Everest House Surgery

Quality Report

Everest Way, Adeyfield, Hemel Hempstead,
Hertfordshire. HP2 4HY.
Tel: 0844 477 8615 or 01442 500164
Website: www.everesthouse.co.uk

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Everest House Surgery on 5 October 2016. The overall rating for the practice was good. However, we identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided safe services. Consequently the practice was rated as requires improvement for providing safe services. The full comprehensive report from the 5 October 2016 inspection can be found by selecting the 'all reports' link for Everest House Surgery on our website at www.cqc.org.uk.

After the comprehensive inspection, the practice wrote to us and submitted an action plan outlining the actions they would take to meet legal requirements in relation to;

- Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

- safe care and treatment.

The areas identified as requiring improvement during our inspection in October 2016 were as follows:

- Ensure that patients prescribed higher risk medicines are monitored and reviewed at the required intervals.
- Ensure that patients in whom Warfarin should be considered are prescribed it, or have the reasons for why they are not receiving it documented.
- Ensure that at all times sufficient processes are in place and adhered to for the management and review of results received from secondary care services, for example pathology results.

In addition, we told the provider they should:

- Ensure that all staff employed are supported by receiving appropriate supervision and appraisal and are completing the essential training relevant to their roles, including infection prevention and control and safeguarding training.
- Ensure that the infection control lead is appropriately trained and that the infection control protocol is fully specific to the practice.
- Ensure actions taken to resolve the risks identified by the fire and Legionella risk assessments are recorded and fully completed.
- Implement a formal and coordinated practice wide approach to ensure the practice's areas of below average Quality and Outcomes Framework (QOF) performance are improved.
- Continue to support carers in its patient population by providing annual health reviews.

We carried out an announced focused inspection on 21 June 2017 to confirm that the practice had carried out

Summary of findings

their plan to meet the legal requirements in relation to the breaches of regulation that we identified in our previous inspection on 5 October 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Our key finding on this focused inspection was that the practice had made improvements since our previous inspection and were now meeting the regulation that had previously been breached.

The practice is now rated as good for providing safe services.

On this inspection we found:

- A sufficient review and recall process was in place to ensure patients prescribed higher risk medicines were monitored and reviewed at the required intervals.
- All patients with Atrial Fibrillation were prescribed an anticoagulant medicine or had the reasons they were not receiving it recorded. (Atrial Fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate).
- A sufficient process was in place and adhered to for the management and review of clinical results received from secondary care services.

Additionally where we previously told the practice they should make improvements our key findings were as follows:

- Staff had completed infection control and adult and child safeguarding training.
- The infection control lead was appropriately trained and the infection control protocol was specific to the needs of the practice.
- Most of the risks identified by the fire and Legionella risk assessments were completed and recorded. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- A programme was in place to ensure all staff received an appraisal on an annual basis and this was on schedule for non-clinical staff. We saw that the 16 applicable non-clinical staff had received fully documented appraisals within the past 12 months. The three non-clinical staff employed for less than a year at the time of our inspection were all scheduled to receive their first annual appraisals between August and October 2017.
- Through implementing a coordinated practice wide approach, the practice had improved its Quality and Outcomes Framework (QOF) performance. (QOF is a system intended to improve the quality of general practice and reward good practice). Figures provided by the practice showed that as of 31 March 2017 the practice had achieved 100% of the total number of points available. This included achieving 100% of the points available for all of the diabetes related indicators. The practice discussed, monitored and reviewed its QOF performance at monthly clinical meetings.
- The practice had identified inaccuracies in its carers register (those patients on the practice list identified as carers). This was due to recording anomalies. As a result, the practice had undertaken a considerable piece of work including the review of 1,157 patient records in order to ensure the carers register was accurate and fit for purpose. This work was due to be completed by July 2017. Along with this the practice had prioritised identifying carers with the most needs such as those with one or more (multiple) chronic conditions so that they received a carers' health check as part of their nurse led review. The senior staff we spoke with told us that by that point they were confident the practice would be in a position to start offering carers' health reviews on a routine basis.

Following our inspection on 21 June 2017 the areas where the provider should make improvements are:

- Ensure that the infrequently used outlet at the practice is appropriately flushed on a weekly basis and that this is recorded.
- Continue to identify and support carers in its patient population.

