

North Laine Medical Centre

Quality Report

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at North Laine Medical Centre on 01 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the all of the population groups. It required improvement for providing safe services.

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, with the exception of those relating to checking emergency equipment, medicines management and legionella.

- Data showed patient outcomes were mixed for the locality. Although some audits had been carried out and audits were used to drive improvement in performance to improve patient outcomes, these were not always full cycle audits.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity and these had been regularly reviewed.
- The practice had proactively sought feedback from staff and patients and used this feedback to develop the service.
- The practice had an active patient participation group in operation.

The areas where the provider must make improvements are:

Summary of findings

- Ensure that a legionella risk assessment has been carried out and any risks addressed and that cleaning checklists are completed to indicate that cleaning has been carried out in line with cleaning schedules.
- Ensure all emergency equipment is subject to regular safety checks and that all medicines (including those used for emergencies) are within date.

In addition the provider should:

- Take action to address practice performance against the quality and outcomes framework (QOF) in areas identified as falling below the local and national average.

- Ensure that the practice policy for undertaking criminal records checks with the Disclosure and Barring Service (DBS) includes the need to hold records of these for the GP partners.
- Ensure that all clinical staff have a good level of understanding of the application of the Mental Capacity Act 2005 and its relevance to their practice.
- Ensure that full audit cycles are completed in order to demonstrate the impact of learning on patient outcomes.

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?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations were carried out and lessons learned were communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, some medicines kept within the practice; including those used for emergencies were out of date and not all emergency equipment was subject to regular checks. The practice had not ensured a legionella risk assessment had been undertaken.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Knowledge of and reference to national guidelines was consistent and there was evidence of clinical audit being used to drive improvement in performance to improve patient outcomes. However, not all audits were full cycle audits, demonstrating ongoing improvements over time. Multidisciplinary working was taking place and was being recorded. Not all clinical staff had attended training in the Mental Capacity Act 2005 and understanding of how this should be applied was varied, however staff agreed that they would address concerns with the GP partners.

Good



Are services caring?

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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Good



Summary of findings

appointments available 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 and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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 governance 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 patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were mixed for conditions commonly found in older people. For example their QOF score for atrial fibrillation, heart failure and osteoporosis was 100%. However, performance for COPD was 88%, 7% below the clinical commissioning group (CCG) and national average and performance for diabetes mellitus was 76%, 16% below the CCG and 14% below the national average. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia, preventing unplanned admissions and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care for working age people. 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. For example the practice offered an evening surgery once a week and used a telephone triage system to enable patients to access medical advice when at 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.

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 including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 62% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and had received training in areas such as supporting victims of domestic violence. 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.

People experiencing poor mental health (including people with dementia)

Good



The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). 86% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with a dementia. We saw that 100% of patients with a dementia had received a review in the preceding 12 months.

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

Summary of findings

organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

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 35 comment cards which contained positive comments about the practice. We also spoke with three patients on the day of the inspection.

We reviewed the results of the national patient survey which contained the views of 112 patients registered with the practice. The national patient survey showed patients were pleased with the care and treatment they received from the GPs and nurses at the practice and the practice scored the same or higher than the CCG and national average in several categories. The survey indicated that 96% of respondents said the last GP they saw or spoke to

was good at explaining tests and treatments and 95% had confidence and trust in the last nurse they saw or spoke to and 98% had confidence and trust in the last GP they saw or spoke to.

We spoke with six patients on the day of the inspection (including three members of the patient participation group) and reviewed 35 comment cards completed by patients in the two weeks before the inspection. The patients we spoke with and the comments we received were mostly positive. Comments included those stating that the service was 'professional and caring', 'friendly' and that staff treat people with compassion and respect. Four cards included comments from four patients who had experience of waiting longer than they would like for appointments, including those who had waited in the waiting room for longer than they felt was reasonable. However, all 35 comments and all six patients we spoke with were positive about the staff.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that a legionella risk assessment has been carried out and any risks addressed and that cleaning checklists are completed to indicate that cleaning has been carried out in line with cleaning schedules.
- Ensure all emergency equipment is subject to regular safety checks and that all medicines (including those used for emergencies) are within date.

Action the service **SHOULD** take to improve

- Take action to address practice performance against the quality and outcomes framework (QOF) in areas identified as falling below the local and national average.

- Ensure that the practice policy for undertaking criminal records checks with the Disclosure and Barring Service (DBS) includes the need to hold records of these for the GP partners.
- Ensure that all clinical staff have a good level of understanding of the application of the Mental Capacity Act 2005 and its relevance to their practice.
- Ensure that full audit cycles are completed in order to demonstrate the impact of learning on patient outcomes.

