

# Rush Hill Surgery

## Quality Report

Rush Hill

Bath

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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 service

Good



Are services safe?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

In December 2015 a comprehensive inspection of Rush Hill Surgery, Bath was conducted, during that inspection we found concerns related to the management of blank prescription security and the systems to monitor this risk. The report setting out the findings of the inspection was published in March 2016. Following the inspection the practice sent us an action plan detailing how they would improve on the areas of concern.

We carried out an announced focused inspection of Rush Hill Surgery on 9 June 2016 to ensure the changes the practice told us they would make had been implemented and to apply an updated rating.

We found the practice had made significant improvement since our last inspection on 17 December 2015. We have re-rated the practice overall as good. Specifically, they had made improvements to the provision of safe services. The ratings for the practice have been updated to reflect our findings.

At this inspection we found:

- Risks to patients were assessed and well managed.
- Systems were in place to monitor and ensure the security of blank prescriptions.

**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.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

**Good**



# Rush Hill Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our follow up inspection was an announced visit by a CQC Lead Inspector.

## Background to Rush Hill Surgery

Rush Hill Surgery is situated on the south west hills of the city of Bath with a branch site at Weston surgery in the north west of Bath.

The practice population is approx.6,350 and is below the national average in areas of social deprivation. During our inspection we visited the site at Rush Hill Surgery and did not visit Weston Surgery.

The Rush Hill Surgery is a purpose built building with level access from the main road. Most of the clinical rooms for patient use are located on the ground floor. A lift is available for those that need to access the clinical rooms on the second floor and are unable to manage stairs. The building is shared with Rush Hill Dental practice which is a provider of dental services.

The practice has four GP partners, two male and two female, one salaried GP and one salaried retained GP. The GPs are supported by three practice nurses and a health care assistant. The practice is a training practice and at the time of the inspection, they had one GP trainee.

The practice is open between 8am and 6pm Monday to Friday. Appointments are available from 8 am to 12.20pm and 2.30pm to 5.20pm. Extended hours surgeries are offered on Monday and Tuesday evenings from 6pm to 7.30pm and alternative Wednesdays until 7:30pm.

Out of Hours services are provided by Bath Doctors Urgent Care accessed via NHS 111 when the surgery is closed overnight and at weekends.

## Why we carried out this inspection

We carried out a comprehensive inspection on 17 December 2015 and published a report setting out our judgements. We undertook a focused follow up inspection on 9 June 2016 to check that the practice had taken the actions they told us they would make to comply with the regulations they were not meeting at the previous inspection.

We have followed up to make sure the necessary changes had been made and found the provider was now meeting the fundamental standards included within this report. The focused inspection also enabled us to update the ratings for the practice.

This report should be read in conjunction with the full inspection report.

## How we carried out this inspection

We undertook a focused follow up inspection at Rush Hill Surgery on 9 June 2016. This was carried out to check that the practice had completed a range of actions they told us they would take to comply with the regulations we found had been breached during an inspection in December 2015.

During our visit we:

- Spoke with one of the GPs, the practice manager, two members of the reception and administration staff.

## Detailed findings

- Reviewed records relevant to the management of the blank prescripion security.

Because this was a focused follow up inspection we looked at one of the five key questions we always ask:

- Is it safe?

# Are services safe?

## Our findings

When we inspected in December 2015 we found the safety systems and processes were not robust in the security of blank prescriptions, specifically prescription pads were not locked within the printers and the clinical rooms were not always locked throughout the day.

This was a breach of regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following publication of our report of the inspection, the practice told us in their action plan the changes they would complete and implement for the practice. Subsequently they provided us with evidence of the changes in blank prescription security, including a detailed action plan and improvements made. We visited on 9 June 2016 to review these systems and ensure the improvements had been completed. On our follow up inspection we found:

### **Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The security of prescription pads had been revised and a robust system was in place. The practice had introduced new key pad locks and a new safe to improve security. We saw the updated protocol for handling, storing, recording and monitoring of blank prescriptions, and minutes of meetings where the processes had been discussed and shared across the practice team. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.