Brinsworth & Whiston Medical Centres

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 an announced comprehensive inspection at Brinsworth and Whiston Medical Centres on 10 May 2016. The overall rating for the practice was good but with requires improvement for safety. The full comprehensive report for the 10 May 2016 inspection can be found by selecting the 'all reports' link for Brinsworth and Whiston Medical Centres on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 14 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 10 May 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 as good.

Improvements had been made since our last inspection on 10 May 2016. Our key findings were as follows:

- A reliable system to ensure emergency equipment was in working order had been implemented. The defibrillators were in working order and all the required equipment to ensure they could be used was available.
- Storage arrangements for emergency medicines had been reviewed and improved to ensure timely access in the event of an emergency.
- Procedures for monitoring vaccine fridge temperatures had been improved to take account of the 2014 guidance from Public Health England.
- Recruitment records had been improved and included when Disclosure and Barring Service checks (DBS) were received. Records of interview were maintained.
- Warning signs to indicate where oxygen was stored had been displayed.
- Staff had completed training in vaccinations and immunisation and infection prevention and control.
- Cleaning schedules had been implemented.

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

Improvements had been made since our last inspection on 10 May 2016 and the practice is now rated as good for providing safe services. Our key findings were as follows:

- A reliable system to ensure emergency equipment was in working order had been implemented. The defibrillators were in working order and all the required equipment to ensure they could be used was available.
- Storage arrangements for emergency medicines had been reviewed and improved to ensure timely access in the event of an emergency.
- Procedures for monitoring vaccine fridge temperatures had been improved to take account of the 2014 guidance from Public Health England.
- Recruitment records had been improved and included when Disclosure and Barring Service checks (DBS) were received. Records of interview were maintained.
- Warning signs to indicate where oxygen was stored had been displayed.
- Staff had completed training in vaccinations and immunisation and infection prevention and control.
- Cleaning schedules had been implemented.

Brinsworth & Whiston Medical Centres

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC inspector.

Background to Brinsworth & Whiston Medical Centres

Brinsworth Medical Centre is situated in Rotherham in the Brinsworth area. There is a branch surgery at Whiston Medical Centre, Hunger Hill, Whiston, Rotherham, S60 4BD. We visited the branch surgery as part of this inspection. Whiston Medical Centre was previously known as the Surgery of Light and merged with Brinsworth Medical Centre formally in September 2015.

The practice provides Personal Medical Services (PMS) for 9,995 patients across the two sites in the NHS Rotherham Clinical Commissioning Group (CCG) area. The practice population reflects the national average with a slightly higher population of working age males and 64 to 80 year old age group.

There are three GP partners, one female and two male, and a managing partner. There are also three salaried GPs and a GP registrar. There are five practice nurses and three health care assistants who all work across the two sites.

There is a large administration team led by the managing partner, an associate practice manager and associate manager.

The practice is open at the following times:

At Brinsworth the practice is open from 7.15am to 6.30pm Monday to Friday.

GP appointments are available 7.30am to 6.30pm Monday to Friday with the exception of Thursdays when the morning surgery begins at 9am.

Nurse and/or health care assistant (HCA) appointments are available at variable times between 7.30am and 6pm most days Monday to Friday.

At Whiston the practice is open between 7.30am to 6.30pm on a Tuesday, Wednesday and Friday and 8am to 6.30pm Monday and Thursday.

GP appointments are available 9.30am to 6.30pm Monday, Thursday and Friday and 9.30am to 4.30pm Tuesday and Wednesday.

Nurses and/or HCA appointments are available 7.30am to 4pm on a Monday and 7.30am to 12.30pm on a Tuesday.

Patients can attend either surgery for an appointment.

Out of hours services are provided by calling the NHS 111 service. NHS Rotherham also provides a Walk-in Centre to deal with minor ailments, illnesses and injuries. It is open from 8am to 9pm every day including Bank Holidays (excluding Christmas Day).

This practice is a GP training practice.

Why we carried out this inspection

We undertook a comprehensive inspection of Brinsworth and Whiston Medical Centres on 10 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our

Detailed findings

regulatory functions. The practice was rated as good overall but with requires improvement for safety. The full comprehensive report following the inspection on 10 May 2016 can be found by selecting the 'all reports' link for Brinsworth and Whiston Medical Centres on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Brinsworth and Whiston on 14 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

During our visit we:

- Spoke with a range of staff (Practice manager and reception staff) and spoke with a representative of the patient participation group.
- Visited all practice locations.
- Looked at records and the information the practice used to deliver care and treatment plans.

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.

Good

Are services safe?

Our findings

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for providing safe services as the arrangements for access to emergency medical equipment and medicines were not adequate. We also found improvements should be made to procedures for monitoring vaccine fridge temperatures, recruitment records and oxygen storage.

