Grange Street Surgery

Quality Report

2 Grange Street, St Albans, Hertfordshire.
AL3 5NF.
Tel: 01727 833550
Website: www.grangestreetsurgery.co.uk

Date of inspection visit: 30 September 2016
Date of publication: 16/12/2016

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.

Ratings

Are services safe?	Good
Are services effective?	Requires improvement

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4

Detailed findings from this inspection

Our inspection team	6
Background to Grange Street Surgery	6
Why we carried out this inspection	6
How we carried out this inspection	6
Detailed findings	7
Action we have told the provider to take	10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Grange Street Surgery on 30 September 2016. This was to check that improvements had been made following the breaches of legal requirements we identified from our comprehensive inspection in January 2016.

The areas identified as requiring improvement during our inspection in January 2016 were as follows:

- Ensure that systems designed to assess the risk of and to prevent, detect and control the spread of infection were fully implemented.
- Ensure that health and safety and fire safety risk assessments were completed and that any issues identified were resolved.
- Ensure a plan of action to control and resolve risks identified by the Legionella risk assessment was completed and that the Legionella Management policy was adapted to the specific needs and requirements of the practice.
- Ensure that a business continuity plan was in place so that a service could be maintained in the event of a major incident.
- Ensure that all staff employed were supported by a formal induction process, were receiving appropriate supervision and appraisal and completing the essential training relevant to their roles.
- Ensure that the practice adhered to current guidance and national standards by including a defibrillator in its emergency equipment or completing a risk assessment as to why one was not required.
- Ensure that at least one piece of photographic proof of identification was included in the personnel file of each member of staff.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grange Street Surgery on our website at www.cqc.org.uk.

Our key findings on this focused inspection were that the practice had made some improvements since our previous inspection and were now meeting regulations that had previously been breached. However, the practice had not taken sufficient action in some areas identified on our previous inspection and were now in breach of legal requirements in those areas. On this inspection we found:

Summary of findings

- Infection control processes were in place and adhered to.
- Systems were in place to ensure that staff employed at the practice received the appropriate recruitment checks.
- There were sufficient systems and processes in place to monitor and address risks to patients and staff.
- Appropriate arrangements were in place to deal with emergencies.
- There were insufficient processes in place to ensure staff received a suitable induction, completed the essential training relevant to their roles and received an appropriate appraisal.

The areas where the provider must make improvements are:

- Ensure that all staff employed are supported by a formal induction process, are receiving appropriate supervision and appraisal and completing the essential training relevant to their roles.

In addition the provider should:

- Ensure a plan of action to control and resolve risks identified by the health and safety risk assessment is completed.
- Ensure that a Legionella risk assessment is completed and that any issues identified are resolved.
- Ensure that the Legionella Management policy is adapted to the specific needs and requirements of the practice.

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

At our comprehensive inspection on 20 January 2016, we identified breaches of legal requirements. Improvements were needed to processes and procedures to ensure the practice provided safe services. During our focused inspection on 30 September 2016 we found the provider had taken action to improve and the practice is rated as good for providing safe services.

- Systems designed to assess the risk of and to prevent, detect and control the spread of infection were in place and adhered to.
- Systems were in place to ensure that staff employed at the practice received the appropriate recruitment checks.
- There were sufficient systems and processes in place to monitor and address risks to patients and staff. However, there was not yet an action plan in place to address the issues identified in a recently completed health and safety risk assessment. Also, an updated Legionella risk assessment was yet to be completed and the Legionella management policy was not adapted to the specific needs and requirements of the practice. We found that plans were in place to address these issues.
- Suitable arrangements were in place for the practice to respond to emergencies and major incidents.

Are services effective?

Requires improvement

At our comprehensive inspection on 20 January 2016 the practice was rated as good for providing effective services. However, we told the provider they should make improvements in some areas to maintain the good rating. During our focused inspection on 30 September 2016 we found the provider had not taken sufficient action in those areas and the practice is rated requires improvement for providing effective services.

- The induction programme in place for newly appointed staff failed to ensure they had a comprehensive understanding of practice processes and procedures, including essential training requirements.
- There were insufficient systems in place to ensure staff completed the essential training relevant to their roles.

