Oughtibridge Surgery

Quality Report

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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 well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Oughtibridge Surgery on 1 June 2016. The overall rating for the practice was good with requires improvement in well led. The full comprehensive report from 1 June 2016 can be found by selecting the 'all reports' link for Oughtibridge Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 13 March 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 1 June 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 good. Specifically, following the focused inspection we found the practice to be rated good for being well led.

Our key findings were as follows:

- The practice had implemented a system to monitor and track blank prescriptions within the practice.
- We saw evidence staff were following practice policies.
- We saw evidence risk assessments had been monitored and reviewed. For example, fire and legionella risk assessments had been updated.
- The practice had completed a risk assessment of staff who performed chaperone duties and staff who had direct patient contact who had not received a DBS check. A rolling programme to complete this by the end of March 2017 had been implemented. The practice provided evidence following the inspection that these had been completed or applied for. (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).
- The practice had completed a risk assessment to ensure the appropriate emergency drugs were available to staff in a central location in an emergency.
- A risk assessment of the security of the dispensary and access to the controlled drug cupboard key had been completed.
- Training updates for the practice nurses and competency assessments of dispensary staff had been completed.

Summary of findings

- The practice had an up to date record of clinical staffs' immunity status as specified in the national Green Book (immunisations against infectious disease) guidance for healthcare staff.
- The practice had installed a thermometer in the dispensary to monitor the ambient room temperature to ensure drugs were stored at temperatures specified in national guidance.

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 well-led?

Good

Improvements had been made since our last inspection on 1 June 2016 and the practice is now rated good for providing well led services. Our key findings were as follows:

- The practice had implemented a system to monitor and track blank prescriptions within the practice.
- We saw evidence at the inspection on 1 June 2016 staff were not following some practice policies. Particularly, procedures specified in the chaperone policy. Staff had received updated chaperone training and staff we spoke with during this inspection explained procedures which aligned with the policy.
- Fire and legionella risk assessments had been reviewed and updated.
- The practice had completed a risk assessment of staff who performed chaperone duties and staff who had direct patient contact who had not received a DBS check. A rolling programme to complete this by the end of March 2017 had been implemented. The practice provided evidence following the inspection that these had been completed or applied for. (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).
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Oughtibridge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector.

Background to Oughtibridge Surgery

Oughtibridge Surgery is located in a purpose built health centre and accepts patients from Oughtibridge and the surrounding area in Sheffield. Public Health England data shows the practice population has a higher than average number of patients aged 40 to 85 years compared to the England average. The practice catchment area has been identified as one of the 8th least deprived areas nationally.

The practice provides General Medical Services (GMS) under a contract with NHS England for 5873 patients in the NHS Sheffield Clinical Commissioning Group (CCG) area. It is a dispensing practice and dispensers medication to approximately 25% of the practice population living in outlying villages. It also offers a range of enhanced services such as anticoagulation monitoring, contraceptive services and childhood vaccination and immunisations.

Oughtibridge Surgery has five GP partners (three female, two male), two practice nurses, two healthcare assistants, three dispensers, practice manager and an experienced team of reception and administration staff.

The practice is open 8am to 6.30pm Monday to Friday with the exception of Thursdays when the practice closes at 12.30pm. The Sheffield GP Collaborative provides cover when the practice is closed on a Thursday afternoon. Extended hours are offered on alternate Tuesday evenings until 8pm and one Saturday morning 9am to 12 noon a month. Morning and afternoon appointments are offered daily Monday to Friday with the exception of Thursday afternoon when there are no afternoon appointments.

When the practice is closed between 6.30pm and 8am patients are directed to contact the NHS 111 service who will offer advice or refer to the GP Collaborative if appropriate. Patients are informed of this when they telephone the practice number.

As part of the Care Quality Commission (Registration) Regulations 2009: Regulation 15, we noted during the inspection on 1 June 2016 that the GP partners registered with the Care Quality Commission as the partnership did not reflect the GP partners at the practice. It was noted at the follow up inspection on 13 March 2017 that this had not been resolved. The practice manager confirmed applications were being progressed through CQC.

Why we carried out this inspection

We undertook a comprehensive inspection of Oughtibridge Surgery on 1 June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good with requires improvement in well led. This is because the service was not meeting one legal requirement and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations. Specifically Regulation 17 Good Governance. The full comprehensive report following the inspection on 1 June 2016 can be found by selecting the 'all reports' link for Oughtibridge Surgery on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Oughtibridge Surgery on 13 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

Before completing the focused inspection we reviewed a range of information we hold about the practice including the action plan submitted by the practice following the comprehensive inspection. We carried out a focused inspection on 13 March 2017. During our visit we spoke with the practice manager, one of the reception staff, reviewed recruitment files, management documents and observed practice procedures.

