Dr Thomas Guilder

Quality Report

Riverbank Surgery
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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

The practice has an overall rating of good.

We carried out an announced comprehensive inspection at Dr Thomas Guilder (also known as Riverbank Surgery) on 9 June 2015. Riverbank Surgery provides personal medical services to people living in Westcott and the Dorking area. At the time of our inspection there were approximately 2,000 patients registered at the practice with a team of a principal GP, a part time locum female GP, a practice nurse, a small team of receptionists / administration staff, a medical secretary and a dispensary manager. At the time of the inspection the practice manager's position was vacant.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It requires improvement for safe. We found the practice was delivering a good service to all its different population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Patients spoke positively about how they were treated by staff. This was consistent with feedback from comment cards and patient surveys.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with the GP and that urgent appointments were available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- There were effective systems in place for the controlling the risk of infection. The practice was clean and hygienic.
- We found that some medicines and equipment for dealing with emergencies were not readily available
- There were effective system for ensuring that changes to patients medication following an outpatient appointment, A&E attendance or recent hospital stay were actioned in a timely manner
- There was close working with other dispensers from local practices to share training and best practice.

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

Importantly, the provider must:

- Ensure equipment and medicines that may be required in an emergency are reviewed and made readily available where deemed appropriate.
- Ensure all staff working under Patient Group Directions (PGDs) are authorised to administer in line with national requirements (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- Carry out regular fire drills

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed but the practice had not conducted regular fire drills. There were enough staff to keep patients safe. Emergency procedures were in place to respond to medical emergencies. However, we found that equipment to deal with emergencies was not readily available for example, oxygen cylinders and that some emergency medicines were not available. We also found an instruction for nurses to administer vaccinations had not been signed by the GP. The practice had policies and procedures in place to help with continued running of the service in the event of an emergency. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained. The practice had risk assessed those staff who needed to have a criminal records check.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with local multidisciplinary teams to provide patient centred care. Regular meetings between the practices' dispensary manager and dispensers from other local practices were arranged to provide training and shared learning.

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. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles in achieving this. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with dignity, kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients told us it was easy to get an appointment and urgent appointments were available on the same day The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (VPPG) was active and participated in staff surveys and provided feedback and suggestions from the results. Staff had received inductions, regular performance reviews and attended staff meetings.

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 patients. 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. Elderly patients with complex care needs all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. Patients were able to speak with or see a GP when needed and the practice was accessible for patients with mobility issues. The practice had a safeguarding lead for vulnerable adults. The practice had good relationships with a range of support groups for older patients. There were arrangements in place to provide flu and pneumococcal immunisation to this group of patients. The practice supported residents at two local nursing homes and provided weekly visits.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medicine needs were being met. The GP followed national guidance for reviewing all aspects of a patient's long term health. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice nurse was trained and experienced to support patients with managing their conditions and preventing deterioration in their health.Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness. The practice had the support from a nurse specialist in diabetes who ran a clinic at the practice once a fortnight.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Appointments were available outside of school hours and the premises was suitable for children and babies. Specific services for this group of patients included family planning clinics, antenatal clinics and childhood immunisations. The practice offered coil fitting and contraceptive implants. Practice

Summary of findings

staff had received training on safeguarding children relevant to their role. Safeguarding policies and procedures were readily available to staff. All staff understood the relevance of their role in relation to safeguarding children and how to respond if they suspected abuse. The practice ensured that children needing emergency appointments would be seen on the day.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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. Patients were able to request a GP to telephone them instead of attending the practice. The practice opened at 7:30am two days a week to help those patients who commuted to attend appointments before work. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Travel advice appointments were offered at times convenient to the patient. Patients were also given smoking cessation advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those who were housebound or with complex health needs. The practice ensured that patients classed as vulnerable were offered annual health checks. It offered longer appointments for patients when required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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 agencies in normal working hours and out of hours. Translation services were available for patients who did not use English as a first language. The practice could accommodate those patients with limited mobility or who used wheelchairs. Carers and those patients who had carers were flagged on the practice computer system and were signposted to the local carers support team.

