Rudgwick Medical Centre

Quality Report

Station Road
Rudgwick
West Sussex
RH12 3HB
Tel: 01403822103
Website: www.rudgwickmedicalcentre.co.uk

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rudgwick Medical Centre on 5 January 2017. The overall rating for the practice was inadequate. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Rudgwick Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced focussed inspection carried out on 17 May 2017 to confirm that the practice was compliant with warning notices issued following the January 2017 inspection. The warning notices were issued against regulation 12 (1) (safe care and treatment) and regulation 17 (1) (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report covers our findings in relation to those requirements. Our findings reflect that the practice had taken action against the warning notices issued and that they were compliant with the warning notices. The ratings remain unchanged from the January 2016 inspection as the purpose of the May 2017 inspection was to review compliance against the warning notices issued.

Our key findings were as follows:

- The practice had a clear, timely action plan in place for how they were addressing the areas of practice activity where improvements were needed.
- The practice had made improvements to recruitment processes and we saw that appropriate employment checks had been carried out on staff including references.
- There was evidence of improvements made to incident reporting, discussion and learning.
- The practice was developing a programme of clinical audit.
- The practice had taken action to improve infection control practices including identifying clear leadership and carrying out an infection control audit.
- The practice had made improvements to risk management processes with evidence of risk assessments and appropriate actions in relation to health and safety, fire safety, legionella and the environment.
- The practice had taken action to review and update policies and procedures including those relating to the dispensary, infection control and health and safety.
- The practice had made improvements in the dispensary in relation to the management and destruction of controlled drugs and relevant record

Summary of findings

keeping. They had engaged with an accountable officer for the destruction of controlled drugs and were working with them to improve practice and provide training for dispensary staff.

- There was evidence of improved communication and cascading of information and learning across staff teams and the organisation as a whole.
- There was evidence of improved leadership in specific identified areas such as infection control and safeguarding.

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?

Inadequate

In January 2017 the practice was rated as inadequate for providing safe services and we told them that improvements must be made. Warning notices were issued because patients were at risk of harm because systems and processes were not in place in a way to keep them safe. There was evidence of incident reporting, however investigations, discussions and learning were inconsistent and records were insufficient and safety was not improved. There was no infection control lead, completed audit or risk assessment in place and fabric privacy curtains did not include a record of laundering at the required temperature. Recruitment checks were generally undertaken although not all staff commencing in post had evidence of satisfactory reference checks. Environmental risks were not routinely assessed in relation to fire, health and safety or legionella within the practice. The practice did not have a cold chain procedure in place and staff monitoring the vaccination fridge were uncertain of the required temperatures or what action to take should the temperature be out of range. There were a number of patient returned controlled medicines that had not been disposed of and there was no evidence of regular monitoring of these and there were crossings out in the controlled drug register.

In May 2017 we saw that improvements had been made to the way incidents were reviewed and discussed and there was evidence of learning and improvements as a result. There was clear infection control leadership and an audit had been carried out with clear action taken. The audit had been repeated on a regular basis to monitor improvements and manage risks. Risk assessments had been carried out, for example in relation to Control of Substances Hazardous to Health (COSHH) and legionella. There was evidence of satisfactory reference checks for new staff commencing in post. The practice had developed a cold chain procedure and staff had been trained in the action required if the temperature of the vaccination fridge was out of range. The practice had worked closely with the local accountable officer for the destruction of controlled drugs and had made improvements in relation to the storage, disposal and recording of controlled drugs. Training had been arranged for dispensary staff in the management of controlled drugs.

Are services effective?

Requires improvement

At our previous inspection on 5 January 2017, we rated the practice as inadequate for providing effective services as there were areas that needed improving. Clinical audits had been carried out, however these were not completed full cycle audits.

Summary of findings

On 17 May 2017 we saw there was some evidence of repeat cycle audits beginning to take place. There were plans in place for second audit cycles in coming months that would be used to identify and demonstrate improvements made.

Are services well-led?