To get to the heart of patients' experiences of care and treatment, we asked the question: Is it well led?

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.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection on 1 June 2016, we rated the practice as requires improvement for providing well led services as there was evidence of systematic weaknesses in governance arrangements such as effective monitoring of procedures and lack of risk assessment.

These arrangements had improved when we undertook a follow up inspection on 13 March 2017. The practice is now rated as good for providing well led services.

Governance arrangements

The practice had implemented a prescription security protocol in September 2016 and a recording system to monitor and track blank prescriptions within the practice had been introduced.

During the inspection on 1 June 2016 we noted staff were not following some practice policies, particularly procedures outlined in their own chaperone policy. During the inspection on 13 March 2017, the practice manager told us all staff who performed chaperone duties had received in-house training and we spoke with one staff member who described chaperone procedures which aligned with the practice policy.

We saw evidence training updates for practice nurses had been reviewed. At the inspection on 1 June 2016 we observed cervical cytology and vaccination training updates had not been completed for some time. During the inspection on 13 March 2017 we saw evidence both practice nurses had attended a vaccination training update on 7 September 2016 and a cervical cytology update on 8 December 2016. The practice manager had included this information on the training matrix to monitor when it was due to be renewed. We did not see evidence that competency assessments of non- clinical staff performing second person checks in the dispensary had been completed. However, the practice manager showed us a form the practice were intending to use. They confirmed they would complete these annually in conjunction with other requirements needed to evidence compliance with the dispensary service quality scheme. These would be completed in the final quarter of the year and were planned to be completed by the end of March 2017. The practice provided evidence following the inspection that these had been completed.

The practice had implemented a system to maintain a complete record of the immunity status of clinical staff. The practice had completed a risk assessment based on national guidance for healthcare staff and had implemented a log sheet to record and monitor this.

The practice had installed a thermometer in the dispensary to monitor the ambient room temperature to ensure drugs were stored at temperatures specified in national guidance.

We saw evidence risk assessments had been monitored and reviewed. For example,

- During the inspection on 1 June 2016 the practice did not have a formal risk assessment in place for legionella to confirm the actions being taken were adequate to manage the risks. (legionella is a term for a particular bacterium which can contaminate water systems in buildings). During the inspection on 13 March 2017 we saw a risk assessment had been completed on 5 August 2016 and water temperatures and flushing of outlets were being completed. These checks were monitored by the cleaning manager and overseen by the practice manager.
- During the inspection on 1 June 2016 we noted the fire risk assessment had not been updated for two years and there was no evidence fire drills had been completed since January 2014. During the inspection on 13 March 2017 we noted the fire risk assessment had been updated in June 2016 and there was a schedule to review this annually. The fire risk assessment stated a fire drill would be performed twice a year. A fire drill had been carried out on 17 August 2016 and one was planned to be completed by 31 March 2017. The fire drill and the weekly fire alarm maintenance tests were recorded on the fire monitoring log sheet.
- The practice had completed a risk assessment to ensure the appropriate emergency drugs were available to staff in an emergency. These were stored in a central location in a labelled cupboard accessible to all staff. A system to monitor the expiry dates of the medications was in place.
- A risk assessment of the security of the dispensary, when dispensary staff were not on duty, and access to the controlled drug cupboard key had been completed on 5 August 2016. Control measures had been implemented and a key safe installed for the controlled

Are services well-led?

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drug cupboard key which was accessible to authorised staff only. The door to the dispensary was to be kept locked and the window hatch closed when dispensary staff were not working in the dispensary.

- The practice had completed a risk assessment on 7 November 2016 of staff who performed chaperone duties and had not received a disclosure and barring service check (DBS). As part of this assessment an action had been agreed to complete DBS checks on all staff who acted as chaperones. The practice manager provided evidence following the inspection that these had been completed or applied for.
- The practice had completed a risk assessment of staff who had direct patient contact and had not received a DBS check. A rolling programme to complete this by the end of March 2017 had been implemented. We saw evidence some checks had been completed and the practice provided evidence following the inspection that the remainder had been applied for. We found appropriate recruitment checks, including DBS checks to ensure staff were of good character had been undertaken prior to employment for new staff employed since the comprehensive inspection on 1 June 2016.