Hobmoor Road Surgery

Quality Report

533 Hobmoor Road
Yardley
Birmingham
West Midlands
B25 8TH
Tel: 0121 789 9744
Website: www.HobmoorRoadSurgery.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

Are services safe?	**Requires improvement** 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Hobmoor Road Surgery on 08 April 2016.

During our previous inspection of the practice on 11 August 2015 we had identified concerns relating to the unavailability of oxygen in case of an emergency. In the absence of this, the practice had not completed a risk assessment to demonstrate how it would manage an emergency which might require the use of oxygen. The practice was issued with a requirement notice for a breach under Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. The practice was previously rated Good overall, but Requires Improvement for providing safe services.

This inspection was to review the action taken by the provider to meet regulatory requirements where we had previously identified a breach by re-inspecting the Safe domain. For this reason we focused the inspection on the Safe domain. The report should be read in conjunction with the full inspection report published in January 2016.

At this inspection we found the practice had made a change since their previous inspection in August 2015 and was now meeting the requirements of the breach identified at the previous inspection. However, we also found new breaches under different regulations (Regulation 17 HSCA (RA) Regulations 2014 Good governance and under Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed). This meant that the practice was still rated as requires improvement for the Safe domain.

Specifically we found:

- Arrangements were in place to help keep patients at safe in relation to medicine management and in an emergency. Since the last inspection, the practice now had oxygen available although only an adult mask was available.

In addition the practice continued to demonstrate good practice in the following areas:

- There was an effective system in place for reporting and recording significant events.
- Risks in relation to the premises, including fire safety were being appropriately managed.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure risks are assessed for all staff acting as chaperones.

Summary of findings

In addition the provider should:

- Review the practice processes for completing and monitoring required infection control and prevention actions.
- Review and update procedures and guidance including the safeguarding policy, to ensure any new arrangements are fully reflected and that all staff are aware of these.

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

- There was an effective system in place for reporting and recording significant events. All complaints received by the practice were automatically treated as a significant event.
- The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse although some information and policies required updating.
- Most risks to patients were assessed and managed including arrangements to respond in a medical emergency, with the exception of those relating to recruitment checks and the assessment of staff carrying out chaperoning duties. For example, not all staff who chaperoned had received a Disclosure and Barring Service check (DBS check). In the absence of a DBS check, no risk assessments had been carried out to determine if DBS checks were required. Post-inspection we received some information from the practice about how this was being addressed.

Hobmoor Road 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 specialist advisor, and a practice manager specialist advisor.

Background to Hobmoor Road Surgery

- Hobmoor Road Surgery is located in Yardley, an area in the east of Birmingham, in the West Midlands. Hobmoor Road Surgery currently provides services to 3005 registered patients and has a higher percentage of patients aged five years to eighteen years of age than the national average.
- The practice has a General Medical Services (GMS) contract. The GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.
- The practice has one principal GP (male), one salaried GP (male), one locum GP (male), two health care assistants, a practice nurse, two practice managers, an assistant practice manager and three administrative/ reception staff.
- The practice is open for appointments on a Monday, Tuesday, Wednesday and Friday from 8.30am to 6.30pm and on a Thursday 8.30am to 1pm each week. In addition to pre-bookable appointments that can be booked up to two weeks in advance, urgent appointments are also available for patients that need them.
- The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. For example, if patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. The practice employs the use of the Birmingham and District General Practitioner Emergency Room group (Badger) to provide this out-of-hours service to patients.

During our previous inspection of the practice on 11 August 2015 we had identified concerns relating to the unavailability of oxygen in in case of an emergency. In the absence of this, the practice had not completed a risk assessment to demonstrate how it would manage an emergency which might require the use of oxygen. The practice was issued with a requirement notice for breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The practice was rated Good overall, but Requires Improvement rating for providing safe services.

This inspection was to review the action taken by the provider to meet regulatory requirements where we had previously identified breach. For this reason we have only rated the location for the Safe domain to which the regulation relates. The report should be read in conjunction with the full inspection report published in January 2016.

Why we carried out this inspection

On the 11 August 2015 we carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We published a report setting out our judgments which identified a breach of regulation and asked the provider to send a report of the actions they would take to comply with the regulation they were not meeting.

