The Practice's response to the CQC inspection, Jan 2019

The practice was extremely disappointed with the outcome of our recent CQC inspection and would like to explain to our patients the following issues and outcomes that arose from the report.

The CQC made the following statements (in italic) and the practice replies follow:

1. *"Staff who acted as chaperones were trained for their role"*

**Practice response:** The practice business manager has investigated the CQC statement and found that on one occasion in the past 12 months a GP requested a member of staff to act as a chaperone, the practice therefore accepts this statement as truth and has reiterated to all GP's ANP's and nurses that that the first choice for chaperones should be either a health care assistant, nurse, ANP or GP. In an extreme circumstance where no clinician is available the practice chaperone policy, attached, has been distributed to all staff for training purposes

2. *"The practice checked the registration of nurses and GPs on employment and carried out monthly Nursing and Midwifery Council (NMC) checks. However, the practice did not carry out an equivalent process for GPs".*

**Practice response:** The practice does not have a policy for checking GP GMC registration, the practice business manager has discussed with our neighbouring practices and none of these practices routinely checks their doctors GMC registration. This check is made at commencement of employment. The practice business manager also sought advice from the LMC who stated, "If this was the Inspectors view, I would suggest that it is the individual Clinicians (GPs & Nurses) responsibility to ensure they meet all the necessary requirements to continue to be performers" and that "there is no statutory regulation on checking GMC registration / revalidation".

3. *"The fire risk assessment had identified 12 actions. We saw that 11 had been completed or noted for ongoing monitoring. For example, it was identified that all fire exit doors were to be kept free of obstructions and this had been actioned. However, the practice's procedure for fire alarm checks was not consistent. On the practice's business risk register, it identified that fire alarm checks should be carried out every six months and on the individual fire risk assessment, it identified that fire alarm checks should be carried out every week. We reviewed the log for the practice's fire alarm checks, and these had been conducted once a month"*

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**Practice response:** The practice has for the past 4 years conducted and documented monthly in-house fire alarm checks, these are completed by the maintenance operative and a log is kept.

The practice additionally conducts a 6 monthly fire alarm full system check by the Alarming Company

The CQC identified a “typo error” in our Annual Fire risk assessment.

The operations manager has written a non-conformity report in relation to this “typo error” this was using the word “weekly” instead of “monthly” in Item 1 – box 1 on the Annual Fire risk assessment report.

The operations manager corrected the typo error, sent this to the practice business manager and added to it the significant event register.

4. *“We found that infection prevention and control processes were not fully embedded. On inspection we found a pair of curtains dated 31 May 2018 and a sharps box dated 28 August 2018 which was not in line with guidance. We raised this with the practice on the day of inspection and the curtains had been replaced by the end of the day”.*

**The Practice response:** The practice has a regular schedule to change the disposable curtains in February and August each year. The curtains in Room 18 at Blackfield Health Centre had been changed in May 2018 as they were contaminated which demonstrates we follow procedure and change the curtains as required to mitigate spread of infection. The curtains were due to be changed on 30th November and were therefore 20 days overdue. This was an oversight and the curtain was changed as soon as we became aware.

The practice sharps bins are checked as part of our cleaning schedule in the clinical rooms to ensure they are not overfilled, and the change date was missed due to human error. The sharps bin was changed as soon as it was highlighted and was overdue by 22 days.

5. *“The practice could not demonstrate how they ensured non-medical prescribers were competent. The practice employed nurse prescribers, but they did not receive regular reviews of their prescribing practices or regular clinical supervision from a GP”.*

**The Practice response:** The nurses who are also non-medical prescribers hold a recordable qualification which is listed separately on the NMC register in addition to their nurse registration. This qualification gives them the same prescribing rights as a doctor allowing them to prescribe any drug listed in the BNF within their levels of competence. They are included in all searches and audits run by the CCG Medicines Management Team e.g. the recent audit on antibiotic prescribing and consequently would come under the same prescribing scrutiny as a GP.

With regard to clinical supervision, the Advanced Nurse Practitioners and UCC nurses have 2 “Support GP” slots every day at both sites where clinical supervision and training is delivered by the supporting GP.

Formal training sessions were identified as a training need during a discussion on teaching for the ANPs and UCC nurses and has subsequently been set up as bi-monthly teaching/clinical supervision session with Dr Fernando

6. “*On inspection we found the system for balance checking the controlled drugs was not embedded. It was practice policy that the controlled drugs would be checked monthly but prior to December 2018, they had not been checked since July 2018. We saw that the practice had raised this as a significant event the day before inspection. An email reminder had been sent to all advanced nurse practitioners and this was to be discussed at the next nurse meeting in January 2019”.*

**The Practice response:** The responsibility for checking the controlled drugs was given to the ANPs along with the other emergency equipment. It was found that the controlled drugs at one Health Centre were being checked regularly by one ANP but at the other Health centre, it had been overlooked. This was dealt with as a significant event and the actions have been completed and this will be reviewed on a monthly basis.

