found reception staff were not aware of the process to manage clinical spillages in the waiting area and were reliant on the nurses to manage this.

An infection control audit was undertaken in June 2013. No actions were identified at that time.

The staff told us they had received updated training in infection control and this was repeated annually.

All clinical staff said they had received a vaccination against the risk of Hepatitis B and we saw this was checked and recorded.

Staffing and recruitment

We looked at four staff files. We found the recruitment of the two most recent staff was not thorough. For example, a receptionist had not had a criminal record check using the disclosure and barring service, and there was no risk assessment in place to show this check was not needed. There was no evidence of a code of confidentiality or a signed contract for these two staff members. There was no induction recorded.

We found the system and overview of individual GP insurances and General Medical Council (GMC) registration had lapsed. For example, one GP file showed the GMC registration had expired in 2009 and the retention fee was due in 2007. This GP was working at the practice on the day of our inspection so able to show us their current medical insurance cover and GMC registration were in date but the file had not been updated.

Dealing with Emergencies

Appropriate equipment was available to deal with an emergency, for example if a patient collapsed. The staff we spoke with all knew where to locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medicines and equipment did not expire. All staff, including administration staff had received training in emergency procedures.

The practice had a contingency plan in place to deal with emergencies. Back up discs of computer data were stored securely in a fireproof safe. Staff knew which organisations to contact in the event of a failure of services such as loss of computer systems, telephones or electricity.

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. For example, fridge temperatures were taken and recorded to show that correct storage temperatures were maintained for vaccines and medicines. Effective checks were performed on oxygen, gases and the defibrillator. We saw all portable appliance testing, water safety, fire safety and other equipment checks had been undertaken with appropriate certification, calibration and validation checks in place.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective.

The practice was effective in meeting the wide range of patients' needs. There was a system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times. Information about individual patients was shared with other healthcare providers such as the out of hours service, midwives and community nursing teams, health visitors, and palliative care services. Patients were provided with information leaflets about their health needs to support them in making decisions about treatment. They were also signposted to relevant agencies and services. This supported the continuity of the patient's care.

There were clinical governance systems in place. The quality of care and treatment was monitored by significant events' learning, practice meetings and patient feedback. There was a commitment to review and improve the effectiveness of treatment however audits and monitoring processes needed improvement to ensure they were complete and up to date.

Promoting best practice

We saw several examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). Where required, guidance from national travel vaccine websites was followed.

Management, monitoring and improving outcomes for people

The practice was keen to ensure that staff had the skills to meet patients 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. These were managed by the nursing team at the practice. Patients with long term conditions were recalled for annual checks in the month of their birthday. This avoided patients with more than one long term condition being called separately for each condition and allowed the clinical staff to treat the patient in a more holistic way.

Information received from the Out of Hours service was checked daily by a nominated GP. The reception staff also checked and triaged the information received into the practice, for example, if the Out of Hours helpline had recommended the patient to attend the practice or if an Out of Hours GP had seen a patient and sent an urgent notification to the practice. The practice policy was everything that came into the practice from the Out of Hours service was dealt with the same day to ensure patient safety.

Significant events were included on the agenda for the monthly practice meeting. This provided a regular opportunity to formally review and learn from any events as they arose.

Staffing

The practice employed two registered nurses (RN) who both had a formal practice nurse qualification. One RN was also a nurse prescriber. They had updated their clinical skills and received a formal appraisal each year, which was documented. Informal supervision was offered on a monthly basis or more if needed. All the nursing team told us they received appropriate support and supervision from their peers, the GPs and the practice manager. 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. A new 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 Foundation Year 2 doctors who spent four months in general practice.

Working with other services

The practice worked with the clinical commissioning group (CCG) and the local health and social care trust providing integrated health and community care to ensure that patients received effective care. The GPs told us there was a very strong link between all the components of care for patients with a terminal illness. The practice had a register of their patients who had cancer and those who were receiving end of life care. There were regular meetings

Are services effective?

(for example, treatment is effective)

between all the services, for example, the local hospice, hospice at home service, the palliative care nurse team, the community hospital, and consultants who carried out home visits.

We were given examples of when multidisciplinary meetings would be held when assessing a patient's capacity to give consent and to ensure decisions were made in the patient's best interest. The practice had identified patients diagnosed with dementia. These meetings ensured all these patients were reviewed.

There were examples of effective working relationships with the rapid access clinic for patients who may need hospital admission. The GPs were able to escalate referrals and in most cases the patient was seen the following day. The GPs told us they were pleased with the current mental health services and said they were effective and responsive to referrals for adults and children. Patients were referred to the dietician department at the local hospital. Patients with two or more coexisting medical conditions or disease processes were referred to the appropriate hospital teams.

Health visitors attended regular meetings with the practice and maintained email contact.