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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). Patients with severe mental health needs had care plans and received an annual physical health check. New cases had rapid access to community mental health teams. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. We received 57 comment cards which all contained positive comments about the practice. We also spoke with three patients on the day of the inspection and the manager from the local nursing home.

We reviewed the results of the national patient survey from 2014 which contained the views of 116 patients registered with the practice. The national patient survey showed patients were consistently pleased with the care and treatment they received from the GP and nurses at the practice. The survey indicated that 95% of respondents found it easy to get through to the surgery by phone, 93% said the last GP they saw or spoke with was good at giving them enough time and 98% said they had confidence and trust in the last GP they saw or spoke with. All of these scores were well above the average for the local clinical commissioning group (CCG).

The practice provided us with a copy of the practice patient survey results from 2015. Results showed that 99% of patients thought they were treated with care and concern. When asked the question if they felt the GP listened to them 97% said they agreed. 94% of patients thought the GP was good or very good at explaining tests and treatments and 99% of patients thought the GP treated them with care and concern.

We spoke with three patients on the day of the inspection and reviewed 57 comment cards completed by patients in the two weeks before the inspection. Comments we reviewed and the patients we spoke with were extremely positive about the practice and the care they received. Comments included that patients felt cared for, respected and that the practice was family orientated. Comments also included that staff were kind, knowledgeable, professional, friendly, caring and they listened to the patients. Patients we spoke with and comments received showed that patients felt the practice had supported them through all of their health needs and those of their family members. Patients also told us that they never felt rushed in consultations and appreciated the time the GP took with them. The manager of the nursing home was also complimentary of the GP and staff at the practice. They commented that they felt the residents within their nursing home were supported by the GP who they described as compassionate, empathetic and understanding.

Areas for improvement

Action the service MUST take to improve

- Ensure equipment and medicines that may be required in an emergency are reviewed and made readily available where deemed appropriate.
- Ensure all staff working under Patient Group Directions (PGDs) are authorised to administer in line with national requirements (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- Carry out regular fire drills

Dr Thomas Guilder

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector. The team included a GP and a pharmacy lead.

Background to Dr Thomas Guilder

Dr Thomas Guilder is situated in a rural area of Westcott, Dorking and offers personal medical services to its patients. It is a dispensing practice. There are just under 2,000 registered patients.

The practice is run by the principal GP and is supported by a female locum GP, a nurse, three receptionist / administration staff, a medical secretary and a dispensary manager. At the time of the inspection the practice manager's position was vacant.

The practice is open from 8am – 12.30pm and from 1.30pm – 6.30pm Mondays, Thursdays and Fridays. It is open on a Tuesday from 7.30am – 12.30pm and from 1.30pm – 6.30pm and on a Wednesday from 7.30am – 12.30pm.

The practice runs a number of services for its patients including reviews for asthma, diabetes and hypertension, as well as smoking cessation and travel advice.

Services are provided from: Riverbank Surgery, Westcott Street, Dorking, Surrey, RH4 3PA

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher number of patients between 40 and 85 years of age than the national and local clinical commissioning group (CCG) average, with a significant higher proportion of patients above 85 years of age compared to the national average. There are significantly fewer patients aged under 5 years of age than the national average. There are lower numbers of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the national average.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out this comprehensive inspection of the practice, on 9 June 2015, 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 was 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.

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the Surrey Downs Clinical Commissioning Group (CCG). We carried out an announced visit on 9 June 2015. During our visit we spoke with a range of staff, including GPs, practice nurses and administration staff.

We observed staff and patients interaction and talked with three patients. We reviewed policies, procedures and

Detailed findings

operational records such as risk assessments and audits. We reviewed 57 comment cards completed by patients, who shared their views and experiences of the service, in the two weeks prior to our visit.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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.

Requires improvement

Are services safe?

