Hillsprings Health and Wellbeing Centre

Quality Report

Lovett Court,
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hillsprings Health and Wellbeing Centre on 22 March 2016. A breach of legal requirement was found and a warning notice was served. The practice sent us an action plan to say what they would do to meet legal requirements in relation to:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We undertook a focused inspection on 31 August 2016. We visited Hillsprings Health and Wellbeing Centre to check that the practice had followed their action plan and to confirm they now met legal requirements in relation to Regulation 12. This report only covers our

Summary of findings

findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hillsprings Health and Wellbeing Centre on our website at www.cqc.org.uk.

Our key findings were as follows:

- The practice had reviewed, updated or developed policies and discussed these with staff at practice meetings.
- The practice had introduced a system to act upon medicines and equipment alerts issued by external agencies. Alerts were reviewed and appropriate action taken.
- The practice had introduced an effective system to ensure the safe and proper management of patients prescribed high risk medicines. Patients prescribed these medicines were monitored in line with recommended guidance.
- Vaccines were being stored in line with manufacturers' guidance.
- Infection control audits had been carried out at each site and action taken to address any identified issues.
- All clinical equipment had been serviced / calibrated and reminders introduced to ensure these checks were carried out annually.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Hillsprings Health and Wellbeing Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor.

Background to Hillsprings Health and Wellbeing Centre

Horsefair Practice is registered with the Care Quality Commission (CQC) as a partnership provider in Rugeley, Staffordshire. The practice holds a General Medical Services contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The main site is Hillsprings Health and Wellbeing Centre, which branch sites in Rugeley and Armitage. The sites are as follows:

- Hillsprings Health and Wellbeing Centre, Lovett Court, Rugeley, Staffordshire, WS15 2 FH.
- Horse Fair Practice Group, Sandy Lane Health Centre, Rugeley, Staffordshire, WS15 2LB.
- Armitage Surgery, Shropshire Brook Road, Armitage, Rugeley, Staffordshire, WS15 4UZ.

We only visited Hillsprings Health and Wellbeing Centre as part of this inspection.

Why we carried out this inspection

This focused inspection was carried out under Section 60 of the Health and Social Care Act 2008 in follow up from previous comprehensive inspection at Hillsprings Health and Wellbeing Centre in March 2016. At our previous inspection we identified breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008. We took enforcement action against Horsefair Practice by issuing one warning notice against Regulation 12 to tell them that services must be improved.

This inspection was to ensure that the provider had met the requirements and timescales of the warning notice issued to them against Regulation 12 under the Health and Social Care Act 2008.

How we carried out this inspection

The practice sent us an action plan detailing how they were going to address the issues in the warning notice. We reviewed the action plan to ensure that the proposed action would effectively address the issues.

We carried out a focused inspection on 31 August 2016. We reviewed policies, procedures and other information the practice provided during the inspection. We spoke with a GP partner, the practice manager, reception supervisor and a member of reception staff.

Are services safe?

Our findings

During our previous inspection in March 2016, we found that care and treatment was not being provided in a safe way for patients. This was because:

- The practice did not have formalised systems in place to act upon medicines and equipment alerts issued by external agencies.
- The practice did not have robust systems in place to ensure that patients who were prescribed high risk medicines were receiving the recommended monitoring in line with the medicine.
- The practice could not demonstrate that vaccines were always stored in line with manufacturers' guidelines.
- The practice did not have robust infection prevention and control measures in place in line with current nationally recognised guidance as annual infection control audits had not been carried out at each site.
- Systems were not in place to monitor when equipment was due for testing / servicing.

Overview of safety systems and processes

Following our previous inspection in March 2016 the practice had made improvements and introduced a formalised system to act upon medicines and equipment alerts issued by external agencies.

We saw that the policy for safety alerts had been reviewed and updated to outline the process to be followed on receipt of an alert. One of the GP partners had been allocated the clinical lead role for the management of safety alerts. The practice manager cascaded safety alerts to all clinical staff via email, and for any medicine alerts initiated a search to identify any patients prescribed the medicine. We saw evidence to support that all safety alerts and any required action was discussed at the monthly clinical meetings. Urgent safety alerts were discussed in between meetings as required. Discussion of safety alerts was a standing agenda item at practice meetings, and this was confirmed by the minutes of these meetings. The nurse manager took responsibility for any safety alerts relating to medical devices. Safety alerts relating to the recall of specific medicines were actioned by the dispensary team. The practice manager maintained a log of the safety alerts and any action taken.