The practice had established links with the local safeguarding teams for both children and adults.

The practice was mindful of where patients lived and which local authority should be contacted, ensuring they were referred to the correct local authority department for services.

Health, promotion and prevention

There were systems in place on the practice computer to identify patients with long term conditions. The nursing team said this was used to identify patients who may need medication reviews, check-up appointments or further care and treatment. New patients found with a higher level of disorders or diseases on the screening assessment or patients with an identified higher level alcohol or smoking risk, were reviewed in the practice by the practice nurse or a GP.

The nurses explained that when patients were seen, 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. Information leaflets were available for patients about mental health issues, smoking cessation, support groups such as domestic violence support, diet and how to live a healthy lifestyle. GPs and nurses also offered leaflets and information documents to assist patients in understanding a diagnosis or health condition, and care and treatment options.

Are services caring?

Our findings

The practice was caring.

Patients experienced compassionate care and staff put significant effort in to providing care that took account of each patient's physical support needs and individual preferences. Patients were involved in planning their care and making decisions about their treatment and were given sufficient time to speak with the GP or nurse. Patients were referred appropriately to other support and treatment services. The Out of Hours service was notified of any pertinent information about individual patients in the event it was contacted by or about the patient. There were opportunities for people to provide feedback about the care and treatment they had received. Patient confidentiality was respected and maintained.

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect at Catherine House Surgery. During our inspection all the staff spoke to patients politely. The five patients we spoke with confirmed this was the case on every previous occasion too.

Due respect was paid to confidentiality. The sliding glass panel used at the practice reception desk reduced the likelihood that staff conversation or phone calls dealt with by the receptionist could be overheard by anyone in the waiting area. 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.

At the reception desk the practice advertised a loop system in recognition that many (mainly older) patients had a degree of hearing loss and wore a hearing aid. Whilst the practice had four GP consultation rooms upstairs, the fifth consultation room and the treatment rooms were on the ground floor, providing level access for patients with limited mobility or using a wheelchair.

Involvement in decisions and consent

Patients felt involved in planning their care and those we spoke with confirmed the GP had explained treatment options so they understood them.

Nursing staff explained how they gave patients verbal information about treatment and choices and they were able to show they had recorded a summary of the issues discussed. Printed records of particular blood test results were held by patients as well as kept on their computerised patient record at the practice. Patients were given a printed instruction sheet about medicines they were prescribed. This enabled them to be clear about the dose, particularly when their medicines regime needed frequent adjustment.

Nursing staff were clear about the need to ensure that if the patient lacked mental capacity, decisions were made in the patient's best interest in accordance with the Mental Capacity Act 2005. They were able to give a particular example and talked knowledgably about the challenges, considerations and process required.

Staff had a variety of ways to record when patients gave consent. There were ways of automatically recording when a patient had given consent for procedures including immunisations, injections, ear syringing and minor surgery. Patients told us that nothing was undertaken without their agreement or consent within the practice. This included the disclosure of test results to a third party.

The practice held a list of all its patients who were over the age of 75 years. They were allocated to the GP who knew the patient best, although patients could express a preference. Patients were able to complete advanced decision forms. Treatment escalation plans (TEP) were considered as part of care reviews, involving the patient's family when possible, as a means of avoiding hospital admission where possible. We were given a recent example of a TEP working well for a patient.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients needs.

The practice was responsive to patient's individual needs and these were met without avoidable delay. Staff were aware of arrangements in place for responding to medical emergencies that may arise. There was an open culture within the practice with a clear complaints and feedback system in place. The practice involved patients, their representatives and external agencies in planning its services, and routinely learned from people's experiences, concerns and complaints to improve the quality of care.

Responding to and meeting people's needs

The practice had one open waiting area with sufficient seating. The reception and waiting area on the ground floor had sufficient space for wheelchair users and a variety of seating options for people who had difficulty sitting or reduced mobility. A consultation room and a treatment room were located on the ground floor which GPs were able to use if the patient was not able to climb stairs.

Patients were pleased with the range of services available and told us the GPs and nurses were caring and compassionate. Patient confidentiality was respected within the practice. The downstairs waiting room was located close to the main reception desk. Staff were sensitive to personal information and made sure conversations between reception staff and patients could not be overheard. We heard that the interactions between reception staff and patients were pleasant and respectful.

Access to the service

The practice had undertaken an audit at the end of 2013 to look at patient access to the service. One outcome of this audit was to open the practice doors at 8.15am to improve reception congestion and initial wait times to see the GPs. The practice also put measures in place to promote appointments with trainee GPs and to use the practice nurses to triage and see patients with minor illnesses, and better advertise the use of online appointment booking. Consideration was given to split extended opening hours across two evenings a week but at the time of our visit this remained at one evening due to a limited take up of appointments (45%).

