Drs Healy, Thornett and Sherringham Desk based inspection review

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a desk top review of this practice on 3 June 2015 to consider the safe domain following the inspection on 4th November 2014 with information provided following that inspection. The current rating is overall good however the safe domain required improvement in relation to the storage, dispensing and administration of medicines, the fabric of the building

Summary of findings

and infection control, contact information for safeguarding children and vulnerable adults, access to the premises and audits. There were no breaches of regulation but we said they weren't safe enough.

Drs Healy, Thornett and Sherringham (also known as Stow Surgery) is a semi-rural dispensing practice providing primary care services to patients resident in Stow-on-the-Wold and the surrounding villages from Monday to Friday. The practice has a patient population of 5,500 of which 28% are over 65 years of age. The practice supports training for medical students and doctors specialising in general medical practice.

We undertook a scheduled, announced inspection on 4th November 2014. The overall rating for the practice was good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older patients, those with long term conditions and families, children and young patients. In addition it was good for providing services for working age patients, those whose circumstances made them vulnerable and people experiencing poor mental health including those living with dementia.

When we reviewed the information supplied by the provider we found they had responded appropriately to the things they should address and improvements had been made so services were now safe for patients, staff and visitors to the practice. However, the rating for Safe will not change until the next comprehensive inspection.

- The provider had undertaken a risk assessment and developed updated standard operating procedures for the storage, dispensing and administration of medicines such as patient group directions and the use of liquid nitrogen.
- Repaired the fabric of the building to aid cleaning and reduce the risk of infection.
- Improved systems to monitor the cleanliness of the building.
- Improved access for patients with mobility needs.
- Developed a schedule of regular clinical audit cycles to demonstrate organisational learning and improved patient care
- Improved availability of information to staff for agencies to contact when there were concerns about patients at risk of abuse.
- Improved systems to audit minor surgery including the follow up of patients test results.

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?

We found the provider had taken actions to provide a safe service following our comprehensive inspection of the practice in November 2014.

The actions taken by the provider now allowed analysis of significant events and the carrying out of audits. Staff had access to information to enable them to report concerns of abuse. The provider had made improvements to the storage of liquid nitrogen and patient group directions for the administration of medicines had been updated. There were improved infection control arrangements and the provider had improved the building by carrying out some repairs and cleaning. Access to the premises had been improved for patients with restricted mobility.

Summary of findings

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Detailed findings

Background to Drs Healy, Thornett and Sherringham Desk based inspection review

Stow Surgery is a small semi-rural dispensing practice providing primary care services to patients resident in Stow–on-the-Wold and surrounding villages. The practice has a planning application in process to build a larger purpose built GP facility in the town.

Most patient services are located on the ground floor of the building. The practice has a patient population of approximately 5,550 patients of which 28% are over 65 years of age.

The practice has two male and one female GP partners. Full time partners work nine sessions per week whilst part time partners work five or six and a half sessions.

They employ a practice manager, four nursing staff, nine administrative staff and two dispensing staff.

Each GP has a specialist lead role within the practice and nursing staff have specialist interests to aid their understanding of patient need within areas such as respiratory disease and diabetes.

Primary care services are provided by the practice Monday to Friday during working hours (8am-6.30pm). In addition early morning and later evening appointments are available one day a week. GPs are available for telephone advice and home visits. The practice has opted out of the out of hour's primary care provision. This is provided by another out of hour's provider. Patients are informed of this provision via the surgery telephone number which automatically diverts the call, the practice website and the practice patient booklet.

Why we carried out this inspection

We reviewed information about this service as part of our inspection programme by carrying out a desk top review.

How we carried out this inspection

We reviewed the information sent to us by the provider following our comprehensive inspection of the practice in November 2014 when we advised they should make improvements in order to ensure services were safe for patients.

Are services safe?

Our findings

Learning and improvement from safety incidents

When we inspected the practice in November 2014 we found the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 18 months. A slot to discuss significant events was on the practice meeting agenda and to review actions from past significant events and complaints was on the quarterly clinical meeting agenda. There was evidence learning had taken place as there had been changes to practice.

We noted the changes had yet to be evaluated to monitor their effectiveness and we saw from meeting minutes that not all of the relevant staff had been included in the reviews. We told the provider they should be able to demonstrate organisational learning and change to patient care as a result.

