Dr Vijay Iyer

Quality Report

Hodgson Medical 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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Vijay Iyer (known as The Hodgson Medical Centre) on 25 April 2016. The overall rating for the practice was good with a rating of requires improvement for providing safe services. The full comprehensive report on the 25 April 2016 inspection can be found by selecting the 'all reports' link for Dr Vijay Iyer on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 28 March 2017 to confirm that the practice had carried out their plan to meet the legal requirements

Summary of findings

in relation to the breaches in regulations that we identified in our previous inspection on 25 April 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as good overall and remains as requires improvement for providing safe services.

Our key findings were as follows:

- There was an effective system in place for; receiving and acting upon patient safety and medicines alerts and for receiving, reviewing and sharing evidence based guidelines.
- These were acted upon to maintain patient safety.
- The practice had implemented a repeat prescribing policy which was being followed to ensure the safe prescribing of medicines.
- The practice had recruited one member of staff since the last inspection and pre-employment checks had improved. However, the recruitment records were not
- Risks associated with fire and legionella had been assessed. Actions had been taken in response to the fire risk assessment. However, there were no records to show the actions had all been completed in relation to the legionella risk assessment completed in August 2016.
- Systems were in place to ensure that all equipment received regular checks in accordance with the manufacturer's guidelines.

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

Importantly the provider must:

- Review the recruitment procedures to ensure that pre-employment checks are completed in line with Schedule 3 of the Health and Social Care Act.
- Ensure that actions are taken in response to the legionella risk assessments and records are maintained to demonstrate the actions are completed in a timely manner.

At our previous inspection on 25 April 2016 we informed the provider they should also make arrangements for the Advanced Nurse Practitioner to receive clinical supervision and for the infection control lead to receive additional training. These arrangements had been completed.

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.

- There was an effective system in place for; receiving and acting upon patient safety and medicines alerts and for receiving, reviewing and sharing evidence based guidelines.
- The practice had implemented a repeat prescribing policy which was being followed to ensure the safe prescribing of medicines.
- The practice had recruited one member of staff since the last inspection and pre-employment checks had improved. However, the recruitment records were not
- Fire and legionella risks had been assessed. Some actions had been taken although there was no record to show the actions were all completed in relation to the management of legionella.
- Systems were in place to ensure that all equipment received regular checks in accordance with the manufacturer's guidelines.

Dr Vijay Iyer

Detailed findings

Our inspection team

Our inspection team was led by:

This follow up inspection was led by a CQC lead inspector who was supported by a GP specialist advisor.

Background to Dr Vijay Iyer

Dr Vijay Iyer, also known as The Hodgson Centre is a well-established GP practice that has operated in the area for many years. It serves approximately 4400 registered patients and has a personal medical services contract with NHS Cambridgeshire and Peterborough CCG. It is located in a residential area of Peterborough with good public transport links and parking.

According to information taken from Public Health England, the patient population has a higher than average number of patients aged 35 to 54 years, a lower than average number of patients aged over 60 years, 25 to 34 years and 5 to 9 years compared to the practice average across England.

The practice team consists of two full time GP partners (male), an advanced nurse practitioner/partner (female), two practice nurses, a health care assistant and a phlebotomist. The clinical team are supported by a practice manager, practice secretary and four reception staff who work part time.

The opening times for the practice are Monday to Friday from 8.30am to 6.30pm except on Mondays when the practice closes from 1pm until 4pm. Extended hours appointments are available after 6pm on Mondays and Thursdays. The advanced nurse practitioner also provided early appointments from 8am on Thursdays When the surgery is closed patients access the out of hour's service via the NHS 111 service. The practice website includes this information including how to locate the local walk-in-centre.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Vijay Iyer on 25 April 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall and requires improvement for providing safe services. The full comprehensive report following the inspection on 25 April 2016 can be found by selecting the 'all reports' link for Dr Vijay Iyer on our website at www.cqc.org.uk.

We undertook a focused inspection of Dr Vijay Iyer on 28 March 2017. 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.

How we carried out this inspection

We carried out a focused inspection of Dr Vijay Iyer on 28 March 2017.

During our visit we:

- Spoke with the partners at the practice and the new practice manager who had been promoted into the role within the last few months.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

Detailed findings

- Reviewed information such as policies and procedures, risk assessment reports and maintenance records.

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

Requires improvement

Are services safe?