Summary of findings

- A system to ensure all staff received an appropriate appraisal of their skills, abilities and development requirements was lacking.

Grange Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This inspection was completed by a CQC lead inspector.

Background to Grange Street Surgery

Grange Street Surgery provides a range of primary medical services from its premises at 2 Grange Street, St Albans, Hertfordshire, AL3 5NF.

The practice serves a population of approximately 9,800 and is a training practice. The area served is less deprived compared to England as a whole. The practice population is predominantly white British. The practice serves an above average population of those aged from 0 to 9 years and 30 to 49 years. There is a considerably lower than average population of those aged from 15 to 29 years.

The clinical team includes two male and two female GP partners, one male and one female trainee GPs, four practice nurses and one healthcare assistant. The team is supported by a practice manager and 15 other administration, reception and secretarial staff. The practice provides services under a General Medical Services (GMS) contract (a nationally agreed contract with NHS England).

The practice is staffed with the phone lines and doors open from 8.30am to 6.30pm Monday to Friday. There is extended opening from 7am every Tuesday and from 8.30am to 10.30am one in every four Saturdays.

Appointments are available from approximately 8.30am to 11.45am and 4pm to 6.30pm daily, with slight variations depending on the doctor and the nature of the appointment. An out of hours service for when the practice is closed is provided by Herts Urgent Care.

Why we carried out this inspection

We undertook an announced focused inspection of Grange Street Surgery on 30 September 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 20 January 2016 had been made. We inspected the practice against two of the five questions we ask about services: is the service safe and effective. This is because the service was not meeting some legal requirements.

How we carried out this inspection

Before our inspection, we reviewed information sent to us by the provider. This told us how they had addressed the breaches of legal requirements we identified during our comprehensive inspection on 20 January 2016. We carried out an announced focused inspection on 30 September 2016. During our inspection we spoke with a range of staff including a GP partner, a practice nurse, the practice manager and members of the reception and administration team.

Good

Are services safe?

Our findings

Overview of safety systems and processes

At our inspection on 20 January 2016 we found the infection control lead was unfamiliar with their role and had not received any specific training for the role. An undated infection control audit was completed during 2015. Many sections of the audit were incomplete and where actions were required there was no plan in place to resolve the issues identified. We told the provider they must make improvements.

Also, when we reviewed five personnel files we saw that most of them lacked one or more pieces of photographic proof of identification. We told the provider they should make improvements.

Following our request, the provider submitted an action plan informing us of the measures they would take to make the necessary improvements. We inspected the practice again on 30 September 2016 to check action had been taken to improve the infection control and recruitment processes in place.

During our inspection on 30 September 2016 we found the infection control lead had completed infection control training in May 2016. During our conversation with them they demonstrated an understanding of their role and responsibilities in ensuring appropriate infection control processes were adhered to at the practice. From our conversations with staff and our review of documentation we saw the latest infection control audit was completed on 19 September 2016. The audit was fully completed and any issues identified and the actions required to respond to any concerns raised were clear. We saw evidence that some action was taken to address any improvements identified as a result.

We reviewed four personnel files of staff employed since January 2016. All of the files contained one or more pieces of photographic proof of identification.

Monitoring risks to patients

At our inspection on 20 January 2016 we found no health and safety or fire risk assessments had been completed at the practice. However, there were records to show that such things as the fire alarm, fire equipment and emergency lighting were regularly serviced and tested. The practice had a Legionella risk assessment in place (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Completed in May 2012, the assessment identified many areas of critical (very high) risk. We saw documents that showed some work had been completed to reduce some of those risks. However, many risk areas had not been dealt with. The Legionella management policy implemented as a result of the risk assessment was a generic policy that had not been adapted to the specific needs and requirements of the practice. We told the provider they must make improvements.

Following our request, the provider submitted an action plan informing us of the measures they would take to make the necessary improvements. We inspected the practice again on 30 September 2016 to check action had been taken to improve the health and safety related processes in place.

During our inspection on 30 September 2016 we found the practice had employed a new non-clinical member of staff in August 2016 whose role included a set amount of time each week as the practice's health and safety administrator. From our review of their staff file and our conversation with them we found they were suitably qualified and experienced to complete the role. We saw the administrator was working to an overarching health and safety action plan to ensure all requirements in this area were met. This was being completed and updated.

