Stonecroft Medical Centre

Quality Report

871 Gleadless Road,
Sheffield
S12 2LJ
Tel: 01142 398575
Website: www.stonecroftmedicalcentre.co.uk

Date of inspection visit: 15 February 2017
Date of publication: 20/03/2017

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	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stonecroft Medical Centre on the 4 May 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the 4 May 2016 inspection can be found by selecting the 'all reports' link for Stonecroft Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 15 February 2017. To confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 4 May 2016. This report covers our findings in relation to those requirements and any additional improvements made since our last inspection.

Overall, the practice is now rated as good in the safe, effective and well-led domains and good overall.

Our key findings were as follows:

- At our previous inspection on 4 May 2016 we found that the records relating to significant event review and analysis and patient safety alerts did not provide an audit of actions taken. At this inspection we found that the practice manager kept a log of all national patient safety alerts and the actions staff had taken.
- At our previous inspection on 4 May 2016, we found the provider had not completed the necessary recruitment checks prior to staff commencing work. These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. We reviewed a member of staff's recruitment file. This member of staff had recently commenced work at the practice. We found appropriate recruitment checks had been carried out prior to employment. However, the recruitment policy required further development. The practice manager agreed to update the policy following the inspection.
- At our previous inspection on 4 May 2016 we found that staff acted as chaperones but had no DBS checks. (A Chaperone was a person who acted as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) At this inspection, we found that that staff who carried out chaperoning had completed chaperone training and had a DBS check in place.

Summary of findings

- At our previous inspection on 4 May 2016, we found that the nursing staff did not have the required medical indemnity insurance in place as required by The Health Care and associated Professions (Indemnity Arrangements) order 2014. At this inspection, we found that the correct medical indemnity was in place for the nursing staff.
- At our previous inspection on 4 May 2016 we found staff monitored vaccine fridge temperatures but the fridges had one thermometer which staff calibrated annually. At this inspection we found the nursing staff had checked and reviewed the temperatures daily using the data logger and the fridge thermometers.
- At our previous inspection on 4 May 2016, we saw that the blinds in the practice did not meet the Department of Health guidance issued February 2015 relating to blinds and blind cords. Some of the blinds had looped cords, which could create a risk of serious injury due to entanglement. At this inspection, the practice manager informed us that in clinical areas the provider had ensured blind cords were secured using a cleat to make sure they were safe. We observed the provider had carried this out in the reception, a treatment room, and a consulting room.
- At our previous inspection on 4 May 2016, we found that the practice did not have a defibrillator available on the premises and the provider had not completed a risk assessment to support this decision. At this inspection, we found that the practice had a defibrillator and the provider had trained staff in its use. The staff had checked to see if it was working correctly weekly but had not recorded this. In addition, the defibrillator did not contain any pads for use on children.
- At the previous inspection we found that the practice had not responded to the GP survey which demonstrated that patients had found it difficult to get through on the telephone and to access a appointment. At this inspection, we reviewed the GP survey and found out of 62 patients asked about telephone access, 30 stated it was very or fairly easy and 18 said it was not very easy. In response the provider had increased the opening hours of the service and improved the telephone system to improve access.
- At our previous inspection on 4 May 2016, we found that the provider did not do all that was reasonably practicable to ensure staff received appropriate support, training, professional development supervision and appraisal to enable them to carry out their duties. At this inspection, we found the practice manager had a system in place to ensure that staff received training updates and staff had completed firemanagement, control of infectious diseases, and safeguarding training. The nursing staff held regular support meetings and attended a person centred care meeting with the GPs. Staff had completed Mental Capacity Act 2015 and basic life support training.
- At our previous inspection on 4 May 2016, we found that the provider had not done all that was reasonably practicable to assess, monitor, manage, and mitigate risks to the health and safety of patients. For example, staff had not completed fire drills, the provider had not completed a general risk assessment of the building, and a legionella risk assessment. At this inspection, we found the provider had arrangements in place to identify risk and staff had completed the necessary training.

However, there were also areas of practice where the provider should make improvements.

The provider should:

- Review the recruitment policy and include all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18, Schedule 3.
- implement procedures which follow the manufacturers instructions and Resuscitation Council guidance to check and record whether the defibrillator is working correctly . In addition, carry out a risk assessment to establish whether the practice needs to purchase children's defibrillator pads.
- implement procedures to ensure there is sufficient oxygen for use in an emergency and the appropriate oxygen masks are available.

Summary of findings

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

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events and national patient safety alerts.
- The practice had carried out the necessary recruitment checks, including checking the clinicians indemnity and carrying out DBS checks.
- The practice had purchased a defibrillator, however staff had failed to record the checking of this equipment and the oxygen.
- The practice had purchased data loggers that accurately monitored and recorded the fridge temperatures.
- The provider had ensured that the blind cords in all clinical areas were secured using a cleat and no longer a risk to patients.

Are services effective?