The provider informed us and provided evidence immediately following the last inspection to show they had taken action to address the issues. We found these actions had been implemented when we undertook a follow up inspection on 14 March 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

- At our inspection on 10 May 2016 we saw that the vaccine fridge temperatures were checked regularly but checks had not always been completed on a daily basis. The temperatures were only checked when nurses were on duty and a member of staff told us they only checked the vaccine fridge in the room they were working in. Public Health England guidance for ordering, storing and handling vaccines 2014 states the vaccine fridge temperatures should be done at the same time every day during the working week. Temperature data loggers were provided for some of the fridges which gave a constant recording of fridge temperatures which could be downloaded onto a computer. These also had light indicators if there had been any time when the fridges were working outside of the acceptable temperature ranges. The practice manager said they would provide this equipment for all the vaccine fridges.

  At this inspection we found daily checks had been consistently recorded. Additionally, data loggers had been provided for each fridge and the records from these were checked weekly or as required in between. Where temperatures had been recorded outside recommended ranges there was evidence of action taken to ensure patient safety, such as contacting manufacturers of the vaccines for advice. However, records relating to actions taken could be recorded in more detail. For example, where vaccines had been destroyed the serial number of these had not been recorded. A cold chain protocol had been developed and implemented.

- At our inspection on 10 May 2016 some practice nurses were unsure if their training was up to date in respect of giving vaccinations. The practice manager told us the staff had attended an awareness course with the lead nurse in this area for Rotherham CCG in September 2015 and accredited training was scheduled at Sheffield University in June and October 2016.

  At this inspection we saw evidence to confirm the nurses who were undertaking vaccinations and immunisations had attended the training in June and October 2016.

- At our inspection on 10 May 2016 staff had received infection prevention and control (IPC) training although not all staff were up to date. For example, a health care assistant had last received training in 2005. We were told the IPC training was scheduled for May 2016.

  At this inspection evidence IPC training had been completed in May 2016 was not available. The practice manager told us this had been completed by the Clinical Commissioning Group (CCG) but certificates had not been provided. The practice manager told us they would contact the CCG to see if any evidence could be obtained.

- At our inspection on 10 May 2016 there was no cleaning schedule and no record of cleaning of equipment such as the spirometer; the practice nurse told us they cleaned equipment after every clinic. The practice manager sent us a revised cleaning schedule after the inspection.

  At this inspection we found a list of equipment in each room and respective cleaning schedules had been developed and had been implemented.

- At our inspection on 10 May 2016 we found although the disclosure and Barring Service (DBS) checks had been completed and the number recorded, the date received and any detail as to whether the DBS was acceptable was not recorded. We also observed records of interview were not maintained.

Good

Are services safe?

At this inspection a DBS check was seen for two newly employed members of staff and all the required information was recorded. Records of interview had also been maintained.

Arrangements to deal with emergencies and major incidents

- At our inspection on 10 May 2016 the defibrillators at both surgeries were not in working condition. At Brinsworth surgery the equipment was not working possibly due to battery failure. Following the inspection the practice manager told us they had purchased new batteries and would keep a spare set at the practice. At Whiston surgery there were no pads for the equipment so this could not have been used. There were records to show the equipment had been checked monthly but no record that they had identified any concerns. The practice manager told us they were aware of the issues at Whiston and had been trying to order the pads but the equipment was old and they could no longer locate these however there were no records to support this action. The practice manager provided an invoice to show that, following the inspection, a new defibrillator had been purchased for Whiston surgery.

  At this inspection we observed the defibrillators were in working order and all the equipment, such as pads were available. Additionally, the practice had implemented new and detailed systems to record the checks of the equipment to minimise risks of a reoccurrence of the issues previously found. We also observed spare batteries were available with the equipment.

- At our inspection on 10 May 2016 we saw that emergency drugs at the Brinsworth surgery were held in a secure cupboard in a secure room on the ground floor. The positioning of this cupboard was away from some of the treatment areas on the first floor and arrangements to gain access to the emergency cupboard keys meant staff may not have been able to access medicines in a timely manner, should these have been required in an emergency. The practice manager provided an invoice to evidence, that after the inspection, they had ordered a new drugs cabinet for the treatment room on the first floor to address this issue.

  At this inspection we observed the storage arrangements for emergency equipment and medicines had been reviewed and had been centralised on the ground floor. We also observed additional emergency medicines and oxygen had been made available on the first floor.

- At our inspection on 10 May 2016 we found oxygen was provided at each surgery but no children's masks were available. One adult mask was available with each cylinder. However, the mask should be for single use only but the masks at both sites had been removed from their packaging. We also saw that warning signs to indicate where the oxygen was stored in the event of a fire were not displayed. The practice manager provided evidence, that following the inspection, signage and masks had been purchased.

  At this inspection we observed signs to indicate where oxygen was stored were displayed and adults and children's masks, in their original packaging, had been provided. Additionally, the practice had implemented new and detailed systems to record the checks of the equipment to minimise risks of a reoccurrence of the issues previously found.