Detailed findings

This focussed inspection was planned to check whether the provider was meeting the legal requirement and regulation associated with the Health and Social Care Act 2008, to look at the overall quality of the service, review the area previously identified as being in breach of regulation and associated rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced focused visit on 08 April 2016.

During our visit we:

- Spoke with three GPs, two practice managers, the practice nurse and a receptionist.
- Reviewed relevant documentation made available to us relating to patient care and the running of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- The practice told us that management would be informed of any incidents and we saw that there was a recording form available on the practice's computer system.
- All complaints received by the practice were automatically treated as a significant event.
- The practice had received three significant events in the last 12 months. We discussed one example in detail and we saw that the practice had taken appropriate action which had resulted in a change in practice process as a result.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. We saw that a safeguarding policy was in place and accessible to all staff. This outlined who to contact for further guidance if they had concerns about a patient's welfare. However, we noted that the policy was out of date and had not been reviewed since December 2014. There had been a lead member of staff for safeguarding who had recently left employment. Although one GP we spoke with told us he was now the safeguarding lead, some staff were not aware that a new safeguarding lead had been identified. Staff we spoke with demonstrated they understood their responsibilities. We saw evidence that one of the GPs was trained to an appropriate higher level in children's safeguarding (level 3) and whilst another GP also informed us he had been trained to this level, the practice was unable to provide us evidence of this.
- A notice was displayed in the waiting room advising patients that a chaperone was available, if required. The practice informed us that if the practice nurse was unavailable, reception staff or the practice manager acted as chaperones. Staff who acted as chaperones had been trained for the role. However, not all staff who chaperoned had received a Disclosure and Barring Service check (DBS check). (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). In the absence of a DBS check, no risk assessments had been carried out to determine if DBS checks were required. Post-inspection we received some information from the practice about how this was being addressed.
- The practice manager was the infection control clinical lead who liaised with the local infection prevention teams. There was an infection control policy in place and staff files we viewed indicated that they had received up to date training. The CCG had completed an infection control audit in February 2015 resulting in 89% compliance and an action plan had been developed as a result. However we noted that this did not detail who would be responsible for the action, the date for implementation or if the action had been completed.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Prescriptions were securely stored and there were systems in place to monitor their use.
- We reviewed four personnel files (for the locum GP, practice nurse, receptionist and assistant practice manager) and found appropriate recruitment checks had not been consistently undertaken prior to employment and the practice recruitment policy had not always been followed. For example, we saw that in some cases proof of identity was missing, satisfactory evidence of previous conduct was not available and DBS checks had not taken place. For example, in the case of the recently employed locum GP, the practice was unable to demonstrate how they assured themselves that all appropriate pre-employment checks had been undertaken and the recently employed member of clinical staff had not received a DBS check. Post inspection, we received evidence to demonstrate that the practice had now submitted applications for DBS checks where appropriate.

Monitoring risks to patients

Some risks to patients were assessed.

Requires improvement

Are services safe?

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and we saw that a health and safety risk assessment had been completed and the practice had up to date fire risk assessments.
- The practice had a variety of other policies and risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (although a policy was seen, a risk assessment had not been undertaken) and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We saw that even though the legionella risk assessment had identified a number of actions to be completed in order to minimise the risk, the practice was unable to provide any evidence of these being completed. Post-inspection we received information of a new legionella assessment that had been completed by the practice manager after the inspection which now indicated that no action was required by the practice to minimise the risk of legionella. Additionally, the practice had also now completed a control of substances hazardous to health risk assessment post-inspection.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- We saw that an alert button had been set-up on the clinical system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff we spoke with knew of their location. All the medicines we checked were in date.
- The practice had a defibrillator and a nebuliser available on the premises.
- Since the last inspection, the practice now had oxygen available at the premises although only an adult mask available. The provider informed us that the oxygen had only just arrived at the practice during the inspection and therefore paperwork or processes relating to this were unavailable.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for the relevant agencies and a copy was also kept off-site.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found the provider had not assessed, monitored or mitigated the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. For example, the practice had not carried out risk assessments for non-clinical staff members who had been required to act as chaperones to determine if Disclosure and Barring Service (DBS) checks were needed. This was in breach of regulation 17 (1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not operated effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying out a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed and is physically and mentally fit for that work. The provider had not ensured that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity. This was in breach of Regulation 19 (1) (2) (3) (4) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.