The Steven Shackman Practice

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

Are services safe?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the practice on 12 January 2016 where breaches of legal requirements were found. After the inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this desk-based focussed inspection on 31 August 2016 to check that the practice had followed their plan to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements and also where additional improvements have been made following the initial inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Steven Shackman Practice on our website at www.cqc.org.uk.

Overall the practice is rated as Good. Specifically, following the focussed inspection we found the practice to be good for providing safe services.

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?

The practice is rated as good for providing safe services as improvements had been made in the procedures for managing significant events, national patent safety alerts,safeguarding and infection control.

Good

The Steven Shackman Practice

Detailed findings

Why we carried out this inspection

We undertook a desk-based focussed inspection of The Steven Shackman Practice on 31 August 2016. This is because the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008. From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified.

At the comprehensive inspection carried out on 12 January 2016 we found the procedures in place for managing significant events, national patent safety alerts,safeguarding and infection control required improvement.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 12 January 2016 had been made. We inspected the practice against one of the five questions we ask about services; is the service safe.

Good

Are services safe?

Our findings

When we inspected the practice in January 2016, we found although there were procedures in place for reporting and recording significant events, there was no policy to govern or manage the process. Staff told us they would inform the practice manager of any incidents however we found a number of different reporting forms used to log significant events and there was inconsistency in how they were recorded. For example, two significant events we reviewed did not detail the action taken as a result. We saw examples of where the practice had carried out analyses of significant events, however these were not always thorough as the write up in meetings where they were discussed was not detailed. One significant event we viewed involved a needle stick injury, however there were no learning outcomes recorded. The practice manager agreed that the process for dealing with significant events was an area for improvement.

Following the inspection the practice provided us with evidence that they had implemented a policy and new procedures for the investigation of significant events which included learning outcomes, actions to be taken by who and by when, and the date for review of the significant event report to ensure that all required actions had been completed.

When we inspected the practice in January 2016, the processes in place for the dissemination of safety alerts to staff who worked within the practice were not effective. We asked the practice manager about the audit trail for the dissemination of National Patient Safety Alerts. She told us that she disseminated safety alerts received by the practice by email to clinical staff. However, there was no system in place to ensure that safety alerts had been read and acted on by individual clinicians. There was no policy in place to govern and manage the dissemination of safety alerts and staff did not have a clear understanding of the different types of alert, for example those from the National Patient Safety Agency (NPSA), Medicines & Healthcare Products Regulatory Agency (MHRA) or or from Public Health.

Following the inspection the practice provided us with evidence that they had implemented a policy and procedures to be followed for the dissemination of safety alert to the relevant staff, including a facility to confirm that the appropriate staff have read and acted upon the alert.

When we inspected the practice in January 2016 we found arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and safeguarding policies were accessible to all staff. However, we noted the safeguarding children policy did not outline who to contact for further guidance if staff had concerns about a patient's welfare.The policy had also not been recently reviewed and contained out of date information.

Following the inspection the practice provided us with evidence that they had reviewed and updated the safeguarding children policy and it contained who to contact for further guidance if staff have concerns about a patient's welfare.

When we inspected the practice in January 2016 we found the practice had carried out an infection control audit in the previous year, however there was no action plan in place to address any improvements identified. We also noted that the curtains in all consulting rooms and treatment rooms were cloth and there was no record of when these were taken down and washed.

Following the inspection the practice provided us with evidence of an updated infection control audit where actions highlighted had been completed. They also provided us with evidence that curtains had been washed and plans in place to repeat on a six monthly basis.