# Northcote House Surgery

## Quality Report

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Date of inspection visit: 5 August 2016
Date of publication: 16/08/2016

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.

## Contents



## Overall summary

### Letter from the Chief Inspector of General Practice

This inspection took place so that we could follow up enforcement action that we had taken after our comprehensive inspection on 20 April 2016. The inspection report at that time rated the practice as inadequate overall and the practice was placed into special measures. You can find the report for the comprehensive inspection on the CQC website (www.cqc.org.uk).

Following the comprehensive inspection we issued a warning notice to the practice because there was immediate risks to patients that required urgent attention by the practice in relation to good governance. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We returned on 5 August 2016 to ensure the practice had taken action to mitigate these risks and complied with the regulations. We found the provider had made

# Summary of findings

appropriate improvements in ensuring that suitable arrangements were in place to improve systems to monitor the quality and safety of the service and ensure that staff received sufficient training and support.

We found that:

- Governance systems had been strengthened and provided evidence to demonstrate that quality improvements were being identified and actioned to promote improvement.
- Evidence to support recruitment checks had improved and staff who required disclosure and barring service checks (DBS) had received these.
- Appropriate calibration of equipment had taken place.

We found the provider should also:

- Ensure that a legionella assessment is undertaken and resulting actions implemented if required.

The practice continues to operate within the special measures applied by the CQC and will continue to do so for a total of six months from the publication of the report. After this time, CQC will revisit and re-inspect the practice and will amend our judgements and ratings in accordance with our findings at that time.

**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?**
We reviewed the urgent actions taken by the practice in response to the warning notice issued to them following the inspection on 20 April 2016. We found that safety systems had been improved.

**Are services effective?**
We reviewed the urgent actions taken by the practice in response to the warning notices issued to them following the inspection on 20 April 2016. We found that staff governance, training and support were more effective.

**Are services well-led?**
We reviewed the urgent actions taken by the practice in response to the warning notice issued to them following the inspection on 20 April 2016. We found that governance systems had been improved.

# Summary of findings

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure that a legionella assessment is undertaken and resulting actions implemented if required.

# Northcote House Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a cqc inspector

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the requirements of a warning notice issued following a comprehensive inspection on 20 April 2016. The warning notice was issued because we found immediate risks that required prompt attention by the practice. We returned on 5 August to ensure the practice had taken action to mitigate the risks.

# Are services safe?

## Our findings

**Safe track record and learning**

At our inspection in February 2016 the practice did not have a robust system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents, and there was a recording form available. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. However, we found that reporting was low with only three incidents reported in the previous 12 months. We saw evidence of, and were verbally told by staff about incidents that had occurred in the practice over the previous few months which had not been recorded as significant event but should have been. During our inspection on 5 August we saw that significant event summary recording was more in-depth and included a variety of topics. Since April the practice had recorded a total of 19 significant events. We saw that appropriate actions were taken where necessary and events and their outcomes were shared with staff if applicable. For example, one significant event had highlighted the need for a change of practice in the practice's IT fault reporting process; the practice had involved a member of staff to determine an appropriate outcome. We also saw that, where appropriate, complaints were treated as significant events. One recent complaint for example, had spurred the practice to revise the way that test results are discussed with patients. The practice manager was developing an additional risk assessment tool to grade the significant events according to the impact they might have.

At our inspection in April 2016 safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) and guidance alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The information was monitored by designated members of staff and shared with other staff electronically. When we asked staff who was responsible for this we did not receive a consistent answer which indicated that the procedures and communication processes for alerts and updates were not robust. During our inspection on 5 August we saw that there was a designated member of staff who had taken responsibility for the maintenance of alerts and updates. A detailed record was kept of the alerts and updates and these were shared with relevant staff. Actions taken as a result were also recorded. There was not yet a system in place which meant the responsible person could maintain overview of who had seen an alert and/or update and who hadn't but they explained to us they would implement this immediately.

**Overview of safety systems and processes**

At our inspection in April 2016 we told the practice to ensure thermometers used to record refrigerator and room temperatures where medicines are stored are validated before use to ensure their accuracy. In addition, the automated external defibrillator must be checked and serviced at regular intervals and at least annually. During our inspection in August we saw certification indicating that defibrillators had been calibrated since our last inspection and the practice had purchased new vaccine fridges with integrated thermometers. The practice used a second thermometer on all fridges to ensure adequate temperature monitoring was in place.

At our inspection in April 2016 we saw that the practice had undergone an externally led risk assessment in October 2015 which had highlighted several areas that required attention. We saw evidence that some areas were addressed but not all. During our recent inspection we saw that the most prominent elements that were outstanding had been addressed. For example, procedures around fire doors had been distributed to staff and a comprehensive library had been devised by a member of staff for the Control Of Substances Hazardous to Health (COSHH).

At our inspection in April 2016 we found that for one clinical member of staff there was no evidence of a Disclosure and Barring Service (DBS) check being done. We saw that this had been addressed and DBS checks were in place for all clinical members of staff. The practice manager explained that they were also in the process of undertaking DBS checks for all other members of staff.

At our inspection in April 2016 we were provided with a legionella risk report. This indicated that following external assessment in 2013 a variety of actions with different priorities had been highlighted as needed addressing. At the time, we were not provided with evidence any of these matters had been addressed. At our inspection in August

# Are services safe?

we saw that this had not yet been addressed but a new legionella assessment had been booked in for September and there was a dedicated member of staff allocated to ensuring actions were addressed.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective staffing**

At our inspection in April 2016 we told the practice to ensure all staff training deemed mandatory by the practice is up to date. During our inspection in August we saw that the practice had signed up to a comprehensive e-learning programme. The practice manager was able to maintain an up to date overview of staff's mandatory training and we saw a clear list of progress made since our last inspection. For example, we saw that since our last inspection staff had received chaperone and complaints handling training through this system. Externally lead infection control training had also been provided recently. The practice manager explained that they aimed for staff to undertake training during dedicated training days but if this was unsuitable or not possible staff would be compensated for their time.

# Are services well-led?

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

## Our findings

**Governance arrangements**

When we reviewed the governance systems in the practice, including a collection of policies available to staff in the staff room and on a shared drive, during our inspection in April 2016 we saw that all policies' review dates dated back to 2014. The overdue review dates meant recent updates were not reflected in the policies. For example, recent changes in advanced directives. As a result service users' leaflets were out of date.

During our inspection in August 2016 we saw that some policies were reviewed and updated, along with associated patient information leaflets. This specifically applied to policies surrounding advanced directives, power of attorney, mental capacity act, significant events and firearm licensing. The practice had adopted the local commissioning group's safeguarding policy. The practice had also gained access to a policy database but we saw that not all of these policies had been amended yet to reflect the practice's details. The practice manager explained that this was an ongoing process.

We noted that the practice's shared drive had been partly re-organised to ensure important policies and procedures (such as significant events procedures) were easily accessible.

During our inspection in April 2016 we found that the quality of record keeping within the practice was inconsistent, with minutes and records required by regulation for the safety of patients being detailed, maintained, up to date and accurate for some meetings but not for others. For example, business meetings involving the lead GP and the practice manager were not minuted, which resulted in the practice not having robust evidence on the decision making processes and rationales. During our inspection in August we saw that business meetings had been recorded since June. We saw evidence of appropriate minutes and summaries of raised points providing a track record of decision making processes.