Patients favoured the open access service (no appointments booked in advance) between 8.30am and 10.30am every day. Two GPs covered the open access hours. Each patient consultation period was not subject to any time restraints and varied according to the nature of the issue being presented to the GP. Patients were kept informed by the reception staff about the length of time they could expect to wait to see the GP. These sessions particularly suited parents with young children. The GPs told us 70% of children were seen during open access service. They concluded that the practice tended to see more patients who were homeless or travellers because they offered the open access service.

The GPs explained they did not run a duty doctor system because there were sufficient GPs on the rota each day and they all knew most patients. Emergency appointments were with the first available GP and patients were satisfied with making a routine appointment if they had a preference about which GP they saw. Any patient who requested a telephone appointment was guaranteed a call by a GP. Patients were also able to request a home visit and we found the GPs made an average of 10 home visits each day.

Standard appointments with GPs were 15 minutes and could be booked up to two months in advance. The GPs told us they saw twice the average number of patients with mental ill health partly because of the open access service, and because they offered longer than average consultation periods. The GPs considered longer consultations provided an improvement in patient safety because they were able to help patients manage their mental illness more effectively.

The practice did not have a high proportion of missed appointments mainly for the above reasons. Afternoon booked appointments were monitored and GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have mental ill health.

Concerns and complaints

The five patients we spoke with felt very confident that they could raise any concerns or complaints without fear of victimisation. 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 could not immediately be rectified. Reception staff were sensitive to the personal nature of

Are services responsive to people's needs?

(for example, to feedback?)

some complaints and offered patients at the reception desk the opportunity to speak in private either at the other end of the desk which was sectioned off from the waiting room, or in a separate room.

We found the practice did not maintain a record of verbal complaints or comments. It was therefore not possible to evaluate the numbers and types of issues patients were raising with the practice.

Are services well-led?

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

Our findings

Overall the practice was well-led but some areas needed improvement.

The practice offered a service that was clinically safe with 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.

Administrative processes were incomplete and could compromise patient safety because clinical governance was not robust and lines of accountability and responsibility were not clear or well-defined.

Leadership and culture

The nursing and administration staff all spoke highly of their employment at the practice and the standard of leadership at the practice. They all said the GP partners were very approachable and there was a strong team ethos throughout the practice.

Governance arrangements

The practice had two partners and two salaried GPs. They preferred not to use locum GPs as they considered there was sufficient capacity (2:2 whole time equivalent GP per patient population). They provided extra sessions to cover each other's absence. The two practice nurses and two healthcare assistants also were able to cover their sessions between themselves. The reception staff multi-tasked and were able to do all the required daily tasks in line with their role.

The GPs and nurses had lead roles such as safeguarding so it was clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice. One of the GPs was responsible for reviewing the practice policies and protocols. These were done on a two year cycle although the GP told us they were checked monthly if there were any contact details to ensure these were kept up to date. The practice manager was responsible for overseeing the day to day running of the service. We found there was a lack of definition between roles of GPs and the practice manager and this contributed for example, to processes being incomplete, out of date information (such as a record of when nurses' registrations were due for renewal) and lack of records of staff competencies.

Systems to monitor and improve quality and improvement

The practice offered a GP induction programme for Foundation year 2 doctors. They were employed by local acute trusts to work at the practice for four months and were insured for clinical activity. These doctors undertook a lot of the practice clinical audits as part of their training programme and educational development in Quality Improvement methodology. Due to the short period of time they were at the practice the audits completed by this group of doctors were quite limited and provided more of a snapshot review. We saw a number of examples of audits undertaken by the practice, for example, patient access and patient attendance at A&E. These were more comprehensive with recommended action to improve the quality of the service offered to patients.

Patient experience and involvement

The clearly visible suggestions box in the waiting area was little used. Earlier this year there had been a comment made that the waiting room noticeboard was cluttered by too many notices and was untidy. At the time of our inspection the noticeboard contained useful information for patients and carers, which was current, topical and tidy.

Patient feedback had also led to the daily open access service being extended by half an hour. The open access service was running successfully, allowing patients to arrive between 08:30 and 10:30 and be seen by a GP. The additional half hour had alleviated pressure and two patients told us they did not feel such a need to arrive early. Staff told us it had also alleviated patients anxiety about catching the bus home.

A patient participation group (PPG) had been newly formed. The PPG is a group of patients who are registered with the practice and have an interest in the services provided. The aim of the PPG is to represent patients views and work in partnership with the practice to promote common understanding and make improvements. The group had six members who had met once. The PPG chair, GPs and practice manager were keen to enlist more members and recognised the importance of representation across all population groups, and the value of patient feedback.

Staff engagement and involvement

Staff were encouraged to communicate informally and formally through meetings and staff appraisal. All of the

Are services well-led?