Good

- Staff had completed the necessary training for their roles.
- Nursing staff took part in clinical supervision.
- The practice had specific treatment protocols in place for the treatment of diabetes, asthma and chronic obstructive airways disease.

Are services well-led?

Good

- The provider had arrangements in place to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews, attended staff meetings, and training opportunities.

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
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People with long term conditions
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Families, children and young people
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Working age people (including those recently retired and students)
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People whose circumstances may make them vulnerable
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People experiencing poor mental health (including people with dementia)
The provider had resolved the concerns for safety, effective and well-led identified at our inspection on 4 May 2016, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Stonecroft Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Two CQC inspectors.

Background to Stonecroft Medical Centre

Stonecroft Medical Centre provides Personal Medical Services (PMS) for 4,078 patients in the NHS Sheffield Clinical Commissioning Group (CCG) area. They have a higher than average 55 year old plus age group and are located in the 5th least deprived area nationally.

The practice provides some enhanced services that include minor surgery, dementia, and learning disability services.

There are two male partners assisted by a female salaried GP. There are two practice nurses and a practice manager. An IT manager and team of receptionists.

The reception is open 8.20am to 6pm Monday to Friday except for Thursday when it is open 8.20am to 12 pm.

Surgery times are 8.20am to 6.00pm Monday, Tuesday, Wednesday and Friday except for Thursday when it is open 8.20am to 12 pm. The practice has a limited service on a Saturday from 8.15am to 10.30am.

A GP collaborative provides a service between 8am and 8.20am and 6pm and 6.30 pm and Thursday afternoon. At all other times NHS 111 service provides the service when the practice is closed.

Why we carried out this inspection

We undertook a comprehensive inspection of Stonecroft Medical Centre on the 4 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on Month Year can be found by selecting the 'all reports' link for Stonecroft Medical Centre on our website at www.cqc.org.uk.

We undertook an announced follow up focused inspection of Stonecroft Medical Centre on 15 February 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff (a practice manager, a practice nurse and two receptionists) .
- Looked at policies, procedures and documents to demonstrate how the practice ensured it was safe, effective and well-led.

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.

Good

Are services safe?

Our findings

At our previous inspection on the 4 May 2016, we rated the practice as requires improvement for providing safe services as we found that staff had not had the necessary recruitment checks. These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

- At our previous inspection on 4 May 2016 we found that the records relating to significant event review and analysis and patient safety alerts did not provide a audit of actions taken. At this inspection we found that the practice manager kept a log of all national patient safety alerts and the actions taken. The nursing staff confirmed that the practice manager sent them and they responded to national patient safety alerts. The practice manager filed the significant events together to provide a audit trail, this included details of the actions staff had taken. The practice manager said the partners discussed significant events at partners meetings and the actions and recommendations were cascaded to the appropriate staff.

Overview of safety systems and process

- At our previous inspection on 4 May 2016, we rated the practice as requires improvement for providing safe services, we found that staff had not had the necessary recruitment checks prior to staff commencing work. The provider sent CQC an action plan on 1 August 2016, to tell us how they would make improvements.

  These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. We reviewed a new member of staffs recruitment file and found the practice had undertaken the appropriate recruitment checks prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS) and two references. (Disclosure and Barring Service (DBS) checks to 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). We reviewed the recruitment policy and found this did not document that clinical staff's medical registration and indemnity should be checked prior to starting work. We discussed this with the practice manager who agreed to review and update the policy.

- At our previous inspection on 4 May 2016 we found that staff acted as chaperones but had not had a DBS check. (A person who acted as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) The provider sent CQC an action plan on 1 August 2016 this stated that all staff had DBS checks and the provider would renew the DBS checks every three years. At this inspection, we found that that staff who carried out chaperoning had completed chaperone training and had a DBS check.

- At our previous inspection on 4 May 2016, we found that the nursing staff did not have the required medical indemnity insurance in place as required by The Health Care and associated Professions (Indemnity Arrangements) order 2014. At this inspection, we found that the correct medical indemnity was in place for the nursing staff.

- At our previous inspection on 4 May 2016 we found staff monitored vaccine fridge temperatures but the fridges had one thermometer which staff calibrated annually. Public Health England (PHE) guidance states; all fridges should ideally have two thermometers, one of which is a maximum/ minimum thermometer independent of mains power. If only one thermometer was used, then a monthly check should be considered to confirm that the calibration is accurate. The provider sent CQC an action plan on 1 August 2016 that they had purchased a data logger for the vaccine fridges and check the temperatures daily. (A data logger checks the temperature of the fridges). At this inspection we found the nursing staff had checked and reviewed the temperatures daily using the data logger and the fridge thermometers.