North Laine Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to North Laine Medical Centre

North Laine Medical Centre offers general medical services to people living and working in the central Brighton area of Brighton and Hove. It is a practice with three partner GPs, a practice nurse, practice manager and a team of administrative staff. There are approximately 4130 registered patients.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

Services are provided from:

North Laine Medical Centre

12-14 Gloucester Street

Brighton

BN1 4EW

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 in paid work or full time education, compared with the

England average. The practice population has a higher number of patients compared with the national average with a long standing health condition and a higher level of deprivation than the national average.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 NHS Brighton and Hove Clinical Commissioning Group. We carried out an announced visit on 1 July 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 six patients. We reviewed policies, procedures and operational records such as risk assessments and audits. We reviewed 35 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:

Detailed findings

- 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.

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw a range of incidents recorded that included those relating to clinical and administrative incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of six significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and as we saw that actions from significant events and complaints were reviewed and learning discussed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, the practice had reviewed and improved their security processes following a breach and all staff we spoke with were aware of the changes to practice as a result. 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.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to

the care they were responsible for. They also told us alerts were discussed at the practice meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and we saw copies of a contact sheet in a number of locations within the practice.

The practice had appointed the senior GP partner as dedicated lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and attended annual updates and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and patients with a learning disability. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their

Are services safe?

responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police, social services and local safeguarding leads. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

We saw that some medicines checks had been carried out; however there was not a comprehensive process in place to ensure this was done consistently. Some of the medicines we checked were outside of their expiry dates, including some emergency medicines that had expired in the previous year. This meant that the practice did not have appropriate emergency medicines within their expiry date in stock at the time of our inspection.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We

viewed evidence of work the practice had carried out to review and reduce the rate of hypnotics prescribing as a result of this, which included contacting patients, conducting medication reviews and successfully reducing prescribing over time. We saw data that demonstrated a 2% reduction in hypnotic prescribing.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated within the previous 12 months. We saw evidence that the practice nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PG.

We saw a positive culture in the practice for reporting and learning from incidents including those relating to medicines and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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. However, checklists to indicate that cleaning had been carried out as per the schedule were not being completed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them 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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about

Are services safe?

infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time.

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 did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) and had not undertaken a risk assessment for legionella.

Equipment

Staff we spoke with told us they had 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 which was in the past 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The practice had a portable defibrillator; however this was not included in the monthly checks of emergency equipment and medicines.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the practice policy did not include the arrangements in place for the recording of DBS checks for GP partners.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment although it was unclear how regularly it was checked. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We were told that processes were also in place to check whether emergency medicines were within their expiry date and suitable for use, however medicines used for anaphylaxis were found to have expired several months prior to our inspection.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions

Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, HIV, mental health and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

Records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs 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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audits. For example, an audit of urinary tract infections was carried out to measure the diagnosis and treatment against national guidelines. The results showed a high level of adherence to the guidelines. The practice showed us five clinical audits that had been completed in the last 12 months. Following each clinical audit, changes to treatment or care were made where needed. Audits we viewed included prescribing audits used to identify whether treatments were prescribed in line with national guidance. We saw that action was taken to ensure treatments were prescribed appropriately, however we did not view any full cycle audits where the audit was repeated a second time to demonstrate the impact of learning on patient outcomes.

The GPs told us 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 high risk treatments in frail elderly patients. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure

Are services effective?

(for example, treatment is effective)

it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 90% of the total QOF target in 2014, which was similar to the national average of 93%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators were similar to the national average.
- The dementia diagnosis rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures with the exception of hypnotic prescribing where we saw action had been taken to review and address this. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw

evidence that after receiving an alert, the GPs 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 practice had made use of 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.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example those with learning disabilities, mental ill health, dementia or living in circumstances that meant they were vulnerable. Structured annual reviews were also undertaken for people with long term conditions (e.g. Diabetes, COPD, Heart failure). We were shown examples of reviews that had been carried out in the last year and we saw that these were comprehensive.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with additional qualifications in HIV, palliative care, paediatric and geriatric medicine. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had attended training in alcohol advice and smoking cessation.

The practice nurse was trained appropriately on administration of vaccines, cervical cytology, ear irrigation and supporting patients with long-term conditions such as asthma, COPD and diabetes.

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out of Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were in line with the national average at 1.4%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems and those with end of life care needs. These meetings were attended by district nurses, social workers, 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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out of Hours provider to enable patient data to be shared in a secure and timely manner. 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 systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004, however training relating to the legislation and staff responsibilities in implementing it had not been carried out and not all clinical staff were consistently able to describe how they implemented it. However, clinical staff we spoke with were able to identify situations where the mental capacity act would apply and reported that they would raise concerns with the GP partners. One of the GP partners had attended training in the Mental Capacity Act and a second had attended additional training in dementia care. The practice manager developed a draft policy for staff relating to implementing the requirements of the Mental Capacity Act 2005 and informed us that the training would be added to the practice training schedule.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, some staff gave examples of how a patient's best interests were taken into account with the involvement of those close to them if a patient did not have capacity to make a decision. Clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. A patient's verbal consent was

Are services effective?

