Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Dr Yahaya Mohammed

Blue Line Lane,, Ashford,, TN24 8UN

Tel: 01233622361

Date of Inspection: 11 December 2013

Date of Publication: January 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Dr Yahaya Mohammed
Overview of the service	Dr Yahaya Mohammed is the principle General Practitioner (GP) of Hollington Surgery, which serves parts of Ashford the surrounding area. The practice supports approximately 3400 patients. Dr Mohammed works with a salaried GP (a GP employed by the provider). The practice offers general treatment and consultation.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 December 2013, talked with people who use the service and talked with staff.

What people told us and what we found

We spoke with four patients and one family member, as a carer. We spoke with staff, including the assistant practice manager and Dr Mohammed.

There was great deal of praise for the surgery and the doctors. Comments we heard from patients included, "can't fault this surgery", "… not a sausage factory" and "they take my worries seriously for example about X-rays for (my) small children". One patient said, "the doctor is a nice man who listens", another said," I was in trouble and very depressed … (doctor's words) … lifted me from my depression".

There were systems in place to ensure that patients were protected from the risk of abuse.

Staff received appropriate professional development, training and appraisal.

There were systems in place to ensure that the quality of service that patients received was monitored.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

Patients' privacy was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. There was a glass screen around the receptionist's working area so that patients could not hear anything said by the receptionist on the telephone. We saw that there was opaque glass in the windows of some consulting rooms. Patients said that staff always made sure that curtains were drawn around examination areas and blinds were closed if necessary. We saw that staff always knocked on doors and waited to be invited in before opening the door.

Patients said that their privacy was respected and that they were treated with respect. One patient said (of respect), "It's not just me … I see it in the way they treat other patients as well". Others commented, "there's always enough time" and "they explain things". Patients said that they could obtain appointments when they wanted them and rarely had to wait long. One patient said, "(home visits) were more awkward to arrange" but that they did happen when necessary.

There was a range of leaflets available in the reception area. These provided health promotion and other medical and
health information for patients. This included information on shingles, support for those with cancer and their families, how to obtain treatment for minor injuries and dementia. There was information on the service provided by the practice. This included surgery times, useful telephone numbers and general medical advice. The minutes of the most recent meeting of the Ashford patient participation group were displayed on a noticeboard in reception. This meant that patients could learn of any recent developments to practices in the Ashford area.

Individual diversity, values and human rights were respected. Patients told us that could request a chaperone. Information on chaperone use was displayed in the waiting area We saw that there was access to interpreters though an NHS approved agency. This was available over the telephone. We saw that there was disabled access throughout the

surgery where patients had access. There was a male and female doctor and patients could see the female doctor if they wanted to.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We looked at the computerised records for two patients who had attended the practice on the day of the inspection. We saw that records contained areas for the recording of items such as allergies, previous medical history, current medication, active problems, significant past events and family history. Other records showed that the nurse reviewed and monitored chronic disease management and used prompts to ensure that all relevant checks and assessments were completed during the appointment. This meant that patients care and treatment reflected relevant research and guidance. A community midwife had two sessions a week, for expectant mothers, at the surgery.

The practice used a prescribing technology tool. At the point at which a medicine was prescribed the system automatically displayed a recommendation, this allowed the prescriber to consider any national guidelines, local initiatives and any generic or branded alternatives. This happened on repeat prescriptions. The system could also support the prescriber, by making recommendations, when considering new treatments during a consultation.

There was evidence in records of discussion about treatment. This was support by what patients told us. Patients said that sometimes options were discussed but acknowledged that sometimes the options were limited. One patient said, "… Options are talked through … we both (patient and doctor) discuss them and we decide the best option between us".

A patient with a chronic condition told us about their regular checks and clinics and how staff explained the way certain lifestyles could affect the condition. Another family talked about the palliative (end of life care) at the surgery which they described as "fantastic". They talked about how the surgery had called them about a worrying test result, how it had been explained and how an appointment to see a doctor immediately had been arranged. The provider might like to note that one patient commented on the e-mail prescription service. The patient said that, "it was not as well managed as it might be …Sometimes (I) don't get all of the items on the list". They also said that sometimes medicines were not delivered when expected.

There was a monthly clinical meeting (the primary care meeting). This was between

doctors and caring professionals in the community. The attendees varied from month to month but included community psychiatric nurses, occupational and other therapists, district nurses and representatives from the local social services. The needs of the most dependent patients were discussed and treatment plans formulated. We saw one case where how to manage a dementia patient was discussed. A particular medicine, that would help, was contraindicated (there were factors that rendered the administration of a drug inadvisable) because of the patient's heart condition. After discussion it was decided to refer the patient for pacemaker to be fitted before proceeding with the medication.

We looked around the treatment room. It was clean and tidy. The room was used for minor surgical procedures (lumps and bumps). The surgery used only disposable instruments meaning the risks to patients, of receiving unsafe treatment, associated with sterilising re-usable instruments were eliminated.

All staff at the practice where trained in basic life support. The practice had equipment on the premises for dealing with emergencies that included oxygen and emergency drugs. We saw these were ready for use. We saw evidence that staff had completed basic life support training and clinical staff had undertaken Cardio Pulmonary Resuscitation updates. There was an automated external defibrillator. This meets guidelines laid down in the Cardiopulmonary Resuscitation Guidance for clinical practice and training in Primary Care (UK resuscitation Council) which recommends that, "Every healthcare practice should be equipped with an automated external defibrillator (AED)".