We saw that a fire risk assessment had recently been completed. The assessment identified each risk and the measures in place to control them. An action plan was in place to address any improvements identified and this was being completed and updated. A health and safety risk assessment had also recently been completed. Although the assessment identified each risk and the improvements required were clear, there was not yet an action plan in place to address these.

From our conversations with staff we found a decision was taken to have a further Legionella risk assessment completed at the practice. This was based on the fact that due to the lack of documentation available, the practice was unclear as to the actions taken in response to the original assessment in 2012. Also, as there was now a member of staff with time dedicated to a health and safety role, the new assessment could be completed in their presence. We saw confirmation the assessment was booked for 3 October 2016. From our conversations with

Good

Are services safe?

staff we found a decision was taken to wait for the Legionella assessment to be completed before adapting the Legionella management policy to the specific needs and requirements of the practice. We saw that completion of both the Legionella assessment and management policy were included in the practice's overarching health and safety action plan.

Arrangements to deal with emergencies and major incidents

At our inspection on 20 January 2016 we found the practice did not have a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The senior staff we spoke with told us that until the plan was developed there were no formal or informal arrangements with other providers in the event of an emergency that prevented the practice operating properly. We told the provider they must make improvements.

Also, the practice did not have a defibrillator or a risk assessment in place as to why one was not necessary. We told the provider they should make improvements.

Following our request, the provider submitted an action plan informing us of the measures they would take to make the necessary improvements. We inspected the practice again on 30 September 2016 to check action had been taken to improve the arrangements in place to deal with emergencies and major incidents.

During our inspection on 30 September 2016 we found 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 staff to use. From our conversations with staff we found an arrangement was in place with a nearby surgery should it not be possible to operate a service from the Grange Street Surgery premises.

We saw the practice had purchased a defibrillator and this had been tested and was fit for purpose.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

At our inspection on 20 January 2016 we found that although there was an induction programme for newly appointed staff, it was completed informally. We found the system of appraisals was behind schedule, but a programme was in place for all staff to be appraised by March 2016. There were gaps in the completion of some essential training (training that each staff member is required to complete in accordance with the practice's own requirements). From our conversations with staff we found that this had not affected their knowledge and understanding in those areas. A programme was in place to ensure that all staff completed the required training. We told the provider they should make improvements.

During our inspection on 30 September 2016 we reviewed four personnel files of staff employed since January 2016. None of the files contained evidence of a completed, documented formal induction programme. We spoke with some of those staff. They said that when they started employment with the practice they had received a basic introduction to processes and procedures and had worked with a more experienced member of staff for a set period of time (shadowing). However, they told us they were not asked to complete any essential training and were unclear as to what the training requirements were at the practice. They displayed a limited knowledge of some of the basic practice processes and procedures we asked them about.

Centrally held records to monitor the essential training completed by the GPs were not kept, although this was available for all other staff. We found that seven non-clinical and nursing staff had not completed any safeguarding training and 17 had not completed any health and safety training. Seven staff had not completed any infection control training and a further seven staff were overdue an update in accordance with the practice's own protocol. However, all four practice nurses had completed their infection control training in May 2016. Also, all staff were booked to complete basic life support training on 23 November 2016.

From our conversations with staff and our review of documentation we found that since our original inspection all four practice nurses had received an appraisal and a further three non-clinical staff previously overdue an appraisal had theirs completed. However, three non-clinical staff employed at the practice for more than one year were still overdue an appraisal. For one of those, the last recorded appraisal was in August 2012. From our conversations with senior staff we found they were unclear as to who was responsible for appraising the healthcare assistant (HCA). Consequently the HCA had not received an appraisal.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found that the registered person had not ensured all persons employed received the appropriate support, training and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The induction programme for newly appointed staff was informal, undocumented and did not provide staff with a comprehensive introduction to the practice's processes, procedures and training requirements. Some staff were not completing essential training in accordance with the practice's own protocols. The practice did not adhere to its own programme of staff appraisal. Some staff had been overdue an appraisal for a long period and one staff member had not received an appraisal in their current clinical role. This was in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.