7. *"On inspection, we found that one of the fridges used to store medicines requiring refrigeration held in a treatment room at the branch site had been out of range for a few days showing a temperature of 9°C. There was no information to show what actions the practice had taken to mitigate risk and ensure that medicines held in the fridge were safe and effective to use "*

**The Practice response:** All practice fridges have a data loggers that record the internal fridge temperatures. This is monitored in addition to our daily fridge temperature charts.
The integrated fridge thermometer records a minimum and maximum temperature for the previous 24 hours and a temperature of 9C would indicate the door being left open for a few minutes while the fridge was being restocked or tidied. The data logger tells us how long the fridge was out of range which is the indicator of whether vaccines become unsafe.
For the fridge in question, the data logger records the internal temperature every one minute and email alerts are sent to the Practice Nurse Manager for review. Figures downloaded from the data logger website show that the longest period of time the fridge went out of range for was 4-5 minutes on Saturday 10th November which is a day that we received a delayed delivery of vaccines from the manufacturer Seqirus and ran a flu clinic which explains why the temperature had risen for short periods during that morning. The error noted from this is that the fridge itself was not being reset properly and this will be raised with the nursing team at our next meeting.

The practice challenges the CQC statement stating that the fridge had been "out of range for a few days" from the summary attached it evidences the fridge went out of range for only 4 – 5 minutes on the day in question due to the fridge being re-stocked with flu vaccinations.

8. *"The health care assistants (HCAs) had not completed the care certificate. Training for HCAs was carried out internally and they were signed off once they were assessed as competent for specific roles".*

**The Practice response:** The practice has supported two of our Health care assistants through the Care Certificate, one of whom used it to support her application for Registered Nurse training at University of Southampton. Copies of certificates were supplied to the CQC.

One of our current HCA is currently working through the standards and the other was employed prior to April 2015 so therefore is not required to undertake the work involved as per guidance is the weblink below.
https://www.wessexlmcs.com/carecertificates

9. *"On inspection we found that the majority of staff felt that leaders were visible and approachable. However, we also received feedback that not all staff felt comfortable raising concerns and that managers were not always open and transparent. Communication was mostly by email and some felt this wasn't satisfactory."*

**The Practice response:** The senior management team has now met with staff, Blackfield 4/2/19 and at Waterside 6/2/19 to reassure staff that concerns can be raised with the immediate line manager, the department manager, the business manager or the staff liaison GP. Staff informed the business manager that they were happy that issues raised would be treated openly and transparently by the management. No evidence was presented to the senior management team to support the CQC statement.

At the same meetings, we also discussed the use of e-mails for communication, with almost 100 staff in the practice; most employees working part-time the only efficient way of communicating with a large group of people is via e-mail. Staff understood the reasoning and agreed that this was the only means of communicating to a large workforce to ensure that all employees received the same information at the same time.

The practice does not agree that the use of e-mails as the primary means of communication means that the practice is not well led.

10. *"We received feedback that not all staff felt that they were able to raise concerns. One staff member said they considered that managers did not listen openly to concerns raised".*

**The Practice response:** The senior management team has now met with staff, Blackfield 4/2/19 and at Waterside 6/2/19 to reassure staff that concerns can be raised with either the immediate line manager, the department manage, the business manager or the staff liaison GP. Staff informed the business manager that they were happy that issues raised would be treated openly and transparently by the management team.

No evidence was presented to the senior management team to support this CQC statement.

The management of the practice have to actively manage the staff team, sometimes this needs to be a patient or business centric decision and the staff request is not granted, this does not constitute not openly listening to concerns raised.

The CQC did not provide any substance to this subjective statement

11. *"The practice did not always have an effective system to manage the performance of clinical staff. For example, the governance processes did not give assurance that non-medical prescribers were competent in their role. Supervision and the practice were unable to assure themselves that GPs continued to revalidate as required".*

**The Practice response:** With regard to clinical supervision, the Advanced Nurse Practitioners have 2 "Support GP" slots every day at both sites where clinical supervision and training is delivered by the supporting GP.

Formal training sessions were identified as a training need during a discussion on teaching for the ANPs and UCC nurses, in 2018, and has subsequently been set up as bi-monthly teaching/clinical supervision session with Dr Fernando (the named Practice GP Lead for the nursing team) (meeting minutes attached as evidence)

Regarding performance management all ANP's, as prescribers are included in all searches and audits run by the CCG Medicines Management Team e.g. the recent audit on antibiotic prescribing and consequently would come under the same prescribing scrutiny as a GP.

The practice does not have a policy for checking GP GMC registration and following advice from the LMC who state "there is no statutory regulation on checking GMC / revalidation registration".

The practice will, in future, conduct and record routine checks on GMC registration and revalidation, for CQC purposes only, but we do not feel that in any way, not doing this prior to the 20th Dec 2018 constitutes the practice being unsafe.

12. *"On inspection we found that the practice's arrangements for identifying, managing and mitigating risks were not always embedded. For example, the process for controlled drugs checks had not been*

*followed, the procedures for fire alarm checks were inconsistent with their risk assessment and out of date equipment had been identified".*

**The Practice response:** The practice accepts that the controlled drugs check at one health centre had not been completed, this had been identified and raised as a significant event prior to the CQC inspection date and the nursing team all informed.

In relation to the fire alarm checks, these are consistent, as the only item which made these look out of sync was a single word typo error and all the fire alarm checks had been completed correctly.

In relation to the out of date curtain and sharps bin, we accept these were, slightly, out of date however these were changed immediately

I hope this explanation will satisfy you that the surgery is safe and well run but should you have any further questions please don't hesitate to contact me at the practice to discuss further.

Yours sincerely

Mr P Sayers MBA DMS
Practice Business Manager