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff we spoke with were aware of what might constitute abuse and how it should be reported. In the practice manager's office there was a flowchart to guide staff on the reporting of abuse. The chart showed the telephone numbers of various contacts within the local safeguarding system. The male doctor always used a chaperone when examining female patients.

Doctors and reception staff had received safeguarding training. Within the last month both of the doctors and the receptionist had been on a course to help them to communicate more effectively with patients who had a learning disability.

Safeguarding issues were discussed at the monthly primary care meeting. We looked at the minutes of some of these meetings. We saw two examples were the welfare of an unborn child was considered. In one case there was a history of domestic violence and in another case poor living conditions were an issue. We saw that on one occasion the midwife had completed a "vulnerability" form drawing the matter to attention. On the second occasion it had been decided that a named doctor should complete a referral to the social services. When we checked this we found that the doctor, named in the minutes, had been unable to complete the form. However the surgery had picked this up and a doctor colleague had completed the form within the agreed timeframe.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Doctors and healthcare staff kept up to date with professional training and appraisal. Both doctors had completed their annual appraisal. The principle doctor had completed his revalidation. This had included feedback from colleagues and patients. Professional training in the last year had included sessions mammalgia (breast pain), chronic obstructive airway diseases, such as emphysema and pain control.

There had been chaperone training for the nurse, healthcare assistant and the receptionist. Other staff had received "in-house" training on chaperoning. The healthcare assistant had had training in using the automated external defibrillator and phlebotomy. The latest training shown was in 2010. In 2012 the practice nurse had had training which included starting patients on insulin. There was training, apparently planned, for 2013/2014 in a diabetic education programme, respiratory disease management and ulcer (wound) care.

There were training records for staff which included immediate life support and fire safety training. These had been completed in march 2011 and were valid for three years.

Staff had up to date appraisals. There was a list of the due dates of staff appraisals. There were goals for clinical staff that were linked to the training. For example the practice nurse's goals included "to help do more (with Drs) to switch patients from short to longer acting inhalers". This was linked to the nurse's training in respiratory disease management planned for this year. The appraisal stated that the practice would pay for the courses attended.

The provider might like to note that training and support for non-clinical staff was not as well carried out. For example one staff member had a goal to develop skills in handling complaints and practice management. However the training associated with the objectives had not happened. We were told that there was a system to monitor what training had been undertaken and what training was due but, in the absence of the practice manager on maternity leave, the practice were not able to produce it.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

There was range of activities designed to monitor the quality of the service provided.

The practice had had an audit from the local prescribing advisor. Following which they changed the administration of certain types of statins (a class of drugs used to lower cholesterol levels) in line with national practice. The visit also identified that the surgery was above the national average in the use of inhaled corticosteroids. This has been addressed by ensuring that training and staff annual appraisals were focused on the issue. We looked at the staff appraisals and there were goals aimed at addressing the issue.

The practice kept informed over NICE (National Institute for Health and Care Excellence) guidelines. The principle doctor kept a file of recent relevant guidance. As result of such guidance the practice had changed the type of medicine administered to help diabetics control their blood sugar. Thirty patients had been considered for change, in 21 cases the medicine had been changed, in nine cases the change had not taken place because of the possibility of unpleasant side effects.

We saw a number of risk assessments. One was a risk assessment for the cleaning of the premises. It was comprehensive and included a checklist so that staff could ensure that the necessary cleaning had been carried out. Another assessment concerned the disposal of clinical waste. It was accompanied by an audit. This identified that the practice needed "large orange lidded sharps (needle) boxes … fixed to the walls". We saw that this had been completed. The provider might like to note that the audit had not identified that the treatment room had wooden skirting board. Guidelines state that flooring should be "coved" up the walls to reduce the likelihood of infectious material lodging in the spaces between the floors and walls (Health Building Note 00-10: Part A Flooring).

There was a system for recording and investigating significant events (serious incidents). There was a policy on significant incidents and staff were aware of it. This meant staff were all reporting against the same criteria. We looked at five significant events. They were well recorded and well investigated. Lessons had been learned from them. We saw there had been an issue of patient identification. Since then an extra check to include the

patient's date of birth had been instituted. There had been an incident involving the prescribing of warfarin (a type of medicine that is given to stop clots forming in the blood). The learning had included discussing the issue at the primary care meeting. We looked at minutes of this meeting and it had been discussed.

There was review of complaints each year. We saw that the practice took complaints seriously. Often they were resolved informally by way of a verbal apology. There was learning from complaints. On one occasion a message had been left on answering machine and staff had relied on this. The message had not, apparently, been received. This was discussed amongst staff who now ensured that messages were actual received by the patient concerned.

The provider might like to note that there was no meeting that involved both clinical and non-clinical staff within the practice. Informing non-clinical staff about changes in professional practice that might affect them relied upon the practice manager telling them at their own meeting. It was planned to hold these non-clinicians' meetings every other month. However there had only been one meeting during the previous year. It had been held in June and the minutes had not been written up. This means that communication needs between clinicians and non-clinicians may not be being met.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk