Hillside Bridge Surgery

Inspection report

Hillside Bridge Health Care Centre
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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.

Overall summary

We carried out an announced comprehensive inspection at Hillside Bridge Surgery on 3 July 2018. The overall rating for the practice was inadequate and the service was placed in special measures. The full comprehensive report for the July 2018 inspection can be found by selecting the 'all reports' link for Hillside Bridge Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 19 September 2018 to confirm that the practice had responded to the warning notice dated 24 July 2018 and met the legal requirements in relation to the breach of Regulation 12 (1), Safe Care and Treatment, identified in our previous inspection on 3 July 2018. The practice was required to be compliant with the concerns documented in the warning notice by 1 September 2018.

This report covers our findings in relation to those requirements.

Our key findings were as follows:

- We found a number of areas where the practice was not compliant with regulation 12 as was required.
- The provider had taken steps to improve the management of medicines in the practice. However, we identified a number of further concerns in this area which needed improvement.
- The provider had reviewed their approach to the management of significant events. We saw that recent events had been reviewed, managed and discussed at staff meetings. We saw evidence that changes were made as a result of the event.
- A process to manage the appropriate use, distribution and storage of prescription pads had been introduced but did not fully meet NHS Protect guidance.
- The system in place to manage the administration of medicines under patients group directions (PGDs) did not meet standards and had not improved. We asked the provide to review this with immediate effect.
- The practice had requested DBS checks for five member of staff who had been transferred from the previous provider; only one of these checks had been returned on the day of our inspection. We asked the provider to further review this to ensure that patients were safe.
- The provider had reviewed their approach to the management of infection prevention and control in the practice. However, a number of related issues had yet to be addressed and additional concerns were found on the day of inspection.

Importantly, the areas where the provider must make improvements as they are in breach of regulations are:

- The provider must ensure that safe care and treatment is provided in a safe way to patients.

We are taking further action in line with our enforcement processes. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector and included a second CQC inspector.

Background to Hillside Bridge Surgery

Hillside Bridge Surgery provides services for 5,307 patients. The surgery is situated within the NHS Bradford City Clinical Commissioning Group and is registered with Care Quality Commission (CQC) to provide primary medical services under the terms of an alternative provider of medical services (APMS) contract. This is a time limited contract between general practices and NHS Bradford City CCG for the delivery of services to the local community.

The provider is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury and maternity, surgical procedures, family planning and midwifery services.

There is a higher than average number of patients under the age of 39, in common with the characteristics of the Bradford City area. There are fewer patients aged over 45 than the national average. The National General Practice Profile states that 54% of the practice population is from an Asian background with a further 12% of the population originating from black, mixed or non-white ethnic groups.

The registered provider at the practice is Dr Poonam Jha who provides one clinical session per week at the practice. Additional clinical sessions at the practice are covered by one male salaried GP and four long term locum GPs, one of whom is female. There are two, part time self-employed female advanced nurse practitioners and a part time practice nurse. Two health care assistants (one male, one female) support the nursing team and there is a practice pharmacist who provides one session per week.

The clinical team is supported by a part time practice manager, a part time office manager and a team of administrative staff.

The characteristics of the staff team are reflective of the population it serves and they are able to converse in several languages including those widely used by the patients, Urdu, Punjabi, English and a number of Eastern European languages.

The practice catchment area is classed as being within one of the most deprived areas in England. Information published by Public Health England, rates the level of deprivation within the practice population group as one, on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. People living in more deprived areas tend to have a greater need for health services. Male life expectancy is 74 years compared to the national average of 79 years. Female life expectancy is 80 years compared to the national average of 83 years.

Hillside Bridge Surgery is situated within a purpose-built health centre with car parking available. It has disabled persons' access and facilities and there is a pharmacy on site.

The reception is open from 8.00am until 6.30pm four days per week and on a Wednesday from 8.00am until 8pm when an extended hours clinic is offered. An additional 50 appointments per month are also available to patients as part of a GP alliance initiative. Patients can attend at three sites across the Clinical Commissioning Group area.

When the surgery is closed patients are advised of the NHS 111 service for non –urgent medical advice.

On the day of inspection, we did not see that the provider was displaying their ratings on the practice website. We asked the practice to immediately review this.

Following a comprehensive inspection on 3 July 2018 the practice was rated as inadequate overall. The practice was in breach of Regulation 12: Safe Care and Treatment and Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Warning notices were issued to the practice on 24 July 2018. The practice was required to be compliant with the concerns documented in the warning notice in relation to Regulation 12 by 1 September 2018.

This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements in relation to Regulation 12.

Compliance in relation to the Regulation 17 warning notice which was issued on 24 July 2018 will be assessed at a further inspection.

Are services safe?

At our previous inspection on 3 July 2018, we rated the practice as inadequate overall and inadequate for providing safe services. Breaches of the regulations were found which included issues with the safe storage of medicines, the signing of patient group directions, (PGDs), the safe storage of prescription stationary and a lack of assurance that five members of staff who had transferred from the previous provider were suitable to work with children and vulnerable adults. The practice did not have an effective system in place for the discussion, review and management of changes following significant events and were found to be failing to assess the risk of the prevention, detection and control of the spread of infections.

At this inspection on 19 September 2018 we found that the provider had taken some actions to improve the provision of care at the practice. However; the practice had not taken all the steps necessary to ensure that care and treatment was provided in a safe way for service users and additional issues were identified.

Safety systems and processes

- At the inspection of 3 July 2018, we found that five members of staff who had transferred from the previous provider did not have Disclosure and Barring Service checks in place. (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.) We saw the provider had now requested these checks but only one was available on the day of our inspection; the other applications were still being processed by the Disclosure and Barring Service. Therefore, the provider was still not able to assure themselves that every member of the team was suitable to work with children and vulnerable adults and had failed to meet the requirements of regulation 12 within the timescale required. Until the outstanding DBS applications had been processed and returned we asked the provider to take interim measures to assure themselves that these staff were suitable to work with these patient groups.
- During the week of our inspection a new system had been introduced to manage the appropriate use, distribution and storage of prescription stationary. The process did not fully meet NHS Protect guidance and we were not assured that the actions taken were embedded within the team.
- At the previous inspection on 3 July 2018 we made the practice aware of several issues relating to the prevention, detection and control of the spread of infections. At this inspection we saw that the practice had:
- Reviewed the immunisation status of some members of the staff team. However, these records were incomplete.
- The practice had completed an interim infection prevention and control audit and requested a further external audit to be undertaken. We saw that action had been taken as a result of the audit. However, on the day of inspection we saw that cleaning schedules for at least one clinical area had not been completed as per practice requirements.

Information to deliver safe care and treatment

- We saw that a new system had been introduced to enable the discussion, review, and management of changes following significant events. Staff we spoke with told us they were aware of significant events and these had been discussed and reviewed in recent meetings. However, we did not see that any issues raised in our previous inspection had been captured as significant events.

Safe and appropriate use of medicines

- The practice had reviewed their approach to the management of vaccines. Designated staff monitored the vaccination refrigerator temperatures twice daily. An electronic data logger (to monitor refrigerator temperatures) had also been purchased, however this was not yet in use. In addition, the practice had updated their cold chain policy.
- At the inspection on 3 July 2018, we observed an open storage container in an unlocked utility room which contained a large amount of unaccounted for medicines. At this inspection on 19 September 2018 we saw that the provider had removed the unwanted medicines and had paperwork in place to evidence safe disposal.
- At this inspection we identified a medicines cabinet which was locked. The practice did not have a key for this cabinet and did not know what was stored inside. We asked the provider to arrange for the cabinet to be opened and for any contents of the cabinet to be managed or disposed of appropriately.

Are services safe?

- The practice had maintained records for the review of their emergency medicines but had not monitored the emergency oxygen cylinder or completed checks to ensure that the defibrillator was fit for purpose.
- We reviewed 17 PGDs currently in use at the practice. (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.) We identified issues with nine of the PGDs we reviewed. In most cases the authorisation signature for the administration of the vaccine was signed before the relevant nurse had signed the paperwork. This meant that the authorised signatory was invalid. We saw that additional signatures were added to the paperwork and not countersigned or authorised and that one PGD had not been signed by a nurse. The nurse assured us they had not administered the vaccine in question. Therefore; we found that PGDs at the practice did not meet the requirements in line with the Human Medicines Regulations 2012. The nursing staff employed by the practice are not authorised by their profession to administer medications unless an appropriately authorised PGD is in place. We asked the practice to review this with immediate effect.

Track record on safety

- The provider had reviewed risk assessments relating to the control of substances hazardous to health (COSHH). Chemicals stored in the practice had a corresponding risk assessment and advice sheet.