Our findings

Safe track record

We saw that the practice was able to demonstrate a track record for maintaining patient safety. The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Staff told us that they were able to discuss significant events, incidents or complaints as they arose. The practice held monthly team meetings at which significant events were also discussed to identify issues and record any actions required. There was evidence that the practice had learned from these and that the findings were shared with all staff. All staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw incident forms were easily accessible to staff. A central log was maintained of all incidents and significant events. Records showed how the practice used significant events reviews to improve the service. For example, following a breach of confidentiality while using a photocopying machine, procedures had been re-enforced with all staff including visiting professionals who used the practice to see patients. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

The practice had a system in place to implement safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and undertook on-going audits to ensure best practice. The GP and the practice's pharmacist searched the practice's database to identify patients who could be affected by the alert, contacted the patients and actioned any changes. The pharmacist advisor also alerted the receptionists to possible queries from patients.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young patients and vulnerable adults. GPs could demonstrate they had the necessary training to level 3 safeguarding children. All the staff we spoke with could demonstrate they understood safeguarding issues and identify concerns. They were all aware of the protocols and process to follow and knew who to speak with if they had a safeguarding concern. We saw that safeguarding flow charts and contact details for local authority safeguarding teams were easily accessible.

There was a system to highlight vulnerable patients on the practice computer system and patient electronic record. This included information so staff were aware of specific actions to take if the patient contacted the practice or any relevant issues when patients attended appointments.

The practice had a chaperone policy. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. Nursing staff could be asked to be a chaperone. Staff told us they were aware of a future need for reception staff to act as chaperones and were in the process of organising criminal records check via the Disclosure and Barring Service and chaperone training for staff. We saw there were posters on display within the clinical rooms and waiting room which displayed information for patients about how to request a chaperone.

Patients' 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 clinical summaries, scanned copies of letters and test results from hospitals.

GPs were appropriately using the required codes on their electronic system to ensure risks to children and young

people who were looked after or on child protection plans were clearly flagged and reviewed. The GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

We found that there were other reliable systems and processes in place to keep people safe which included the safe storage of prescription pads and confidential patient records.

Medicines management

We checked how medicines were ordered, stored and handled at Riverbank Surgery. Patients who lived more than one mile away from the nearest pharmacy could choose to have their prescriptions dispensed by the GP practice. There were numerous ways that patients could request medicines and staff working within the dispensary went out of their way to ensure patients received their medicines in a convenient and timely manner, sometimes by delivering them personally.

Medicines were stored securely, in a clean and tidy manner and were only accessible to authorised staff. Medicines were purchased from approved suppliers. Expired and unwanted medicines were disposed of in line with waste regulations and confidential waste was appropriately handled. However, during our inspection, we found two boxes of medicines that had expired. Systems were in place to action any medicine recalls.

We saw that medicines requiring cold storage were kept at the required temperatures and staff knew what to do in the event of failure. It was clear that staff were monitoring the current, minimum and maximum temperatures of the fridges on a daily basis but it was not being documented accurately. One of the two fridges had a battery operated backup thermometer to measure the temperature should there be a power failure. There was no thermometer in the dispensary and staff were unable to tell us if room where medicines were stored remained within the recommended temperature ranges.

The practice met regularly with the clinical commissioning group (CCG) pharmacist. We saw that a recent audit had taken place within the practice to ensure that important information, regarding the use of medicines, was being accurately recorded on the system. Following this audit a new way of working had been introduced so that communications regarding medicines following an outpatient appointment, A&E attendance or recent hospital stay were actioned in a timely manner and that any changes had been acted upon and discussed with the patient. We also saw that this included documenting any medicines which were supplied and prescribed only by the hospital onto the GP's patient record.

Blank prescription forms were handled in accordance with national guidance and kept securely at all times and only accessible to authorised staff.