The GP spoken with during the inspection had a good knowledge of the most recent alerts. We looked at the recent safety alert for a specific medicine (canagliflozin). We saw that the alert had been emailed out to all clinicians and the search had identified eight patients who were prescribed this medicine. We saw that this information had been discussed at the clinical meeting held in July 2016, and a decision made to prescribe the patients an alternative medicine. The practice pharmacist wrote to each of these patients informing them of the change to their medicine, and changed the prescription on the electronic patient record.

Medicines Management

Following our inspection in March 2016 the practice had made improvements and introduced effective systems to ensure the safe and proper management of patients prescribed high risk medicines.

The practice had developed a policy for the management of disease modifying anti-rheumatic drugs (DMARDs) and shared this with all staff. An audit had been undertaken to identify patients who were prescribed DMARDs. Each patient had been contacted to advise them to book for blood tests in line with current guidance and this had been followed up in writing. We saw evidence of computer alerts on patient records so all staff were aware which patients were prescribed DMARDs and needed to have their bloods taken. Reminders were also included on patient prescriptions. Reception staff knew to check whether up to date blood results were available before they processed repeat prescription requests. Where blood results were not available, reception staff alerted the GPs.

We looked at records for three particular medicines. There were 47 patients prescribed methotrexate and we reviewed the records of five patients. There were 20 patients prescribed azathioprine and we reviewed the records of four patients. The records supported that monitoring and prescribing was following recommended guidance. There were two patients on lithium therapy, and both had evidence in their records of three monthly blood tests for lithium levels and regular monitoring of renal and thyroid function.

The practice had also made improvements in how they demonstrated they stored vaccines in line with manufacturers' guidelines.

The practice had reviewed the policies and procedures in place for recording the temperature of vaccine refrigerators across all three sites. The practice had introduced an

Are services safe?

electronic recording system for temperatures and the responsibility had been delegated to reception staff. The member of staff responsible for checking the temperatures at each site was clearly identified on the reception staff rota. They were given dedicated time to carry out this task before the practice opened to patients. We spoke with a member of the reception staff who clearly explained the process and the action they would take if the temperature was outside of the recommended range. The records seen supported that the temperature of the refrigerators had been checked and recorded each working day. When the temperature was outside of the recommended range, any mitigating circumstances had been recorded, for example, restocking the refrigerator or immunisations clinics. The member of reception staff told us checking the records was also part of the closing up procedure at the end of the day. They said that if the temperature had not been recorded, they would check the temperatures before they left the building and report the error to the nurse manager. They told us this had not occurred since the new procedure had been introduced. We saw that the recording of refrigerator temperatures had been discussed at the practice meeting held in July 2016.

Infection Prevention and Control

Following our inspection in March 2016 improvements had been made to the infection prevention and control measures in place at each site.

The infection prevention and control (IPC) lead for the practice was the nurse manager. They had attended infection control training organised by the local Clinical Commissioning Group in July 2016 and were a link member with the IPC team. The management hours for the nurse manager had also been increased so they had sufficient time to carry out administrative tasks, such as audits. We saw that infection control audits had been carried out at each site during May 2016. There was evidence to support that the practice had taken appropriate action to address any identified issues. For example, the immunisation status of one of the GPs had been established following a blood, test, new wipeable chairs were on order and policies and procedures had been updated. The water at all three sites had also been tested for legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The results were negative.

Monitoring risks to patients

Following our inspection in March 2016 the practice had introduced systems to monitor when equipment was due for testing / servicing.

The clinical equipment across all three sites had been checked to ensure it was working correctly during May 2016. All equipment had passed, although advisory notes were given to the practice regarding some items of equipment. We saw that the practice had acted on this advice. For example, batteries identified as running low had been replaced, the vaccine refrigerators had been relocated, an ear syringing machine had been replaced and spare batteries and pads for the defibrillator had been ordered for each site.

We saw that a calendar had been created to record when the equipment was due to serviced again. This included the date the service was due and the date when the practice needed to contact the company to book the service.