Inadequate

In January 2017 we found that the practice had some policies and procedures to govern activity, but in some cases these were several years out of date and had not been reviewed. In other areas policies were unable to be located. Risks were not consistently identified or managed. Learning from significant events and complaints was not evident. Clinical audits were not full cycle. The leadership structure and capacity was unclear in relation to the areas where improvements needed to be made.

During our May 2017 inspection we found that the practice had made improvements to their policies and procedures. Action had been taken to improve the assessment and management of risks and clear action had been taken to mitigate risks identified. Learning from significant events was evident in the recorded discussions and we saw evidence of preventative action taken as a result of significant events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.

People with long term conditions

Inadequate

At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.

Families, children and young people

Inadequate

At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.

Working age people (including those recently retired and students)

Inadequate

At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review

Summary of findings

the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.	
People whose circumstances may make them vulnerable At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.	**Inadequate**
People experiencing poor mental health (including people with dementia) At the January 2017 inspection we identified concerns in safe and well-led services and rated the provider as inadequate in these domains and overall. The concerns leading to this rating apply to everyone using this practice, including this population group. The May 2017 inspection was a focused follow up inspection to review the provider's compliance against warning notices issued following the January 2017 inspection. The ratings for the practice and this population group were not reviewed as part of the May 2017 inspection.	**Inadequate**

Rudgwick Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Rudgwick Medical Centre

Rudgwick Medical Centre offers general medical services to people living in Rudgwick, Horsham with a patient list size of 3500. The practice population has a slightly higher than average proportion of elderly patients and those with a long standing health conditions. They had a lower proportion of children under 18 and a lower than average number of working patients and also patients that are unemployed. The practice is placed in one of the least areas of deprivation.

The practice holds a General Medical Service contract and is led by two GP partners (male). The GPs are supported by a part time salaried GP (female), two practice nurses, a healthcare assistant a practice manager, and a team of dispensary, reception and administrative staff. This comprises of roles that include a combination of reception and dispensing duties. In addition the practice had appointed a new member of staff to provide support to the practice manager and GPs in addressing the areas of practice activity where improvements were required. A range of services are offered by the practice including asthma reviews, child immunisations, diabetes reviews, new patient checks, and smoking cessation.

The practice has a dispensary offering pharmaceutical services to those patients on its practice list who live more than one mile (1.6km) from their nearest pharmacy premises.

The practice is open between 8.30am and 6.30pm on a Monday to Friday. Telephone lines are open from 8.00am. Appointments are available between 8.30am and 12.00pm and between 2.00pm and 6.30pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider (111).

Services are provided from:

Rudgwick Medical Centre, Station Road, Horsham, West Sussex, RH12 3HB.

Why we carried out this inspection

We undertook a comprehensive inspection of Rudgwick Medical Centre on 5 January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on 5 January 2017 can be found by selecting the 'all reports' link for Rudgwick Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up warning notice focused inspection of Rudgwick Medical Centre on 17 May 2017. This inspection was carried out to review compliance and action taken by the practice against warning notices issued

Detailed findings

in relation to Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out a warning notice focused inspection of Rudgwick Medical Centre on 17 May 2017. During our visit we:

- Spoke with a range of staff (GPs, practice management staff, nursing, dispensary and reception staff.
- Reviewed records relating to how the practice was run including risk assessments, policies, meeting minutes and clinical audits.
- Visited all practice locations
- Looked at 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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 5 January 2017, we rated the practice as inadequate for providing safe services as; the arrangements in respect of cleanliness and infection control were not adequate; risks and significant events were not adequately managed; monitoring of controlled drugs and arrangements relating to the cold chain were not effective; and, recruitment processes did not always include obtaining satisfactory information about conduct in a previous role.

Safe track record and learning

During our inspection on 5 January 2017 we found that safety incidents were not always recorded and there was little evidence of significant event discussions with staff and no evidence of the identification of themes, trends and lessons learnt.

During our follow up inspection on 17 May 2017 we found that significant events were recorded and there was evidence of discussion at team meetings and involvement of staff in actions and learning outcomes. This was an improvement since the previous inspection. For example, there had been two incidents where patients had presented at the practice with symptoms of acute illness. As a result of these incidents emergency procedures within the practice had been reviewed and an emergency flowchart had been created. The practice manager and GP had met with staff involved and discussed learning and arrangements were in place to ensure this information was cascaded to all staff.