The practice held stocks of controlled drugs. These medicines require extra checks and special storage arrangements because of their potential for misuse. Standard procedures set out how they were managed and they were stored securely and only authorised staff could access these drugs. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff ensured that prescriptions were signed before medicines were handed to patients. Safe systems of dispensing were in operation with a system of second checking in place by another member of staff, this included compliance aid dispensing. Dispensary staff were keeping a log book of dispensing errors and near misses, which was reviewed and actions implemented if necessary. The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Members of staff involved in the dispensing process had received appropriate training. The lead dispenser organised and met regularly with other dispensing colleagues from other practices to receive training and learn from shared experiences.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions but not all directions had been signed by the doctor to authorise the nurse to administer the vaccine.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. All staff received induction training about infection control specific

to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed in a timely manner.

An infection control policy and supporting procedures were available for staff to refer. This enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had undertaken a recent risk assessment for legionella (a germ found in the environment which can contaminate water systems in buildings). The practice medical secretary was in the process of creating an action plan for any areas of concern highlighted from the report.

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 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. We saw evidence of calibration of relevant equipment. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. There was also a system for members of staff to cover annual leave. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice had not employed any new staff for five years, therefore files we reviewed were not governed by our regulations at the time of recruitment. We spoke with the practice medical secretary regarding the current recruitment process. They were able to explain to us the information required to ensure that new staff members were suitable and of good character before being employed. This included receiving a CV which contained a full employment history with any gaps in employment explained, photographic proof of identify, references from relevant past employers, qualifications, registration with the appropriate professional body and where appropriate a criminal records checks via the Disclosure and Barring Service.

We noted there were policies and protocols in place for when the practice used locum staff. For example, the practice policy for using locums highlighted all of the necessary employments checks that needed to be completed before starting work at the practice.

Monitoring safety and responding to risk

The practice had systems 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 checking equipment. The practice 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.

Identified risks were discussed at staff meetings. For example, findings from a recent infection control audit were discussed with staff. 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, patients with long term conditions that had a sudden deterioration in their health, had care plans developed and were visited in their homes if needed. The GP also gave examples of how they had responded to patients experiencing a mental health crisis, including supporting them to access appropriate care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. However, the practice did not have available emergency equipment for example, oxygen or an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Requires improvement

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. However, some emergency medicines were not available; this included medicines for the treatment of seizures, hypoglycaemia, or suspected meningitis. Medicines in the anaphylactic emergency kit were checked regularly and were suitable for use.

An emergency and 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, staff shortages and access to the building. The document also contained relevant contact details for staff to refer to. We noted the practice had a mutual aid arrangement with a neighbouring practice. For example, the other practice could help in the event of the not being able to use the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. However, the practice had not practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the GP carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. We also noted that a diabetic nurse specialist visited the practice twice a month to help support patients.

The GP 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, that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GP and nurse were aware of their professional responsibilities to maintain their knowledge so as to ensure the best outcomes for patients in their care.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the learning disabilities and palliative care register. Identified patients with complex needs had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used national standards for the referral into secondary care. For example, suspected cancers were referred and seen within two weeks.

We spoke with the manager of the local nursing home. We were informed that the GP provided care and support to the 60 residents. They confirmed that needs assessments were completed when required. The practice also supported 17 residents at a local care home and 11 people with learning difficulties within the community. We saw that care plans had been created and were regularly updated.

Discrimination was avoided when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and dates recorded for the audit to be repeated to ensure outcomes for patients had improved.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of a particular antibiotic medication. Following the audit, the GP carried out medication reviews for patients who were prescribed this medicine and where appropriate altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 92% of patients with diabetes had received the flu jab. We also noted that 87% of patients with chronic obstructive pulmonary disease (COPD) had a review, undertaken by a healthcare professional; including an assessment of breathlessness in the preceding 12 months and that 100% of patients aged 75 or over with a fragility fracture, were currently being treated with an appropriate bone-sparing agent. The percentage of patients with hypertension having regular blood pressure tests was similar to the national average. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GP had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs. Patients we spoke with confirmed that their medicines were regularly reviewed.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

All of the staff at Riverbank Surgery were long serving and had been at the practice for at least four years. The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. Staff files we received showed that staff had gone through an induction process.

