Clementhorpe Health Centre also known as Cherry Street 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 safe?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused desktop inspection of Clementhorpe Health Centre also known as Cherry Street Surgery on 28 July 2016 to assess whether the practice had made the improvements in providing safe care and services.

We had previously carried out an announced comprehensive inspection at Clementhorpe Health Centre (also known as Cherry Street Surgery) on 2 February2016 when we rated the practice as good overall. The practice was rated as requires improvement for providing safe care. This was because of how the fridge temperatures that stored vaccines were managed. In addition some non-clinical staff who undertook chaperone duties had not received a Disclosure and Barring Service check (DBS). (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 chaperone policy was re-written to assert that only clinicians who held a current DBS check would perform chaperone duties. We asked the provider to monitor that the changes made to the chaperone policy were sustainable and that staff who performed this role would be DBS checked.

The provider was also asked to improve the access for patients to named GPs to improve continuity of care.

We asked the provider to send a report of the changes they have made to comply with the regulations; they were not meeting on the 2 February 2016. This was in relation to the management of the fridge temperatures that stored vaccines. In addition we asked the provider to send a report detailing the impact, if any, of the changes they had made to the provision of chaperones. We asked for an update on patient access to a named GP.

The practice was able to demonstrate that they were meeting the standards. In addition patient access to named GP had improved as reflected in the July 2016 patient survey. We were told that the provider continued to trial different ways of working to improve continuity of care for their patients.The practice is now rated as good for providing safe care. The overall rating remains as good.

This report should be read in conjunction with the full inspection report dated 31 May 2016

Our key finding across the area we inspected was as follows:

- There was an open and transparent approach to safety and an effective system in place for the management and monitoring of fridge temperatures.
- The practice had clearly defined and embedded systems, processes and practices in place to keep

Summary of findings

patients safe and safeguarded from abuse. Patients were not disadvantaged by the changes to the chaperone policy and this was to be closely monitored to assure sustainability.

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

There were safe and effective systems in place:

- For the management of vaccine fridge temperatures.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.Patients were not disadvantaged by the changes to the chaperone policy and this was to be closely monitored to assure sustainability.

Clementhorpe Health Centre also known as Cherry Street Surgery

Detailed findings

Background to Clementhorpe Health Centre also known as Cherry Street Surgery

Clementhorpe Health Centre (Cherry Street Surgery) provides Personal Medical Services to their practice population. They are also contracted to provide other enhanced services for example: services for violent patients and minor surgery. Cherry Street Surgery is part of one large York practice (Priory Medical Group) who has nine locations. All patients can be seen at any of the locations; however,most attend one for continuity of their care.The total practice population is currently 55, 920. The practice population lives mainly in a less deprived area than average for England.

This is a teaching practice for medical students who are studying at Hull& York Medical School (HYMS).It is also a training practice for qualified doctors wishing to qualify as GPs.

At this location there are three GPs, the Practice Management is from a central location. There are two Practice Nurses and two Health Care Assistants (HCAs). They are supported by, secretaries, administration and reception teams.

Clementhorpe Health Centre is open from 8.30am-6pm Monday- Friday. There is extended opening and Saturday morning appointments available from other locations within the group. Priory Medical Centre, is open Monday to Thursday from 6.30pm until 8pm and on Saturday morning from 8.30am -11.15am by appointment. Heworth Green Surgery has extended hours Monday –Thursday from 6.30pm until 8pm by appointment.

The practice website and leaflet offers information for patients when the surgery is closed. They are directed to the Out of Hours Service provided by Northern Doctors Urgent Care.

We previously inspected Clementhorpe Health Centre on 2 February 2016. Following this inspection, the practice was given a rating of good. The practice was rated as requires improvement for providing safe care. This was because of how the fridge temperatures that stored vaccines were managed. In addition some non-clinical staff who undertook chaperone duties had not received a Disclosure and Barring Service check (DBS). (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).

A copy of the report detailing our findings can be found at www.cqc.org.uk/

Detailed findings

Why we carried out this inspection

We carried out an announced inspection at Clementhopre Health Centre (Cherry Street Surgery) on 2 February 2016, when we rated the practice as good overall. Specifically, the practice was rated as good for being well led, providing effective care, for being caring and outstanding for responsiveness and required improvement for safe care.

As a result of the inspection in February 2016, the provider was found to be in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. Due to lack of appropriate action and escalation; patients were exposed to the potential risk of harm due to the recording of the vaccine fridge temperatures being out of range for storing of some medicines safely. This meant that the practice could not be reassured that vaccines stored within the fridge were safe and effective for use.

We asked the provider to send a report of the changes they made to comply with the regulation, they were not meeting at that time. We have followed up to make sure that the necessary changes have been made and found the provider was now meeting the regulation included within this report.

We also asked the provider to send a report detailing the impact to patients of the changes they had made to the provision of chaperones within the practice. The practice was able to demonstrate that they were meeting the standards. In addition patient access to named GP had improved as reflected in the July 2016 patient survey.

This report should be read in conjunction with the full inspection report dated 31 May 2016.

How we carried out this inspection

We have not revisited Clementhorpe Health Centre (Cherry Street Surgery) as part of this review because they were able to demonstrate that they were meeting the standards without the need for a visit. We carried out a focused review based on the evidence the practice provided.

Following the inspection in February 2016, the provider sent us evidence which demonstrated how the vaccine fridges were now closely monitored and that appropriate action was taken if temperatures fall outside of the recommended range for the safe storage of vaccines. In addition the provider sent us evidence which demonstrated how they monitored the impact on patients as a result of the changes to the chaperone policy.

Good

Are services safe?

Our findings

Overview of safety systems and processes

At our last inspection on 2 February 2016, we found that the temperatures for fridges which stored vaccines, had on occasions exceeded the recommended levels for the safe storage of vaccines. Daily temperature readings were taken and recorded. However, on more than one occasion, high readings (in excess of 8°C) were recorded without a satisfactory explanation or check to establish if this was an on-going problem. This had not been escalated as per their safe storage of medicines policy. This meant the practice could not be reassured that vaccines were safe and effective for use.

We were sent information on 3 February 2016 which confirmed the immediate attention given and all actions noted by Public Health England were being implemented across the whole group with immediate effect. We were informed once the investigation had been completed that none of the vaccines stored in the fridges were compromised in anyway. Patients could be assured of the efficacy of their immunisations.

On the 20 July 2016 the practice supplied evidence to show how they had improved their procedures and were now complying with the regulation. The practice submitted fridge temperature logs and records. Staff re-training dates and information, the significant event meeting with actions and staff meeting minutes.

The practice had an effective system in place to monitor the safe storage of vaccines. Temperature recordings were now three times daily and we had received copies of these from February 2016-July 2016. As an extra precaution further fridge thermometers had been purchased. Vaccine fridges continued to be serviced annually to ensure they continued to be fit for use. In addition the staff had been reminded of the safe storage of medicines policy and the need to escalate any excess temperature readings to a member of the management team for immediate investigation. There was evidence of interactive training about the information logged on the computer by the in-fridge thermometer link. Data had been downloaded from 2014 which showed no breaches.

Furthermore, on the 2 February 2016, we found that all chaperones had been trained for this role however, some non clinical staff had not 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).

The chaperone policy was re-written to assert that only clinicians who held a current DBS check would perform chaperone duties.

On the 20 July 2016, the practice was able to provide evidence which supported the sustainability of provision of suitably DBS checked chaperones. Patients were not disadvantaged by the changes to the chaperone policy and the changes remained closely monitored to assure sustainability. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.