Overview of safety systems and process

During our inspection on 5 January 2017 we found that the practice had some systems, processes and practices in place to keep patients safe. However, there were issues relating to cleanliness and infection control, medicines management and recruitment checks:

- On 5 January 2017 we found that appropriate recruitment checks had not been undertaken prior to employment and in line with the practice policy. For example references had not been obtained for two staff that had commenced in post during the preceding six months. On 17 May 2017, we viewed one personnel file of a member of staff who had commenced in post in the preceding six months and saw that references had been obtained to ensure satisfactory information had been obtained about conduct in previous employment. The practice had updated their policy using guidance from NHS Employers.
- On 5 January 2017 we found that infection control processes within the practice were unclear and there was no allocated infection control lead. The infection control policy had been due for review in 2007 but there was no evidence that this had been done. There was no infection control audit available and we had been told by staff that these had not been carried out. Cleaning schedules were not in place and there were no records of the laundering of linen privacy curtains in use within clinical areas. On 17 May 2017 we found that an infection control lead had been identified and they had attended relevant training and forum meetings in order to carry out their role. An infection control policy had been developed in April 2017 with relevant protocols in place. Cleaning schedules were in place and were being followed by staff and we saw evidence of the laundering of privacy curtains at the required temperature. All curtains were labelled with clear dates of when they were due to be laundered. An infection control audit had been completed and this was reviewed on a fortnightly basis with clear action plans in place. The improvements to infection control had been reviewed in partnership with the infection control lead from the CCG (clinical commissioning group).
- On 5 January 2017 we saw that while the temperature of the vaccine fridge was monitored on a daily basis, the practice did not have a clear policy in place relating to what staff should do if the fridge temperature was outside of the range at which vaccines were required to be stored. Other policies such as the destruction of controlled drugs and assembling and labelling of dispensed medicines had not been reviewed when due. Staff were unclear of the required temperature range. On 17 May 2017 we saw that a new cold chain policy had been developed and information relating to this had been shared with relevant staff to ensure they were all aware of the required temperature range and action to be taken. All other medicines and dispensary policies and procedures had been reviewed and updated and information had been shared with staff to ensure they were aware of changes.
- On 5 January 2017 we found there were a number of patient returned controlled medicines that had not been disposed of and there was no evidence of regular

monitoring of these. On 17 May 2017 we found that the practice had addressed the disposal of patient own controlled medicines and they had sought the advice and guidance of the local accountable officer for the destruction of controlled drugs. There were clear records of the disposal of controlled drugs and the practice were in the process of updating their controlled drugs registers to ensure greater efficiency of records. They had also arranged training for all dispensing staff on the management of controlled drugs. The practice had been undertaking weekly controlled drug audits with plans for these to change to monthly now that improvements to the systems had been made. In addition the lead dispenser within the practice was regularly attending a dispensary forum within the locality.

Monitoring risks to patients

On 5 January 2017 we found that there were insufficient procedures in place for monitoring and managing risks to patient and staff safety:

- On 5 January 2017 the practice had a fire risk assessment in place although this had not been repeated or reviewed since 2013 and there was no evidence of it having been used by the practice. Mitigating action to manage risks such as fire training and fire drills were not in place and there was little evidence of learning from a fire incident that occurred within the practice. On 17 May 2017 we saw that a fire risk assessment had been carried out in March 2017. One specific action as a result of this was to clear brambles from the escape pathway at the back of the building. A fire evacuation rehearsal had taken place in April 2017 and staff were undertaking fire safety training.
- On 5 January 2017 the practice did not have records to demonstrate that a legionella risk assessment had been carried out. On 17 May 2017 we saw that a legionella risk assessment had been undertaken in March 2017. Specific action taken relating to this included weekly flushing of infrequently used water outlets and monthly water temperature checks. There was a plan in place to undertake an annual in-house legionella risk assessment and a bi-annual external one.
- On 5 January 2017 we identified that the practice did not have a variety of risk assessments in place to monitor the safety of the premises. For example, there was no risk assessment relating to the control of substances hazardous to health (COSHH) and there was no environmental risk assessment. On 17 May 2017 we saw that a COSHH risk assessment had been carried out and that safety data sheets were available for all potentially hazardous substances in use within the practice. In addition environmental risk assessments had been carried out in April 2017, including for the dispensary, general health and safety and for the use of display screen equipment (DSE). An example of action taken as a result of the environmental risk assessment was that one member of staff had the keyboard for their computer raised to ensure a more comfortable position of use.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 5 January 2017, we rated the practice as inadequate for providing effective services as there were areas that needed improving. Clinical audits were not completed, full cycle audits.