All staff received annual training that included, safeguarding children, safeguarding vulnerable adults, basic life support, information governance awareness and infection control. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Staff we spoke with told us they felt that appraisals were useful and gave them the opportunity to discuss any concerns they had, their performance and any future training needs. The lead dispenser organised and met regularly with other dispensing colleagues from other practices to receive training and share learning.

The GP was up to date with their yearly continuing professional development requirements and had recently been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England)

The practice nurse was expected to perform defined duties and we saw evidence that demonstrated they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from three local hospitals including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP and relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP was responsible for the action required. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with end of life care needs. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We saw that the lead dispenser organised regular meetings between dispensers from other local practices and the practice met regularly with the clinical commissioning group (CCG) pharmacist.

We spoke with the manager at the local nursing home whose residents were registered with the practice. They told us that the practice carried out regular weekly visits to the home. They also confirmed that the GP would visit outside these arrangements if needed and responded promptly to any concerns they had. They told us that reception staff were very polite and receptive to them when they phoned the practice.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used 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 used a referral system for patients requiring specialist treatment. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information about this was available on the practice website and patients are given the opportunity to opt out of the process.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (SystmOne), to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff we spoke with highlighted how patients should be supported to make their own decisions and how this would be documented in the medical notes. We saw evidence that the GP had received training for the Mental Capacity Act (MCA) 2005 in February 2014 and was in the process of booking training on Deprivation of Liberty Safeguards (DoLs). We noted that the practices consent policy made reference to the Mental Capacity Act 2005.

Care plans were used to support patients to make decisions regarding their care. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GP demonstrated a clear understanding of Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The GP we spoke with told us they always sought consent from patients before proceeding with treatment. They told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. There was a practice policy for documenting consent for specific interventions for example, insertion of contraceptive coils. 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.

When a person did not wish to be resuscitated in the event of severe illness a 'Do not attempt resuscitation' (DNAR) form was completed to record this in their records to protect them from the risk of receiving inappropriate treatment. We spoke with the manager at the local nursing home who told us that the GP discussed the completion of forms with residents and their family members when appropriate.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. Any health concerns detected were followed up in a timely way. We noted a culture within the practice to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of patients with poor mental health and 95% had seen a GP for an annual review and had a comprehensive care plan agreed.

Good

Are services effective?

(for example, treatment is effective)

The practice had identified the smoking status of 85% of patients over the age of 15 and we noted that 81% of those patients recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months.

The practice offered a full range of immunisations for children, and flu vaccinations in line with current national guidance. The practice's performance for cervical smear uptake was 75%, which was slightly below the national average. We also noted that 65% of patients aged 65 and older had received a seasonal flu vaccination which was similar to other practices in the clinical commissioning group area. There was a mechanism in place to follow up patients who did not attend screening programmes.

Health information was made available during consultation and the GP used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website provided links to other websites for patients looking for further information about medical conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. Data from the national patient survey showed that 96% of patients rated their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 94% of practice respondents saying the GP was good at listening to them and 93% said the last GP they saw or spoke to was good at giving them enough time. We also noted that 98% of patients had responded that they had confidence and trust in the last GP they saw or spoke to and 96% said the same about the last nurse they saw.