Monitoring risks to patients

- At our previous inspection on 4 May 2016, we saw that the blinds in the practice did not meet the Department of Health guidance issued February 2015 relating to blinds and blind cords. Some of the blinds had looped cords, which could create a risk of serious injury due to entanglement. The provider sent CQC an action plan on 1 August 2016 documenting that staff had cut all of the

blind cords, and the practice was planning to replace them. At this inspection, the practice manager informed us in the clinical areas the provider had ensured blind cords were secured using a cleat to make sure they were safe. We observed the provider had carried this out in the reception, a treatment room, and a consulting room.

Arrangements to deal with emergencies and major incidents

- At our previous inspection on 4 May 2016, we found that the practice did not have a defibrillator available on the premises and staff had not completed a risk assessment to support this decision. The provider sent CQC an action plan on 1 August 2016, which stated that the practice had purchased a defibrillator and clinical staff were to have training on its use. At this inspection, we found that the practice had a defibrillator and the provider had trained staff in its use. The staff had checked to see if it was working correctly weekly but had not recorded this. In addition, the defibrillator did not contain any pads for use on children.
- We found that staff carried out a weekly check on the oxygen and the emergency drugs. However, they had not included the monitoring of this on the emergency drug checklist. In addition, the practice did not have a children's mask and the adult masks appeared to have passed their expiry date. The practice nurse agreed to check if the adult's masks were within the expiry date and to purchase a children's mask.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 4 May 2016, we rated the practice as requires improvement for providing effective services as the arrangements for staff training and nurses clinical supervision needed improving.

These arrangements had significantly improved when we undertook a follow up inspection on 15 February 2017. The practice is now rated as good for providing effective services.

Effective needs assessment

- At our previous inspection on 4 May 2016, we found that the GP partners said they did not discuss changes to clinical guidance with the nursing staff. In addition, the practice did not have specific clinical pathways for staff to follow to promote consistent patient care. The provider sent CQC an action plan on 1 August 2016 this stated that clinical policies would be in place by October 2016. At this inspection, we found the nurse had specific protocols for the treatment of diabetes, asthma, and chronic obstructive airways disease. In addition, the practice nurse told us they now attended person centred care meetings with the GPs where changes to clinical guidance may be discussed.

Effective staffing

- At our previous inspection on 4 May 2016, we found that the provider had not carried out all that was reasonably practicable to ensure staff received appropriate support, training, professional development supervision, and appraisal to enable them to carry out the duties they perform. For example, staff had not always completed induction training. Staff had not completed the necessary training, such as the management and control of infectious diseases and the Mental Capacity Act 2015. The practice nurses had not received clinical supervision. The provider sent CQC an action plan on 1 August 2016, this stated that the provider would address all of these issues and they would be implemented by 1 July 2016.

  At this inspection, we found the provider had an induction pack for all new staff and a new member of staff had followed this. The practice manager had a system in place to ensure that staff received training updates and staff had completed firemanagement, nd control of infectious diseases, and safeguarding training. The nursing staff held regular support meetings and attended a person centred care meeting with the GPs. Staff had completed Mental Capacity Act 2015 and basic life support training.

Are services well-led?

Good

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

Our findings

At our previous inspection on 4 May 2016, we rated the practice as requires improvement for providing well-led services because we found no overarching governance structure in place.

We issued a requirement notice in respect of these issues and found arrangements had significantly improved when we undertook a follow up inspection of the service on 15 February 2017. The practice is now rated as good for being well-led.

Governance arrangements

At our previous inspection on 4 May 2016, we found that the provider had not carried out all that was reasonably practicable to assess, monitor, manage, and mitigate risks to the health and safety of patients. For example, staff had not completed fire drills, training records showed not all staff had not received fire safety training, the provider had not completed a general risk assessment of the building and a legionella risk assessment had not been completed. The provider sent CQC an action plan on 1 August 2016, this stated that the provider would address all of these issues by 1 July 2016.

At this inspection we found:-

- The practice manager had completed a fire risk assessment on the 13 December 2016, staff had received fire training, and a fire drill had taken place on 3 October 2016. However, the fire risk assessment would have benefited from further details about the premises. Such as the inclusion of a plan of the premises.
- The provider had contracted an external organisation on the 13 July 2016 to carry out a legionella risk assessment.
- There was a general risk assessment for the premises that identified any risks in the premises.
- Staff had secured the blind cords at the windows in clinical areas.
- The provider had purchased a defibrillator.
- The practice manager had a system in place to ensure staff received the necessary training updates.
- The practice manager had commenced a review of staff skills as part of the practice development scheme.

In addition,

- At the previous inspection we found that the some staff were not involved in the running and development of the practice. At this inspection, we found the GPs had partner meetings that the practice manager attended, the nursing staff met regularly. Nursing staff and the GPs attended patient centred care meeting and multi-disciplinary team meetings. Administration staff also reported now attending meetings with the practice manager.
- At the previous inspection, we found that patient information leaflets and notices were available in the patient waiting area that told patients how to access a number of support groups and organisations. However, this did not contain information for people living with dementia or experiencing poor mental health. At this inspection, we found leaflets were available for patients living with dementia and experiencing poor mental health.