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

At our comprehensive inspection on 5 October 2016, we identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided safe services. During our focused inspection on 21 June 2017 we found the provider had taken action to improve and the practice is rated as good for providing safe services.

- A sufficient review and recall process was in place to ensure patients prescribed higher risk medicines were monitored and reviewed at the required intervals.
- All patients with Atrial Fibrillation were prescribed an anticoagulant medicine or had the reasons they were not receiving it recorded. (Atrial Fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate).
- A sufficient process was in place and adhered to for the management and review of clinical results received from secondary care services.
- Staff had completed infection control and adult and child safeguarding training.
- The infection control lead was appropriately trained and the infection control protocol was specific to the needs of the practice.
- Most of the risks identified by the fire and Legionella risk assessments were completed and recorded. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, we found the requirement to flush the infrequently used outlet at the practice on a weekly basis was not properly completed or recorded.

Everest House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP acting as a specialist adviser.

Background to Everest House Surgery

Everest House Surgery provides a range of primary medical services from its premises at Everest Way, Adeyfield, Hemel Hempstead, Hertfordshire, HP2 4HY.

The practice serves a population of approximately 13,647 and is a training practice. The area served is slightly less deprived compared to England as a whole. The practice population is mostly white British. The practice serves a slightly above average population of those aged from 0 to 9 years, 30 to 39 years, 55 to 59 years and 80 years and over. There is a slightly lower than average population of those aged from 10 to 29 years, 40 to 49 years and 65 to 80 years.

The clinical team includes four male and five female GP partners, one trainee GP, three practice nurses and one healthcare assistant. The team is supported by a practice manager, a deputy practice manager and 17 other administration and reception staff. The practice provides services under a General Medical Services (GMS) contract (a nationally agreed contract with NHS England).

The practice is fully open (phones and doors) from 8.30am to 1pm and 2pm to 6.30pm Monday to Friday. Between 1pm and 2pm daily the doors are closed and phones switched to voicemail and patients directed to emergency numbers if required. There are 27 hours of extended opening each month (just over six hours each week) at various times on various days depending on the GP available. However, this always includes the second Saturday of each month from approximately 9am to midday. Appointments are available from 8.30am to 12.30pm and 3.15pm to 5.45pm daily, with slight variations depending on the doctor or nurse and the nature of the appointment.

An out of hours service for when the practice is closed is provided by Herts Urgent Care.

Why we carried out this inspection

We undertook a comprehensive inspection of Everest House Surgery on 5 October 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Overall the practice was rated as good. However, we identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided safe services. Consequently the practice was rated as requires improvement for providing safe services.

The full comprehensive report following the inspection on 5 October 2016 can be found by selecting the 'all reports' link for Everest House Surgery on our website at www.cqc.org.uk.

We undertook an announced follow up focused inspection of Everest House Surgery on 21 June 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.

Detailed findings

How we carried out this inspection

Before our inspection, we reviewed information sent to us by the provider. This told us how they had addressed the breaches of legal requirements we identified during our comprehensive inspection on 5 October 2016. We carried out an announced focused inspection on 21 June 2017.

During our inspection we spoke with a range of staff including two GP partners, one practice nurse, the healthcare assistant, the practice manager, the deputy practice manager and members of the reception and administration team. We reviewed a sample of the personal care or treatment records of patients to ensure safe systems and processes were in place.

Good

Are services safe?

Our findings

Overview of safety systems and process

At our inspection on 5 October 2016 we found that the arrangements for managing medicines in the practice did not always keep patients safe. The process to ensure patients prescribed higher risk medicines (specifically Methotrexate and Lithium) were monitored and reviewed at the required intervals was insufficient. Not all patients with Atrial Fibrillation not on an anticoagulant medicine for whom Warfarin should be considered were being prescribed it or had the reasons they were not receiving it recorded. Also, the process for the management and review of results received from secondary care services was lacking. Our review of the practice's pathology results system showed there were examples of results being received for patients that were not appropriately dealt with. We told the provider they must make improvements.