We also reviewed a practice patient survey from 2015 of which the practice. Results showed that 99% of patients thought they were treated with care and concern by the doctor. When asked the question if they felt the GP listened to them 97% said they felt it was good or very good and 97% said they felt the doctor took their symptoms seriously. During our inspection, we observed that reception staff treated patients with dignity and respect. Patients spoke positively about how they were treated by the GP and practice nurse and this was also consistent with comment card feedback.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and the treatment room so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. All of the patients we spoke with and the comments we had received told us that patients felt the practice had supported them through all of their health needs and that of their family members. Patients also told us that they never felt rushed in consultations and appreciated the time the GP took with them.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract. We saw that staff were careful to follow the policy when discussing patients' treatments so that confidential information was kept private. The reception desk was shielded by glass partitions which helped keep patient information private. We also noted that music was played in the waiting area which helped to protect patient privacy. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, the national patient survey 2014 showed that 95% of patients said they found the receptionists at the practice helpful compared to the clinical commissioning group (CCG) average of 83% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 93% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above average compared to the clinical commissioning group area. The results from the practice's own satisfaction survey showed that 94% of patients said they felt the GP explained things well and 94% of patients felt they were involved in decisions about their care. The practice asked patients to complete the new Friends and Family Test and initial feedback had been positive with 100% of patients recommending the service to their friends or family.

Patients spoken with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that 96% of patients said the last GP they saw or spoke to was good at treating them with care and concern and that 86% of patients said the nurses were also good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We noted an information folder in the waiting area which contained information for carers to ensure they understood the various avenues of support available to them.

Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer them to the GP if needed. Staff told us they were invited to funerals and attended when possible. The GP would contact family members and if needed arrange a home visit. Staff told us that they knew patients well and a patient's death was always handled sensitively. Staff could also arrange a patient consultation at a flexible time and could give them advice on how to find support services.

The manager from the local nursing home told us how the GP conducted a weekly ward round but would often visit the care homes on more occasions during the week. They told us the GP always spent time with the residents and their relatives. The home had received feedback from relatives that they thought the GP was compassionate and understanding.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was responsive to people's needs and had sustainable 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. This understanding was reflected in the services provided, for example vaccination programmes for children and residents at the local nursing home.

The practice offered a range of appointment options to meet the needs of its patient groups including appointment booking by phone, online or in person. Early morning extended hours were available Tuesday and Wednesday at 7:30am. Home visits were available and patients were also able to leave messages with reception requesting that a GP call them back. Longer appointments were available for patients who needed them and for those with long term conditions.

The practice had a "virtual" Patient Participation Group (PPG – a patient led forum for sharing patients' views with the practice). The PPG was comprised of 16 patients who participated by email rather than face to face meetings. The most recent survey that had been conducted indicated that the group felt that a touch screen booking in system would be beneficial and help with patient confidentiality. We saw that the practice business plan had incorporated this idea in to the plan for this financial year.

The practice provided care for people with learning difficulties as well as for people with dementia in residential nursing homes and residents in a local care home. Patients with long term conditions had their health reviewed in an annual review. The practice provided care plans for patients with asthma, chronic obstructive pulmonary disease (COPD), diabetes, dementia and severe mental health. Childhood immunisation services were provided with administrative support to ensure effective follow up.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The GP had recognised that some patients would prefer to see a female GP. We saw there were arrangements in place for a female locum to attend the practice on a fortnightly basis so that patients could choose to see a female doctor if they preferred.

Access to the service

The practice appointment system offered patients the opportunity to have pre-bookable and same day appointments, urgent appointments, telephone consultations, call backs and home visits by the doctor. The practice was open from 8am to 12:30 and 1:30 to 6:30pm Monday to Friday. However, the practice closed on Wednesday afternoons. There were extended hours every Tuesday and Wednesday morning with the practice opening at 7:30am.

Patients could book appointments by telephone, face to face or online. Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included details of how to arrange urgent appointments and home visits.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an Out-of Hours service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

Patients were satisfied with the appointments system. All of the patients we spoke with told us that they found it easy to get through on the telephone to book an appointment. We

Good

Are services responsive to people's needs?

(for example, to feedback?)

noted data from the 2014 national patient survey indicated that 95% of patients thought it was easy to get through to the practice by phone and 98% of respondents said the last appointment they received was convenient**.** Results from the practice's own survey indicated that 94% of patients were happy with the opening times of the practice and 99% of patients said they found it easier to get through via the phone line.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. All staff we spoke with were aware of the system in place to deal with complaints. They told us that any feedback was welcomed by the practice as this was seen as a way it could improve the service, however the practice had received no complaints for us to review.