(for example, treatment is effective)

documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. Staff were clear about when to obtain written consent.

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Where patients had risk factors for disease identified at the health check there was a process in place for prompt follow up.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 83% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 74% of these patients. In the waiting area there was information available to patients relating to improving their health, including a health promotion board. Areas

addressed included healthy eating, childhood immunisations, substance misuse, smoking cessation and education for patients with diabetes. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 94%, which was similar to the national average of 98%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice nurse had responsibility for following up patients who did not attend and there was a named member of the administrative team who was lead for the practice's DNA (did not attend) procedure. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 70%, and at risk groups 50%. These were similar to national averages.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2 July 2015 and a survey of patients undertaken by the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 97% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 98% said the GP gave them enough time compared to the CCG average of 84% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 96% said the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments included concerns about waiting times for appointments but these included positive comments about the staff and the service received. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Patients were encouraged to inform reception staff if they wished to speak privately and we saw that this was facilitated by staff when that happened. Additionally, 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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:

- 96% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 94% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.
- 92% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared with the CCG average of 84% and the national average of 85%.

Patients we spoke 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

Are services caring?

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

We saw that patients with long-term conditions were involved in agreeing their care plans and that patients at the end of life were involved in planning their care, including identifying their preferred place of care at the end of life.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 96% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

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 patients needed help and provided support when required.

Notices in the patient waiting room, on the TV screen 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example clinical staff had additional training in areas such as HIV and mental health support due to a relatively significant number of patients with needs relating to these conditions.

The practice engaged with the NHS England Area Team and clinical commissioning group (CCG) regularly, and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was involved in local cluster activities with other practices with regard to proactive care and attended regular meetings about the development of this.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the practice had worked with the PPG to develop patient information guidance on how to access appointments and how to gain access to records.

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. We were told that all patients with a learning disability would be given a 20 minute appointment. The majority of the practice population were English speaking patients but access to online, telephone and face to face translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

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 toilets and baby changing facilities.

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.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. However, they told us there was a dedicated GP practice in the area that specialises in supporting patients of "no fixed abode" so they would also support patients to access that service if appropriate. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Patients could make appointments by telephone, calling at the surgery, or online. Repeat prescriptions could be ordered online. The surgery was open from 8.30am to 1pm and 2pm to 6pm Monday to Friday. There were arrangements in place for an Out of Hours provider to cover when the surgery was closed so that if a patient called they could still access advice and support during this time.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

Are services responsive to people's needs?

(for example, to feedback?)

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 79% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 85% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 73%.
- 61% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.
- 88% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient told us they had been able to access a same day appointment on the day of our inspection.

The practice had worked to provide accessible services for working age people and participated in a locally commissioned service providing an evening surgery once a

week for working patients. The practice also offered a telephone triage service which enabled patients to access medical advice when they were at work. Staff within the practice also told us they could extend the surgery times to enable patients to attend and that this had included offering patients appointments extended into the lunch break or at the end of the afternoon surgery if required.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were 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.

We saw that information was available to help patients understand the complaints system, including a poster displayed in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found that these were satisfactorily handled in a timely way and discussed in monthly meetings. We saw that learning had been identified and cascaded to staff as necessary.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and the statement of purpose. This included such things as the delivery of high quality services, ensuring that patient satisfaction was a priority and improving access to the practice.

We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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 eight of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 12 members of staff and they were all 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 practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This 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 action plans were produced to

maintain or improve outcomes. For example we saw that the practice had engaged in a new enhanced service for difficult to reach patients with poor mental health who had not attended for annual reviews within the practice.

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. For example we viewed a number of medication audits that ensured medication prescribing was in line with current guidance. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. 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 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 an annual health and safety and fire risk assessment had been carried out and actioned. The practice monitored risks on a regular basis 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction policy and whistleblowing which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were

Are services well-led?

Good 

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

involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included a small number of representatives from one or two of the population groups including older people and those with a long term condition. The practice also had a patient reference group (PRG) whose views were sought via electronic communication. This group included a broader representation from the various population groups. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice.

The practice had also 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.

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 five 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 staff away days where guest speakers and trainers attended.

The practice was not a GP training practice although they provided support to medical students.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw an action point for clinical staff to more actively encourage patients to participate in national screening following a number of patients who had cancer diagnosed as a result of routine screening.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>We found that the registered provider did not ensure that effective systems were in place to assess the risk of, and to prevent, detect and control the spread of infections due to not assessing the risk from legionella bacteria and not ensuring that cleaning records were maintained.</p> <p>The registered provider did not ensure that sufficient medication was available in case of emergencies and did not ensure adequate systems for the proper and safe management of medicines.</p> <p>This was in breach of regulation 12 (1) (2) (f) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> |
| Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury | <p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>How the regulation was not being met:</p> <p>The provider had failed to ensure that equipment for use in emergencies was subject to regular checks to ensure it was in full working order.</p> <p>This was a breach of regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> |