On 17 May 2017, we saw some improvement in relation to the completion of full cycle clinical audits and this was an area that the practice continued to work on.

Management, monitoring and improving outcomes for people

- On 5 January 2017 we saw evidence of single cycle, incomplete clinical audits. There was limited evidence that the findings were used by the practice to improve services or that they were being used within the practice to assess and monitor the quality and safety of services provided. On 17 May 2017 we found that since the previous inspection work had developed in relation to clinical audits with evidence of further single cycle audits, for example in relation to the use of a medicine used in the treatment of cardiac arrhythmia and appropriate monitoring of patients. We saw that the use of clinical audits had been discussed at management meetings and we were told of plans in place to undertake repeat cycles of some existing audits over the coming months.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 5 January 2017, we rated the practice as inadequate for providing well-led services as the overarching governance structure was not supported by effective systems in relation to the management of significant events and complaints, the management of policies and procedures and the management of risk within the practice.

We issued warning notices in respect of these issues and found arrangements had improved when we undertook a follow up warning notice inspection of the service on 17 May 2017.

Governance arrangements

- On 5 January 2017 we saw that some practice specific policies were in place although there was no system for regular review and some polices were difficult to locate at the time of inspection. For example, a health and safety policy was unable to be located and an infection control policy had not been reviewed in more than ten years. On 17 May 2017 we saw that a number of policies had been updated. For example, all medicines management policies had been reviewed and updated. A health and safety policy had been developed in February 2017 and a fire policy in March 2017. Policies were available to all staff via a shared drive on the computer and paper copies were available in the manager's office and reception area. Staff were informed of policy updates in staff meetings and via email and they had to sign to state they had read and understood updated policies.
- On 5 January 2017 it was identified that the practice did not have in place a programme of clinical audit to monitor quality and make improvements. On 17 May 2017 we saw evidence of the development of clinical audits to ensure improvements. This was a work in progress and repeat cycle audits were planned in some areas in order to identify and demonstrate improvements made.
- On 5 January 2017 there were limited arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. On 17 May 2017 we saw that the practice had made improvement to the management of risks within the practice. Risk assessments had been developed in a number of areas including health and safety, fire safety, infection control and legionella.
- On 5 January 2017 the processes for recording, investigating, discussing, taking action and learning from complaints and significant events were not in place or consistently applied. On 17 May 2017 we saw that improvements had been made in this area. For example, significant events were recorded on a reporting form in line with practice policy. There was evidence of review and discussion and action being taken to address significant events. For example, we saw that significant event and complaints discussions were standing agenda items for all meetings within the practice. There was evidence of action being taken to ensure learning as a result of significant events. For example, there had been two incidents of patients presenting at the practice feeling unwell where there was a potential for the situation to escalate and become an emergency. The manager and GPs within the practice had worked with the reception staff to identify learning and had developed an emergency flowchart as a guide to ensure that timely referral to medical staff was in place in future. Staff we spoke with told us they had been involved in discussions about significant events within the practice.

Leadership and culture

- On 5 January 2017 we found that leadership in some areas of the practice was unclear. For example, there was no identified lead for infection control and not all staff were aware of who the safeguarding lead was. On 17 May 2017 we found that the practice had addressed the areas of leadership identified and staff were aware of who the safeguarding lead was. In addition an infection control lead had been identified and had attended relevant training and external meetings in order for them to carry out their role.