Farnham Integrated Care Services

Inspection 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

Overall rating for this location	Good
Are services safe?	**Good**

Overall summary

The service is rated as Good overall and Good for providing safe services.

We carried out a comprehensive inspection of Farnham Integrated Care Services (FICS) in July 2019. Following this inspection, we rated the service as good overall, but requires improvement for providing safe services as we found concerns relating to the monitoring and tracking of blank prescription stationery and issues relating to the monitoring of fridge temperature checks and escalation processes.

We carried out a focused inspection of the service on 13 February 2020 to follow up on these concerns. We also followed up on areas where the service was not always following best practice standards.

Farnham Integrated Care Services is a federation of five NHS GP services. They provide support and additional services to the patients registered with these practices.

One of the GPs is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Blank prescription security had been improved and we saw evidence of tracking processes.
- The January 2019 intercollegiate guidance for child safeguarding had been embedded in the service policy and all staff had been trained to the appropriate level.
- Gaps in recruitment files had been reviewed and systems put in place to ensure these were checked as part of the recruitment process.
- The system for reviewing patient safety and medicines alerts had been improved and the provider ensured all relevant staff were informed when they were received.
- Fridge temperature checking logs had improved, although we noted there were repeat measurements noted over several days in the last two months, which may indicate non-compliance with re-setting procedures. There had been one episode of the fridge going out of the recommended range which had not been escalated using the appropriate process.

In addition to the areas above, we reviewed how the service monitored consent seeking processes. The provider showed us a consent audit which had reviewed patient records where formal consent had been gained. The consent forms used had been adopted from a local hospital trust and the provider had deemed they were in line with legislation and guidance for seeking consent. The service computer systems had an informed consent prompt which could not be bypassed when updating patient records.

Whilst there were no breaches of regulation, the provider **should**:

- Implement a review of the fridge temperature re-setting process to ensure it is being undertaken correctly.
- Inform staff of the appropriate escalation processes if the fridge temperature goes out of the recommended range (including the minimum and maximum temperatures recorded).

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was carried out by a CQC lead inspector.

Background to Farnham Integrated Care Services

Farnham Integrated Care Services (FICS) is a federation of five NHS GP services from the Farnham area of Surrey. FICS is part of North East Hampshire and Farnham Clinical Commissioning Group.

FICS provides a same day appointment service (for GP and Advanced Nurse Practitioner appointments) to patients from three of the GP practices from 8am to 6.30pm Monday to Friday. In addition, they offer an improved access service (extended hours for routine appointments) for all five GP practices from 6.30pm to 8pm Monday to Friday and 9am to 12pm on Saturdays. The provider also offers a pro-active care management service, a paramedic home visiting service, an integrated care service and a referral management service.

The provider registered with the Care Quality Commission in June 2017 to provide the following regulated activities; Treatment of disease, disorder or injury, Surgical procedures, Diagnostic and screening procedures and Maternity and midwifery services.

Services and regulated activities are provided by Farnham Integrated Care Services Ltd from: Farnham Centre for Health (also known as Farnham Hospital), Hale Road, Farnham, Surrey, GU9 9QS.

The service has a Practice Manager representative from each of the five GP practices within the federation and four FICS directors for the service. There is a service manager, a proactive care lead, two paramedic practitioners, two healthcare assistants and three receptionists. Other staff who provide the same day and improved access services are sourced from the five GP practices on a rota basis. This includes GPs and nurses.

Good

Are services safe?

During our July 2019 inspection, we rated the service as requires improvement for providing safe services, because the provider was not following guidance for checking and monitoring medicines fridge temperatures or monitoring of blank prescription stationery. We also found some governance and documentation concerns with staff training for safeguarding, staff recruitment files and the dissemination of medicine and patient safety alerts.

After the inspection in February 2020, we rated the service as Good for providing safe services.

The provider had reviewed the areas of concern following the last inspection and initiated an action plan to ensure suitable changes were made and embedded in practice. All the areas identified at the last inspection for review had been improved, except the cold chain checks and escalation processes which had improved but were still in need of further review.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- Recruitment files had been reviewed to ensure any noted employment gaps within staff files had been corrected. For example, the employee who had only added the years of employment had updated their CV to include the month and year. This addition showed there were no gaps in their employment history.
- The provider had not recruited any new staff since the last inspection. We looked at the recruitment process that had been updated by the service since the last inspection. We found there was a new prompt included to check the employment history for any gaps and document the reason for these, where necessary.
- The service safeguarding policy had been updated in September 2019 to include the recommendations for staff training levels in line with intercollegiate guidance.
- We reviewed the service training matrix and observed all staff had received training to the appropriate level.

Appropriate and safe use of medicines

The service had systems for appropriate and safe handling of medicines.

- Blank prescription security had been improved. The service had added printer locks to all the printers within clinical rooms. Access to these was restricted to the staff responsible for checking and stocking the printer (administration and reception staff).
- We were shown a blank prescription stationery tracking log which recorded boxes received into the service and when batches of the blank prescriptions had been added to a printer. The first and last number of each batch was recorded on the log. We noted the batches were not counted (for example, batches of 25), which would enable the service to identify if any had gone missing. The service told us they would implement a system to count out batches of prescriptions of a certain number, so tracking the blank prescription stationery could be carried out comprehensively.
- After the last inspection the provider had reviewed their fridge temperature checking processes, updated the cold chain guidance and offered further training to staff. They had also purchased a second thermometer to corroborate the fridge readings. We found the log of daily temperature checks had been completed every day the service was open (Monday to Saturday). We were told the second thermometer was checked each day but had not been documented.
- We found one instance (in January 2020) where the minimum temperature had fallen below the recommended minimum of 2 degrees Celsius. This had not been escalated in line with the service policy. The service told us they thought there had been a misunderstanding with the staff checking the temperatures and they were only escalating if the actual temperature (at the time of checking) was outside the recommended range of 2 degrees Celsius to 8 degrees Celsius. The service told us there had been no medicines stored in the fridge during this time and therefore no risk to safety. The provider told us they would ensure staff were given further training to understand when to escalate the temperatures appropriately.
- We also found several instances in the medicine fridge temperature logs where the recorded minimum and maximum temperatures were a repeat of the previous days (indicating the fridge was not being appropriately reset on each occasion the fridge was checked). The provider had checked that staff were resetting the fridge after each recording but could not explain why the temperatures ranges were repeating. (Fridge

temperatures will fluctuate during each 24-hour period and the process of 'resetting' the fridge, ensures only the minimum and maximum temperatures from the time of the reset are assessed at the next check). We saw a guide on how to reset the fridge had been added to the front cover of the fridge checking log. The provider told us they would review the resetting processes with staff to ensure they were undertaking this task appropriately. They also initiated increased occasions of temperature checking and fridge resetting on the day of the inspection, to identify if there was a problem with the fridge itself that required input from the manufacturer. The provider also told us they would commence logging the readings from the second thermometer after the inspection.

Track record on safety

The service had a good safety record.

- Patient safety and medicines alerts were received by the service manager and overseen by the long-term locum advanced nurse practitioner, to determine if any clinical action or investigation was required. If so, the information was printed and placed in a file, with each clinicians' initials written on the front. Once it had been read by the individual clinician they ticked their initials to show they had seen it. We saw the recent alerts regarding an outbreak of a contagious respiratory (lung) disease had been printed, signed for and posters put up in each clinical room.
- Patient safety or medicines alerts that related to primary medical services and required a search of patients or equipment/medicines not held by Farnham Integrated Care Services were printed for reference, but the responsibility for checking these had been read and actioned was expected to be provided by the five individual GP providers that made up the federation.