Rushey Green Group Practice

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.

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

We carried out an announced comprehensive inspection of the practice on 10 June 2015. Breaches of legal requirements were found such that the safe domain was rated as Requires Improvement. After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breaches of regulation 12 (1) (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focussed inspection on 30 March 2016 to check that they had followed their plan and to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Rushey Green Group Practice on our website at www.cqc.org.uk.

Overall the practice is now rated as Good. Specifically, following the focussed inspection we found the practice to be good for providing safe services.

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

Care and treatment for service users was being provided in a safe way as the practice had taken steps to make suitable arrangements for emergency equipment and infection control and prevention.

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.

Improvements had been made in the way the practice provided safe care and treatment to patients, specifically in relation to emergency equipment and infection prevention and control.

Rushey Green Group Practice

Detailed findings

Why we carried out this inspection

We undertook a focussed inspection of Rushey Green Group Practice on 30 March 2016. This is because at the June 2015 inspection the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008. Specifically, breaches of regulation 12 (1) (2) (a) (b) (g) (h) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

At the June 2015 inspection we identified improvements were required in the arrangements for the management of medicines, emergency equipment, infection prevention and control and staff recruitment. What we found was:

- There were some arrangements for managing medicines, including emergency drugs. However, we had noted that there was no system in place for the management and monitoring of the usage of FP10 forms (prescription forms). We found 53 pads of FP10 forms and five blue script pads kept in an unlocked cupboard.
- Infection prevention and control (IPC) arrangements needed improvement. The practice's designated IPC lead had no protected time to carry out their role. We saw evidence of high and low level dust in clinical rooms, and cleaning schedules were not in place for all areas. The local CCG had completed an IPC audit in November 2014, accompanied by an IPC training session for the staff team, but at the time of our June 2015 inspection the practice had not completed the majority of recommended actions identified in the audit. The practice also did not carry out its own internal IPC audits periodically. Cleaning staff employed by the practice had cleaning schedules in place as part of their contract with the practice but the cleaning staff had not confirmed their hepatitis B status and vaccination history, and there was no record of their completing IPC training for their role. No legionella risk assessments had been completed in the practice by the landlords of the premises.
- We found that particular items that needed regular thorough cleaning or replacement, such as privacy curtains and fabric covers had only been cleaned periodically. In the waiting area, a number of fabric chairs had tears in them making it particularly difficult to clean them adequately.
- We reviewed six staff files and, while most indicated appropriate recruitment checks had been undertaken, one staff file contained no CV or application form, and a second file showed their professional registration had not been checked since 2013. The provider sent us evidence of the appropriate information being available for the two staff files, and promptly after our inspection had ensured all staff files had checklists attached as a cover page to help verify that all the necessary information was in place.
- We found staff received annual basic life support training. However, records showed that some staff were due to have update training. There were emergency medicines and equipment available and accessible to staff in the practice, and staff we spoke with knew of their location. Oxygen with adult and children's masks was available, but there was no defibrillator available on the premises. Most of the medicines we checked were in date and fit for use. However we saw water for injections and sterile gloves in an emergency intubation kit had

Detailed findings

been out of date since August 2013 and March 2015 respectively. We alerted staff to this and these items were immediately replaced and the out of date items disposed of.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 10 June 2015 had been made. We inspected the practice against one of the five questions we ask about services: is the service safe.

Good

Are services safe?

Our findings

Overview of safety systems and processes

The practice had put in place a system to manage and monitor the use of prescription forms and we saw records to confirm this. Forms were now being stored in a locked cupboard.

The infection prevention and control (IPC) staff member was not on duty at the time of our visit. However we were told that they were now provided with designated time each month for IPC work. The cleaning contractor had been changed and new daily, weekly and monthly schedules were in place, These were signed by the cleaner and overseen by the practice manager. The contractor confirmed the cleaner had undergone relevant training and their hepatitis B vaccination status was up to date.

The practice manager had carried out a comprehensive IPC audit in March 2016. This included any action to be taken and timescales for re-auditing. We were told that the IPC lead had reviewed the external IPC audit carried out by the local clinical commissioning group (CCG) in November 2014 and had taken action where appropriate. We were unable to directly discuss this with the IPC lead as they were not present at the inspection. We were told the practice had requested a re-audit by the CCG however currently the CCG did not have the resources to assist. We inspected three of the clinical rooms and found they were visibly clean. Chairs in the reception area and clinical rooms had been replaced and were now constructed of easy, wipe clean materials. Privacy curtains in the clinical rooms we visited had been changed in August 2015 and we were told they were changed on an annual basis.

We saw the practice had contracted with an external company to carry out a Legionella check on the premises and this check had been arranged for 31 March 2016.

We reviewed three staff files and saw appropriate recruitment checks had been undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Arrangements to deal with emergencies and major incidents

We reviewed the basic life support staff training record, and staff told us the practice policy was for clinical staff to receive annual training and administrative staff to receive training every three years. The record indicated all but three of the clinical team had received training within the last year. Two staff had undertaken training in early March 2015, so had just exceeded the 12 month timeframe for repeat training, whilst the practice was waiting for the certificate for the third who had undergone the training recently. All administrative staff had undergone training within the previous three years.

A defibrillator had been ordered and the practice was waiting for delivery. We were provided with the order invoice to verify this.