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

staff we spoke with had worked at the practice for many years and were positive about 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.

Learning and improvement

All the staff and GPs we spoke with and staff files we looked at showed staff had annual appraisals. They had opportunity for professional development and kept up to date with best practice guidance.

Identification and management of risk

The practice had a business continuity plan with proposals for how the practice could develop and improve over the next five years.

It 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 open access service daily, standard booked consultations were 15 minutes and a weekly multi-disciplinary meeting reviewed vulnerable patients.

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.

Our findings

Catherine House Surgery held a list of its 300 patients who were over the age of 75 years. The practice had a higher proportion of older patients registered than the national average. They were allocated to the GP who knew the patient best although patients could express a preference. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer patients to local services such as dementia screening clinics and falls assessment clinics.

Patients and their families were encouraged to complete treatment escalation plans to facilitate improved treatment in the event of a medical emergency or rapid decline in health. Multi-disciplinary meetings were held to assess a patient's capacity to give consent and to ensure decisions were made in the patient's best interest. The practice had identified patients (mainly older people) diagnosed with dementia. Monthly multi-disciplinary meetings ensured all these patients were reviewed.

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).

Our findings

Catherine House Surgery cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. They were also recalled for annual checks in the month of their birthday. This avoided patients with more than one long term condition being called separately for each condition and allowed the clinical staff to treat the patient in a more holistic way.

The practice treated a high prevalence of patients with diabetes (4.5%). One of the practice nurses was the diabetic lead for the practice and able to provide insulin initiation and adjustment for patients with Type 2 Diabetes. This nurse was also the diabetes group education lead for the local health and social care Trust and held a diploma in clinical education. The other practice nurse held diplomas in care of patients with chronic obstructive pulmonary disease (COPD) and asthma.

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.

Our findings

Young families were registered as patients with Catherine House Surgery. The open access service (no appointments booked in advance) held daily particularly suited parents with young children. The GPs told us 70% of children were seen during open access service.

The GPs provided family planning. The practice had a lower proportion of patients less than 18 years of age registered than the CCG and England average so there was not a high percentage of teenagers who were pregnant registered with the practice. There were a large proportion of mothers and women who were pregnant. The practice had its own a midwife who ran a clinic weekly. Health visitors maintained regular contact with the practice via meetings and emails.

The practice had a high screening rate for Chlamydia as young people were able to self-screen (self-testing kits were provided by the practice). GPs were able to refer patients to a local sexual health clinic for advice and support with sexually transmitted diseases.

Effective systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of neglect. GPs and practice nurses monitored these families with escalation to the relevant agencies as needed.

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.

Our findings

Catherine House Surgery offered longer opening hours one evening a week to accommodate working patients' needs outside working hours. The practice had considered increasing this to two evenings a week however take up of these appointments was less than 50%. Patients were able to request a telephone consultation by a GP which the GPs guaranteed would be on the same day. Patients would be called in to the practice if the GP felt this was more appropriate than a telephone call.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs.

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).

Our findings

Catherine House Surgery had a higher than average number of homeless people, travellers and boat community registered with it. The GPs considered this may be because they offered an open access service each morning as well as the town having a good reputation for people in vulnerable circumstances.

Due to the transient patient population, statistically the practice did not measure well in some areas for patient care and review, for example, the completion of physical health checks for some patients. This was because patients may have been seen and diagnosed but never returned for health screening and monitoring because they had moved away from the practice.

There were annual check and health action plans for patients living with learning disabilities. These were managed by the nursing team at the practice.

There were few patients who could not communicate in English however the practice had access to translation services. Patients were also asked if they had a family member or friend who could act as a translator for them. Information about who provided translation was recorded on the patient's record. There was a note for staff if there was a particular person the patient wished to be their representative and point of contact for translation purposes. Confirmation of consent to disclose personal health information to the translator was also recorded on the patient's record.

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.

Our findings

Catherine House Surgery had twice the average number of patients with mental health needs. The GPs considered this was because the practice previously provided medical care at a local psychiatric hospital for over 25 years. Also it was due in part to the daily open access service which had no time constraints on consultations, and because the GPs offered longer than average booked consultation periods. The practice did not have a high proportion of missed appointments mainly for these reasons. Afternoon booked appointments were monitored and GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have poor mental health. The GPs considered longer consultations provided an improvement in patient safety.

The practice offered support and treatment for patients of all ages with mental health needs. The GPs told us they were pleased with the current mental health services which were effective and responsive to referrals for adults and children.

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 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 practice did not undertake adequate checks to ensure information from Schedule 3 was available for all staff. The recruitment process was not robust to effectively protect patients from being cared for or supported by unsuitable staff. Risk assessments were not in place for roles that were considered by the practice to not require a criminal record check.**