Clement Road Medical Practice

Quality Report

Clement Road Medical Centre
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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

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

Areas for improvement 5

Detailed findings from this inspection

Our inspection team 6

Background to Clement Road Medical Practice 6

Why we carried out this inspection 6

How we carried out this inspection 6

Detailed findings 8

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit of Clement Road Medical Practice in August 2016. As a result of our comprehensive inspection the practice was rated as requires improvements for providing safe services. This was because we identified areas where the provider must make improvement and also some areas where the provider should improve.

We undertook a focused inspection on 12 April 2017 to check that the provider had made improvements in line with providing safe services. This report only covers our findings in relation to those requirements. You can read the report from our previous inspections by selecting the 'all reports' link for Clement Road Medical Practice on our website at www.cqc.org.uk.

Our key findings across all the areas we inspected were as follows:

- During our comprehensive inspection on 25 August 2016 we found that the practice could not demonstrate that the nurses also received safety alerts. When observing the alerts process during our follow up inspection we saw that alerts were disseminated across the whole practice team and acted on where required.
- When we inspected the practice in 2016 we found that systems were not effective across all areas such as following up on child missed appointments at hospital. As part of our most recent inspection, we noted that there was a process for monitoring and following up on missed hospital appointments, for adult and child patients. However, we found that the GPs did not always keep a record to evidence when they had reviewed the missed hospital appointments.
- Previously we found that risk had not been assessed in the absence of emergency medicine associated with minor surgery and fitting specific contraceptive devices. We also found that regular fire alarm tests and fire drills had not taken place in the practice. During our follow up inspection we observed adequate stock of emergency medicine suitable for the practice and the services provided. Records were kept to demonstrate that the fire alarm was frequently tested and we saw that a fire drill had recently taken place.
- When we inspected the practice in August 2016, we identified an area where the practice should improve with regards to supporting carers. During our follow up inspection we noted significant improvement and due to staff taking an active approach in identifying carers,

Summary of findings

we found that the carers register had increased from 3% to 4% between August 2016 and April 2017. These carers were offered support, flexible appointments and flu vaccinations.

- For instance, due to staff taking an active approach to identifying carers we found that the carers register had increased from 3% to 4% between August 2016 and April 2017. Flu vaccinations were offered to carers and carers were included in the programme for flu vaccinations to ensure that they were contacted and offered a flu vaccine.
- Since our previous inspection, comprehensive carer packs had been developed by the practice; these packs were handed out to all carers. The packs contained a wide range of information including signpost information to various carer support groups, this included support for young carers; to help the young carers identified on the practices register.

We identified one area of practice where the provider should make improvements:

- Improve record keeping specifically when reviewing missed hospital appointments, to reflect the system used in practice when reviewing and following up on missed hospital appointments.

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

The practice is rated as good for providing safe services.

- During our comprehensive inspection on 25 August 2016 we found that the practice could not demonstrate that the nurses received safety alerts. When observing the alerts process during our follow up inspection we saw that alerts were disseminated appropriately and we saw various examples of alerts shared with members of the nursing team, GPs and non-clinical staff for information purposes.
- Previously, we found that systems were not effective across all areas such as following up on child missed appointments at hospital. As part of our most recent inspection, we found that the practice operated a more effective process for monitoring and following up on missed hospital appointments, for both adult and child patients. However, we found that the GPs did not always keep a record to evidence when they had reviewed missed hospital appointments.
- When we looked at the practices emergency medicines during our previous inspection we found that risk had not been assessed in the absence of emergency medicine associated with minor surgery and fitting specific contraceptive devices. We also found that regular fire alarm tests and fire drills had not taken place in the practice.
- During our follow up inspection saw that the emergency equipment and emergency medicines were regularly checked to ensure they were in date and fit for use and there was adequate stock of emergency medicine suitable for the practice and the services provided. We saw that the fire alarm was frequently tested and we saw that a fire drill had recently taken place.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

We identified one area of practice where the provider should make improvements:

- Improve record keeping specifically when reviewing missed hospital appointments, to reflect the system used in practice when reviewing and following up on missed hospital appointments.

Clement Road Medical Practice

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 advisor.

Background to Clement Road Medical Practice

Clement Road Medical Practice is a long established practice located in the Halesowen area of the West Midlands. There are approximately 3400 patients of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The clinical team includes a male principal GP and a male GP partner, as well as an advanced nurse practitioner and two practice nurses. The principal GP, GP partner and the practice manager form the practice management team and they are supported by a team of seven staff members who cover financial, secretarial, administration and reception duties. The practice also employs a cleaner and a long term locum GP works at the practice every Friday.

The practice is open for appointments between 8am and 6:30pm Monday to Friday. During the winter pressure period the practice also offers appointments every Saturday between 9am and 12pm, this service is available until June 2017. There are also arrangements to ensure patients received urgent medical assistance when the practice is closed during the out-of-hours period.

Why we carried out this inspection

We undertook an announced focused inspection of Clement Road Medical Practice on 12 April 2017. This inspection was carried out to check that the provider had made improvements in line with the recommendations made as a result of our comprehensive inspection on 25 August 2016.