The practice manager wrote to us in May 2015 with evidence of improvements made. They told us the practice was signed up to the Primary Care Offer Care Episode Statistics (CES) and as part of this had submitted cancer diagnosis audits, since the inspection. Learning from the audits was to be shared through county-wide Protected Learning Time sessions. Also as part of the Primary Care Offer CES the surgery was actively auditing non-attenders of the breast screening service and producing follow-up letters to maximise attendance for screening appointments. The practice manager said the practice now reviewed audits of patients who had recently died at home and new cancer diagnoses on a quarterly basis with the wider healthcare team, including a local home nursing charity.

In addition the practice manager told us quarterly clinical audit activity would be continued through NHS Gloucestershire Care Services (PCCAG), including reviewing audit feedback and implementing suggestions highlighted within the provided audit results. All GPs in the surgery were involved in clinical audit as this was a requirement for GP revalidation.

A meeting which was scheduled to discuss further embedding significant event auditing and clinical audit into the practices regular meetings and clinical practice had to be postponed and was re-scheduled for 20th July to ensure that the whole staff team could be involved. The practice manager told us any changes to current practice would be implemented following the meeting.

Reliable safety systems and processes including safeguarding

When we inspected the practice in November 2014 we saw there were dedicated GP's with lead responsibilities for safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that one member of staff had not received relevant role specific training about safeguarding children. The member of staff had recently joined the practice.

Arrangements were in place for training to be updated. Four of the five GPs had undertaken level three safeguarding children training in line with national guidance. We noted only two members of staff had completed safeguarding vulnerable adults training. Medical, nursing and administrative staff we spoke with explained how they recognised signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing within the practice and the documentation of safeguarding. However, not all staff we spoke with were confident about the relevant external agencies to contact in and out of hours. The practice safeguarding policy included a link to the local authority safeguarding website and a shortcut to the same link was on the practice desktop. The policy did not include telephone numbers or contact details of other agencies such as the Care Quality Commission or the police.

We told the provider they should improve the information about alternative agencies to contact when there were concerns about patients at risk of abuse.

We received confirmation from the practice manager in May 2015 that the protocols for the safeguarding of adults and children have been reviewed and are confirmed as being up to date. In addition they told us multi-agency training was arranged for clinical staff in November 2015.

Are services safe?

The practice manager said they and a GP partner undertook some checks and clarified with the CQC and the Designated Doctor for NHS Gloucestershire which alternative agencies should be contacted and when. They told us this information has been circulated amongst the team.

During our inspection in November 2014 we noted that the system which followed up on patients test results following minor operations undertaken at the practice was not regularly completed. We said they should improve systems to audit minor surgery undertaken in the practice and the follow up of patient test results.

When they wrote to us in May 2015 the practice manager sent us a copy of the minor surgical procedures audit tool they had compiled in March 2015. It stated its purpose was to ensure that all surgical procedures carried out in the practice were undertaken to a high standard and to monitor competency of those practitioners carrying out the procedures. It could also be used to assess post-op infection rates. They confirmed all minor surgical operations would be audited regularly by GPs.

The practice manager told us all GPs providing minor surgical procedures had received appropriate training and undertaken sufficient procedures to ensure that their skills were up to date. They said this was included in the GP annual appraisal toolkit. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

The practice manager told us the surgery met all the requirements for the Service Level Agreement (SLA) for the provision of the Directed Enhanced Service – Minor Surgery produced by NHS England, Bath, Gloucestershire, Swindon & Wiltshire Area Team. They told us that Whilst the Enhanced Service allowed for the removal of low risk Basal Cell Carcinomas, below the shoulder, these were referred to secondary care.

They also told us the "fail safe" log of procedures and histological outcome, to ensure that patients were informed of the final diagnosis and whether any further treatment or follow up was required, currently in place at the surgery, would be enhanced.

Medicines management

When we inspected the practice in November 2015 we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

We found the storage of liquid nitrogen for the use of cryosurgery (the destruction of tissue by application of extreme cold; for example, wart removal) had not been risk assessed. The storage vessel was kept in the staff toilet. Warning signs were not displayed on the door to inform staff or patients of the risks. There was not a procedure regarding the management and use of liquid nitrogen as guidance for staff.

We advised the practice they should undertake a risk assessment and develop and update standard operating procedures for the storage, dispensing and administration of medicines such as patient group directions and the use of liquid nitrogen.

