St Davids Practice

Quality Report

Feltham Centre for Health
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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 of St Davids Practice on 24 October 2016. The overall rating for the practice was good with requires improvement in Safe. Breaches of legal requirements were found relating to the Safe domain. The registered person did not have a clear process in place for analysing significant events, incidents and near misses. The provider did not ensure that there was a defibrillator available at the practice or conduct a risk assessment to indicate the risks of not having one had been assessed.

After the comprehensive inspection, the practice submitted an action plan, outlining what they would do to meet the legal requirements in relation to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The full comprehensive report can be found by selecting the 'all reports' link for St Davids Practice on our website at www.cqc.org.uk.

This inspection was a document-based review carried out on 12 September 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 24 October 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

The practice is now rated as Good for providing Safe services, and overall the practice remains rated as Good.

Our key findings were as follows:

- The practice had reviewed its policy on safeguarding and its process for recording and reporting safeguarding concerns. We saw a revised policy, we saw comprehensive safeguarding minutes, detailing all safeguarding cases, including a description, action plan and learning points.
- The practice had reviewed its policy on significant events we saw a revised policy detailing the process for recording and reporting all significant events. We saw comprehensive minutes of significant events and analysis meeting minutes detailing five significant events that had occurred between May and July 2017, including case discussions, reflection, actions taken and lessons learnt.
- The practice had carried out a risk assessment on 14 April 2017 to demonstrate that they had considered and mitigated against the risk of not having access to their own defibrillator.

Summary of findings

- The practice also submitted a written agreement to confirm arrangements were in place to borrow a defibrillator from the practice they shared premises with. However, whilst it was signed by both parties there was no date.
- The practice had reviewed its policy on carers. We saw a revised policy detailing the process for identifying and registering new carers. The practice had now identified (47 patients) as carers 0.6% this had increased by 0.1% since the last inspection.

The area where the provider should make improvements are:

- Continue to review arrangements in place to ensure that patients with caring responsibilities are identified and their needs met.

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 is rated as good for providing safe services.

- The provider now ensured there was a clear process in place for analysing significant events, incidents and near misses.
- The provider had carried out a risk assessment on 14 April 2017 to demonstrate that they had considered and mitigated against the risk of not having access to their own defibrillator.

St Davids Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Background to St Davids Practice

St Davids Practice, provides primary medical services in the London Borough of Hounslow to approximately 7400 patients. The practice operates under a General Medical Services (GMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract).

The practice operates from one site. The surgery is a purpose built health centre, which they share with four other practices. The ground floor is occupied by retail shops; the health centre is located on the first floor with lift access. There is ramp access to the waiting area and reception desk. The practice has six consulting rooms.

The practice clinical team is made up of three GP partners (male and female), one practice nurse, two healthcare assistants (HCA), one phlebotomist and non-clinical staff.

The practice offers 26 GP sessions per week.

The practice opens between 8.30am and 6.30pm Monday to Friday. Appointments are available between 8:30am to 6:30pm. Extended hours are available from 6:30am to 8:30am on Tuesdays.

When the practice is closed patients can call NHS 111 in an emergency or a local out of hours service.

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

Why we carried out this inspection

We undertook a comprehensive inspection of St Davids Practice, on 24 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 overall and requires improvement in the safe key question. The full comprehensive report following the inspection 24 October 2016 can be found by selecting the 'all reports' link for St Davids Practice on our website at www.cqc.org.uk.

During the comprehensive inspection carried out on 24 October 2016 we found that the practice did not have a clear process in place for analysing significant events, incidents and near misses. The provider did not ensure that there was a defibrillator available at the practice or had not conducted a risk assessment to indicate the risks of not having one.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 24 October 2016 had been made.

We undertook a follow up desk-based focused inspection of St Davids Practice on 12 September 2017. We inspected the practice against one of the five questions we ask about services: is the service safe. 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.

Detailed findings

How we carried out this inspection

We carried out a desk-based focused inspection of St Davids Practice on 12 September 2017. This involved reviewing evidence:

- Looked at policies procedures and action plans.
- Looked at minutes.
- Reviewed risk assessments.
- Reviewed carers health check template.
- Looked at carers leaflet.

Good

Are services safe?

Our findings

At our previous inspection on 24 October 2016, we rated the practice as requires improvement for providing safe services as the practice did not have a clear process in place for analysing significant events, incidents and near misses. Also the provider did not ensure that there was a defibrillator available at the practice or that a risk assessment had been conducted to indicate the risks of not having one had been assessed.

These arrangements had improved when we undertook a follow up inspection on 12 September 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

During the initial inspection on 24 October 2016 the practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, they did not always recognise safeguarding concerns, for example, they incorrectly identified and recorded a safeguarding concern as a significant incident.

During the document based follow-up inspection we saw there was a clear process in place for analysing significant events, incidents and near misses. The practice had reviewed its policy on safeguarding and its process for recording and reporting safeguarding concerns. We saw a revised policy, we saw comprehensive safeguarding minutes, detailing all safeguarding cases, including a description, action plan and learning points. The practice had reviewed its policy on significant events we saw a revised policy detailing the process for recording and reporting all significant events. We saw comprehensive minutes of significant events and analysis meeting minutes detailing five significant events that had occurred between May and July 2017, including case discussions, reflection, actions taken and lessons learnt.

Arrangements to deal with emergencies and major incidents

During the initial inspection on 24 October 2016 the practice did not have their own defibrillator available or a risk assessment to show that they had considered and mitigated against the risk of not having one.

During the document based follow-up inspection we saw the practice had carried out a risk assessment on 14 April 2017 to demonstrate that they had considered and mitigated against the risk of not having access to their own defibrillator. The practice also submitted a written agreement to confirm arrangements were in place to borrow the defibrillator from the practice they shared premises with.