At our inspection on 5 October 2016 we also identified areas where we told the practice they should make improvements. Not all staff had completed infection control and adult and child safeguarding training. Despite this, the staff we spoke with were knowledgeable about safeguarding and infection control processes relevant to their roles. The infection control lead had not completed any infection control training, although we saw this was booked for December 2016. There was an infection control protocol in place; however it lacked some detail that was specific to the practice around areas such as training and roles and responsibilities.

Following our request, the provider submitted an action plan informing us of the measures they would take to make the necessary improvements. We inspected the practice again on 21 June 2017 to check the practice had taken action to improve.

During our inspection on 21 June 2017 and from our conversations with staff, our observations and our review of patient records and other documentation we found the practice had taken action to improve in these areas.

We saw the practice had a sufficient review and recall process in place to ensure patients prescribed higher risk medicines were monitored and reviewed at the required intervals. As part of this, an up to date and comprehensive recording system was in place and there were nominated members of staff who ensured the process worked effectively. We saw that 10 patients were prescribed Methotrexate (a medicine used to treat rheumatoid arthritis and other autoimmune diseases such as psoriasis). Of those, all had received the required three monthly blood test when prescribed Methotrexate. We saw that nine patients were prescribed Lithium (a medicine mainly used for the treatment of bipolar disorder). Of those, eight had received or were booked to receive the required four monthly blood test when prescribed Lithium. For the remaining patient, the practice was able to demonstrate they took every appropriate step to communicate with them and manage their care appropriately and that they were booked to receive the required testing at a secondary care provider in July 2017.

We found that patients with Atrial Fibrillation were appropriately managed. (Atrial Fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate). There were 283 patients on the practice's Atrial Fibrillation register. Of those, all had received a monitoring review and 281 were recorded as being prescribed Warfarin or a new oral anticoagulant (NOAC) (Warfarin and NOACs are anticoagulant medicines used to reduce the risk of blood clots forming and help prevent strokes). For the remaining two patients, we saw there were clearly documented reasons why they were not yet prescribed anticoagulant medicines.

We saw there was a sufficient process in place for the management and review of results received from secondary care services. This ensured that results were viewed and managed appropriately by named GPs within 24 hours of receipt. In the absence of any named GP an appropriate cover system was in place which included any urgent results being dealt with on the same day by the duty doctor. Our review of the practice's pathology results system showed that for all the examples we looked at the results were viewed and managed appropriately.

We looked at the training records of 20 staff members. We found they had all completed training in adult and child safeguarding and infection control within the required timescales. We saw the infection control lead had attended externally provided training on infection prevention and control in general practice in December 2016. In our conversation with them they told us it had been a good learning experience. We looked at the practice's infection

control protocol and saw this was specific to the needs of the practice and included sections on training requirements and the roles and responsibilities of staff and the practice in relation to infection control.

Monitoring risks to patients

At our inspection on 5 October 2016 we identified areas where we told the practice they should make improvements. The practice had up to date fire and Legionella risk assessments in place (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw that some of the necessary actions had been completed and others were in progress. However, there were not always records to demonstrate this.

During our inspection on 21 June 2017 and from our conversations with staff, our observations and our review of documentation we found the practice had taken action to improve in this area.

We looked at the fire risk assessment and action plan in place at the time of our comprehensive inspection in October 2016. We saw that all the necessary actions had now been completed and recorded. This included the installation of a new fire escape stairwell and the provision of an evacuation chair for the first floor. Since our last inspection another fire risk assessment had been completed in November 2016 and records were available to demonstrate the limited actions from this had been completed or were completed on a recurring basis.

We looked at the Legionella risk assessment and action plan. We saw that most of the necessary actions had been completed and recorded. This included the monitoring and recording of specific hot water temperatures and the displaying of not drinking water notices in certain areas. However, we found the requirement to flush infrequently used outlets on a weekly basis was not properly completed or recorded. We noted that the only infrequently used outlet at the practice was the shower located in one of the toilets. We saw records which showed that this was visually inspected in January and April 2017. From our conversations with staff it was clear that due to a lack of understanding about the requirement to flush the shower outlet on a weekly basis, it was unlikely this was completed and no records were available to demonstrate this had been done.