In May 2015 the practice manager sent us a photograph to show signage had been procured and fixed in place for the revised storage area. They sent us a risk assessment for the storage of liquid nitrogen had been undertaken on 4 December 2014 by an external consultant. Following the move of the liquid nitrogen to a more suitable area the liquid nitrogen policy was updated and circulated amongst staff. We saw it included the procedures for use and what to do in the event of spillage or other emergency. The practice manager also sent us the Control of Substances Hazardous to Health (COSHH) product data safety risk assessments which confirmed they were now stored with the liquid nitrogen storage container.

The practice manager sent us a spreadsheet to show Patient Group Directions for the administration of vaccines had been updated since the inspection visit.

Cleanliness and infection control

When we inspected the practice in November 2014 we saw cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However, we saw in the treatment room where minor operations took place, there was dust on the window blinds and the skylight was dirty. The taps at the

Are services safe?

hand washing sink were badly lime scaled. The floor seams were not intact and edging to some of the skirting was damaged. We noted in consultation rooms carpets were stained. There was carpet in a clinical area used for taking blood and other minor clinical procedures. Failure to maintain and clean the appropriate surfaces allowed dust and debris to accumulate and could have presented a risk of cross infection.

The practice had a lead for infection control. We saw evidence the lead had carried out an infection control audit in 2014. There were some areas of improvement identified from the audit. An action plan which identified when the improvements would be completed and who was responsible for ensuring the work was done had not been produced.

We saw from training records three of the four nursing staff had received infection control training within the last year. Other staff had not received infection control training.

We told the provider they should ensure the décor and fabric of the building were repaired and updated to aid cleaning and reduce the risk of infection. In addition we said they should improve systems to monitor the cleanliness of the building.

The practice manager wrote to us in May 2015. They told us some repairs have been carried out since the inspection. For example, the sink in the large treatment room which had calcified taps had been replaced and they sent us a photograph as evidence. They confirmed kickboards around the building had been replaced or repaired.

They confirmed deep cleaning of the treatment rooms had taken place with window blinds being thoroughly cleaned and the vents in the skylight cleaned and replaced.

We were sent a copy of and saw the checklist for the monthly cleanliness audit performed by the Practice Manager had been enhanced. A review meeting between the owner of the cleaning business and the Practice Manager had been scheduled after each audit to provide feedback. This meeting also included a review of the comments left in the book for the cleaners during the previous month.

The practice manager told us all of the nursing team staff have now completed infection prevention & control update training for clinical staff and many of the non-clinical staff had completed appropriate infection prevention and control training relevant to their role. A further face to face training session had been arranged for June 2015.

Monitoring safety and responding to risk

When we inspected the practice in November 2014 we told the provider to ensure the building and facilities were updated to improve access for patients with mobility needs. This was because the practice premises were not purpose built and therefore the access and facilities were not suitable to address the needs of all the patients groups. For example patients using mobility aids or mothers and babies.

The practice had made some adjustments to the building for patients with mobility needs. For example, the provision of a toilet for people with disabilities and access to downstairs consulting rooms for appointments. However, some clinical rooms were too small to allow wheelchair access or the provision of a couch for patients needing to lie down. We observed staff offered help when they were aware a patient needed to enter the building.The practice had secured funding for new purpose built premises but building work was delayed because the planning application was refused. The Practice Manager wrote to us in May 2015 and told us they had made enquiries to find out if there was an access officer or an access group in the local area that could offer advice and discovered there was not.

The practice involved its Patient Participation Group members in discussion and considerations were required. Healthwatch was approached and supplied information to aid discussion. A discussion was held with the local NHS England Estates Advisor about updates to the building and facilities.

As an outcome of the consultations we saw a photograph to show a sign had been installed on the front of the building with a bell inviting people to ring the bell for assistance. We were told receptionists received training on how to respond and the type of assistance that could be provided.

The practice manager said patients with mobility restrictions were receiving information individually on an opportune basis about the ramp which was in place to the surgery rear door which patients may find easier to access.

Are services safe?

They told us assistance was being given to the surgery by NHS England to consider the rental of a Portakabin which would provide two consulting rooms and which would be sited in the surgery car park close to the front door. This would have ramp access and make the practice completely DDA compliant with the Disability Discrimination Act

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.