We saw that information was available to help patients understand the complaints system, with details about how to make a complaint in the practice booklet and in a complaints leaflet. We saw posters that provided a summary of the complaints process was displayed in the waiting room. Detailed information on the complaints process was also available on the practice website. A Friends and Family test suggestion box was available within the patient waiting area which invited patients to provide feedback on the service provided, including complaints. None of the patients we spoke with had ever had cause to complain.

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

The staff we spoke with told us that they felt well led. All the staff we spoke with told us there was a 'no blame culture' in the practice and they felt that staff members were supportive to each other. The practice was clinically well led with a core ethos to deliver high quality care and promote good outcomes for patients. We viewed the practice's statement of purpose which included its aims and objectives. These included working in partnership with patients, their families and carers and to involve them in decision-making about treatment and care and to treat all patients and staff with dignity, independence, respect and honesty in an environment which is accessible, safe and friendly. Staff we spoke with told us the vision of the practice was to provide a service they would expect and want if they were patients at the practice.

We spoke with five members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these. Staff spoke very positively about the practice. They told us that they felt strongly about working together as a team to provide positive outcomes for patients. There was evidence of strong team working. Records showed that monthly meetings took place which all staff attended. Staff felt able to contribute to meetings and raise any ideas for improvement or issues of concern if necessary.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of the policies and procedures and found they were up to date and held relevant information for staff. This included the confidentiality protocol, infection control and safeguarding children policies.

There was a clear leadership structure and the five members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and all staff took an active involvement for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and actions discussed to improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the clinical commissioning group (CCG).

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, we saw a recent risk assessment had been completed for disability access to the practice. We saw that where necessary actions had been created to help minimise risk. The practice monitored risks to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. Clinical audits and significant events were regularly discussed at meetings. These meetings also enabled staff to keep up to date with practice developments.

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly with all staff members. Notes were recorded so that staff who were unable to attend could be updated with discussions had. Staff told us that staff would discuss concerns, significant events or complaints outside of these meetings if necessary. They told us that these discussions meant that they could be offered support or advice straight away. There was an open culture within the practice and staff told us they were happy to raise issues and felt

Are services well-led?

Good

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

encouraged to do so. Staff told us that social events had been arranged by the practice. These events were used for senior staff members to thank staff for their work and provided an opportunity for reflection.

We saw there were a number of human resource policies and procedures in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on harassment, sickness and equal opportunities. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the practice and senior team members would take their concerns seriously and support them. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys and patients comment. The practice had an active "virtual" patient participation group (PPG) of approximately 16 patients contacted by email. The PPG had developed an annual action plan with the practice and we saw evidence of how the practice had acted on the group's comments. We were shown the analysis and action plan of the last patient survey in March 2015. For example, in response to patient and staff suggestions in relation to patient privacy, a system had been introduced to allow only one patient at a time to approach the reception desk. The results and actions agreed from these surveys were available on the practice website. The practice reception staff encouraged patients attending to complete the new Friends and Family Test as a method of gaining patients feedback. Initial feedback had been positive with 100% of patients recommending the service to their friends or family.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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 electronically on any computer within the practice. Staff we spoke with told us they would have no concerns in using the policy to protect patients if they thought it necessary.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had regular training organised by the practice. The lead dispenser organised and met regularly with other dispensing colleagues from other practices to receive training and learn from shared experiences.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients and could discuss better ways of working.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Medicines to deal with emergencies were not readily available, this included oxygen and medicines for the treatment of seizures hypoglycaemia, or suspected meningitis. Staff working under Patient Group Directions (PGDs) were not always authorised to administer in line with national requirements due to a form not being signed by the GP. This was a breach of regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not completed regular fire drills and therefore was not doing all that was reasonably practicable to mitigate fire risks. This was a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014