Lambourn Surgery

Quality Report

Lambourn Surgery
Bockhampton Road
Lambourn
Berkshire
RG17 8PS
Tel: 01488 72299
Website: www.lambournsurgery.co.uk

Date of inspection visit: 17 May 2017
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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?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lambourn Surgery on 7 October 2016. The overall rating for the practice was good. However, the practice was found to require improvement in the provision of safe services. The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for Lambourn Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 17 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach in regulations that we identified in our previous inspection on 7 October 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Provision of safe services is now rated good and overall the practice remains rated as good.

Our key findings were as follows:

- Medicines fridges were kept in a secure location within the practice.
- Vaccines stored within medicines refrigerators were kept in accordance with best practice guidance.
- Treatment room flooring was fitted in line with best practice for reducing the risk of cross infection.
- Appropriate systems were in place for the safe disposal of sharps bins.
- Staff training was up to date and relevant to the roles of staff.
- Competency checks had been completed and recorded for dispensary staff.
- An appropriate system was in place to report dispensing incidents, including near misses. Learning from dispensary incidents was shared and staff were aware of the learning.

We found aspects of the service where the provider should make improvement:

- A review of the risk assessment for keeping liquid nitrogen on site should be completed in sufficient detail to identify all storage risks.

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?

Good

The practice had taken appropriate action and is now rated as good for the provision of safe services.

- The area where medicines fridges were located was kept secure.
- Vaccines were kept in medicines fridges in accordance with best practice guidance.
- Appropriate systems were in place for the disposal of sharps bins and treatment rooms were fitted with appropriate floor coverings.
- Training in delivery of safe services had been completed. For example, safeguarding and basic life support.
- Appropriate arrangements were in place for the reporting, recording and learning from events that occurred in the dispensary.
- The risk assessment for keeping liquid nitrogen on site had not been reviewed in detail to assess associated with the room in which it was stored.

Lambourn Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This focused inspection was undertaken by a lead CQC inspector.

Background to Lambourn Surgery

Lambourn Surgery is located in Lambourn, Berkshire. The practice resides in purpose built premises and there is parking available. The practice has approximately 6,500 registered patients. The practice has patients from varying age groups with a slightly higher proportion of patients aged 40 to 79. The area in which the practice is located is placed in the third least deprived decile. In general, people living in more deprived areas tend to have a greater need for health services. According to the Office for National Statistics and information provided by the practice, the practice catchment area has a high proportion of people from a White British background.

There are four GP partners (one in their probation period) and one salaried GP, consisting of three male GPs and two female GPs. GPs provide approximately 35 sessions per week in total. The practice employs three female practice nurses and one health care assistant/ phlebotomist. The practice manager is supported by a team of administrative and reception staff.

The practice provides teaching to medical students and training for qualified doctors who are seeking to become GPs. The practice provides a dispensing practice to approximately half of its patients, who lived more than a mile from a community pharmacy. The practice employed four members of dispensary staff and one relief dispenser. The practice is open between 8am and 6.30pm Monday to Friday.

When the practice is closed patients can access the Out of Hours Service via NHS 111 service Services are provided via a General Medical Services (GMS) contract (GMS contracts are a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

Services are provided from the following location:

Lambourn Surgery

Bockhampton Road

Lambourn

Berkshire

RG17 8PS

Why we carried out this inspection

We undertook a comprehensive inspection of Lambourn Surgery on 7 October 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good but provision of safe services was rated as requires improvement. The full comprehensive report following the inspection of October 2016 can be found by selecting the 'all reports' link for Lambourn Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Lambourn Surgery on 19 May 2017. This inspection was carried out to

Detailed findings

review in detail the actions taken by the practice to improve the quality of care to confirm that the practice was now meeting legal requirements and to provide an updated rating for provision of safe services.

How we carried out this inspection

During our visit we:

- Spoke with two members of the dispensary staff, a practice nurse and met with the practice manager.
- Visited the dispensary and undertook observations around the practice.
- Looked at information the practice used to deliver care and manage the service.

Good

Are services safe?

Our findings

At our previous inspection on 7 October 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of safely storing medicines, monitoring the quality of the dispensing service and completion of safety training all required improvement.

Specifically we found:

- Vaccines were not being stored safely in their original packaging.
- Medicine fridges were not held in a secure location.
- Systems for monitoring the delivery of dispensing services were not always effective.
- Training specific to delivery of safe services was not always completed in a timely manner in accordance with practice training schedules.
- Competency checks of dispensary staff had not all been undertaken or recorded.

These arrangements had improved when we undertook a follow up inspection on 17 May 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

There were systems in place to record and share learning from events that occurred in the practice dispensary:

- The practice demonstrated that there was a system to record all errors arising from within the dispensary. This included near misses. Staff were able to identify incidents that had occurred in the last six months. This included an incident that had resulted in the raising of a significant event. Staff we spoke with also described how they made entries in the errors record log.
- We reviewed minutes of dispensary staff meetings. These showed that the errors log was discussed at every meeting and learning identified from incidents was shared with the team to reduce the likelihood of recurrence.

Training and learning related to safe provision of services was undertaken:

- We reviewed the training timetable and records of completed training. This demonstrated that staff had completed appropriate levels of training in child and adult safeguarding. A range of training related to safety including; manual handling and health and safety had also been completed by all staff who had been in post for more than three months. There were training timetables in place for newly appointed staff.
- Competency assessments of dispensary staff had been completed and recorded.

Overview of safety systems and process

The practice maintained appropriate standards of cleanliness and hygiene:

- Appropriate floor covering had been installed in all treatment rooms. This facilitated easy cleaning and maintenance of relevant cleaning standards and reduced the risk of cross infection.
- There were appropriate arrangements in place for disposal of clinical waste including sharps bins. Staff were aware of the requirements to ensure sharps bins were not overfull and that these were removed for collection by approved contractors at appropriate intervals.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety:

- The practice had installed a lock to the external door adjacent to the room where medicines fridges were kept. Security of medicines fridges had been improved.
- Vaccines stored in medicines fridges were kept in their original packaging to reduce the risk of administration errors. We noted that some boxes of vaccines were stored against the internal fridge wall which reduced air circulation around the boxes of vaccines. This issue was corrected immediately it was identified. This did not follow storage guidance. We checked six vaccines stored and all were in date and fit for purpose.

There were systems in place to monitor the performance of the practice dispensary:

- The practice had commissioned an external review of their dispensary service in January 2017. The external expert advisor had produced a report that the practice was using as an action plan to improve service delivery. For example, the action plan identified the need to hold operating procedures for the dispensary in electronic format, make layout consistent and identify review dates. The practice identified that all operating

Good

Are services safe?

procedures required updating and were six weeks overdue such an update. Time had been set aside to complete the review of all procedures and achieve a common review date of early June 2017.

- The practice manager had conducted a review of the dispensary procedures. Action taken included ensuring the dispensers were not interrupted by phone calls to reduce the risk of dispensing errors. In addition a third check of items prepared to dispense to patients had been instituted to further reduce the risk of errors.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There were a range of health and safety policies and procedures and risk assessments in place. We noted that liquid nitrogen was held at the practice and that a risk assessment had been undertaken. However, the risk assessment had not identified the need to review ventilation in the room where the liquid nitrogen was stored.

These actions and improvements were now ensuring that requirements relating to safe care and treatment were being met.