We inspected the practice against one of the five questions we ask about services: is the service safe. This was because during our inspection in August 2016, breaches of legal requirements were found and the practice was rated as requires improvements for providing safe services. This was because we identified some areas where the provider must make improvements and additional areas where the provider should improve.

How we carried out this inspection

The inspection team:-

- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced focussed inspection on 12 April 2017.
- Spoke with staff and observed the premises.

Detailed findings

- Reviewed a range of practice records.
- Reviewed some of the practice's policies and procedures.

Good

Are services safe?

Our findings

Overview of safety systems and processes

When we carried out our comprehensive inspection in August 2016 we saw evidence to demonstrate that the GPs received safety alerts and acted on them where necessary. However, the practice could not demonstrate that nurses also received alerts, such as medicines and device alerts from the Medicines & Healthcare products Regulatory Agency (MHRA).

When we returned to the practice in April 2017, we saw that safety alerts were disseminated by the practice manager with oversight by two pharmacists from the Clinical Commissioning Group (CCG). The practice worked closely with the pharmacists, they assisted the practice with medicine audits and monitored their use of antibiotics to ensure they were not overprescribing.

When observing the alerts process, we saw that alerts were disseminated appropriately and we saw various examples of alerts shared with members of the nursing team, GPs and non-clinical staff for information purposes. We discussed examples of specific alerts that were appropriately disseminated and acted on in the practice. For example, we saw records to confirm that the practice had conducted searches on the patient record system to identify patients prescribed with specific medicines with regards to a medicines recall. We saw instances where no action was required in relation to alerts and other instances where patients had been called in to the practice for a medication review, with their medication altered or changed accordingly. The practice also had a system in place to monitor the alerts and any action taken.

During our previous inspection we looked at safeguarding and we found that systems were not effective across all areas. For example, we noticed that the practices safeguarding policy did not outline who to contact for further guidance if staff had concerns about a patient's welfare. Although, staff we spoke with were aware of who to go to and how to report a safeguarding concern.

- As part of our follow up inspection we observed the practices safeguarding policies, we saw that the policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. This included reference to the practice safeguarding leads, as well as contact information for external safeguarding organisations. One of the GP partners was the lead member of staff for safeguarding, the other GP partner was the deputy lead and the advance nurse practitioner was also the named nurse lead in the practice. The safeguarding leads attended regular safeguarding meetings and provided reports where necessary for other agencies.
- We spoke with three staff members during our inspection; staff demonstrated that they understood their responsibilities. We also saw that staff had received the appropriate level of safeguarding training relevant to their role including level three training for clinicians and ongoing training updates were routinely planned.
- We noted that staff had access to safeguarding resources, policies and access to training material through the practices shared drive, e-learning and through resources on a safeguarding board situated behind reception.
- Notices were displayed to advise patients that a chaperone service was available if required. The nursing staff and members of the reception team would usually provide a chaperoning service. We saw that disclosure and barring (DBS) checks were in place for most members of staff who chaperoned and all of them had received chaperone training. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. At the time of our follow up inspection one member of the non-clinical team did not have a DBS check in place and therefore to manage risk the practice ensured that the staff member was never left alone with patients when chaperoning. We saw that this was documented on a risk assessment record which was provided as part of our follow up inspection.

When we inspected in August 2016 we found that the practice did not actively review or follow up on children who had missed hospital appointments. As part of our most recent follow up inspection we reviewed the practices system for acting on missed hospital appointments, including the process followed in the event of children failing to attend hospital appointments. Staff explained that admissions and missed appointments were reviewed on a day to day basis; we saw that missed hospital

appointments were coded on the system to support this. Staff also advised that GPs ran a monthly secondary search on the system to ensure they had followed up on any missed appointments.

Although we had no concerns regarding the system adapted in practice, we found that the GPs did not always keep a record to evidence when they had reviewed missed hospital appointments. For example, we saw that two out of 17 missed hospital appointments had no record to support that the GP had reviewed or followed up if necessary. Although the GP we spoke with gave us assurance that this had been done and this was evidenced during the inspection, they acknowledged that records were not always made to support this action. We discussed this during our inspection and staff advised that moving forward evidence would be documented in records to provide a clear audit trail to support this.

Monitoring risks to patients

When we looked at the practices emergency medicines during our previous inspection we found that risk had not been assessed in the absence of emergency medicine associated with minor surgery and fitting specific contraceptive devices. When we inspected the practice most recently in April 2017, we observed the practices emergency medicines, the defibrillator and oxygen. The emergency equipment and emergency medicines were regularly checked to ensure they were in date and fit for use and there was adequate stock of emergency medicine suitable for the practice and the services provided. We also saw that records were kept to support these checks.

During our inspection in August 2016, we found that regular fire alarm tests and fire drills had not taken place in the practice. As part of our follow up inspection we saw that the fire alarm was frequently tested and we saw that a fire drill had recently taken place. Staff had also received fire training and records demonstrated that fire safety equipment was checked and serviced when required.

Arrangements to deal with emergencies and major incidents

During our previous inspection we noted that the content of the business continuity plan was outdated in areas; such as the emergency contact numbers. When we returned to the practice in April 2017 we saw that the business continuity plan had been reviewed with updated versions available to staff. The content was current and comprehensive with relevant contact numbers for staff to access in the event of an emergency or major incident.