Our findings

At our previous inspection on 25 April 2017, we rated the practice as requires improvement for providing safe services as the arrangements in respect of managing risks identified through medicines safety alerts, the prescribing of high risk medicines and environmental risks needed to improve. We also found that pre-employment checks were not fully completed.

Some of these arrangements had improved when we undertook a follow up inspection on 28 March 2017; however risks relating to recruitment and environmental risks still required improvement. The practice remains as requires improvement for providing safe services.

Safe track record and learning

During our inspection in April 2016 we found the practice did not have a designated member of the team with overall responsibility for managing incidents and significant events. Over a 14 month period, eight significant events had been reported and actions were taken but there were no records to demonstrate the learning that had been identified or the resulting improvements. The practice could not show there was a system in place to discuss and share the learning from incidents and significant events with staff.

When we visited the practice on 28 March 2017, we found the practice had made improvements. The senior partner managed the incident and significant events process and ensured that detailed records were maintained. We looked at two examples in the past twelve months and found the issues had been thoroughly investigated; appropriate action had been taken and the learning identified had been discussed with relevant staff at monthly practice meetings. The practice also linked with another local practice to share learning from significant events on a quarterly basis.

Overview of safety systems and process

During our inspection in April 2016 we found there was no policy in place to guide the process for issuing repeat prescriptions to patients. When we completed a random check of patients receiving high risk medicines on repeat prescription, we identified that one medicine had been re-prescribed within a seven day period without adequate explanation. Another medicine, the subject of a safety alert issued by the Medicines and Healthcare Products Regulatory Agency, had not been reviewed in line with the alert. We also found that the system for sharing patient safety alerts, including medicines alerts was not effective. We reviewed three recruitment files and found that pre-employment checks were not always evidenced prior to staff commencing their employment.

When we visited the practice on 28 March 2017 we met with the senior GP who had ensured that a repeat prescribing policy had been introduced to guide safe practice. The policy detailed that listed high risk medicines were only issued with the authorisation of a GP. The practice had completed an audit of the medicine Methotrexate in January 2017and March 2017 to ensure that patients had received appropriate blood tests whilst taking this medicine. The audit showed improved compliance with 100% of patients receiving appropriate monitoring in March 2017. We also completed a random check of patients taking lithium. This showed the appropriate monitoring was in place.

A system had been implemented by the practice to log all medicine alerts received and discuss them with relevant staff to ensure they were actioned. We saw two examples of medicines safety alerts that had been actioned to ensure that safe prescribing continued for these patients. All of the medicines alerts were printed and stored in a file for staff reference. The medicine alerts were also discussed at monthly meetings. A system was also in place to ensure that a named GP had responsibility for monitoring national guidelines which were also shared at staff meetings. Detailed minutes of the meetings confirmed this.

The practice had employed one member of staff since the inspection in April 2016. The recruitment records included evidence of previous employment, skills and experience, references, the interview and an induction process. However, there was no photo identification or health check/declaration held on file. Although a disclosure and barring service check had been completed and this was confirmed by the member of staff, there were no records on file to support this. The practice took immediate action to apply for this. The recruitment policy contained a brief description of the recruitment procedure but did not include detailed information about the types of references that were needed and had no detail about the checks required for staff with the Disclosure and Barring Service.

Requires improvement

Are services safe?

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.

Monitoring risks to patients

In April 2016 we found the practice had not completed a fire risk assessment and the fire safety policy required a review. Other environmental risk assessments including the assessment of the risk of legionella were not in place. Although electrical and clinical equipment was checked, there were no records in place to demonstrate that these checks were being monitored to ensure that items were maintained for safe use.

During the visit on 28 March 2017 we found that a fire risk assessment was not available and it was unclear whether the fire policy had been reviewed. However, these were sent to us immediately after the visit. The fire risk assessment was completed in October 2016 and identified two actions; the addition of two fire exit signs and the completion of fire training for all staff. The actions had been completed. The fire policy had also been updated to reflect local arrangements.

A legionella risk assessment had been completed in August 2016. It identified that the building was a low-medium risk and included some recommended actions. Although some of the actions had been completed, the practice did not have a written record to demonstrate this or to ensure that progress was completed. The senior GP agreed to take further action.

The practice manager kept records to show that electrical safety checks and servicing of clinical equipment had been completed since the last inspection and further checks had been scheduled.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured that; • Recruitment procedures were followed in line with Schedule 3 of the Health and Social Care Act. • Actions were completed in response to the legionella risk assessment. Regulation 12 (1) (2)