Dr R M, D R & J N Patel

Quality Report

Dartmouth Medical Centre
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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr R M and D R Patel's practice in Dartmouth Medical Centre on 10 January 2017. Concerns relating to the lack of contemporaneous records were identified. Under Section 31 of the Health and Social Care Act 2008 conditions were imposed on the registration of the provider in respect of the following regulated activity: Treatment of Disease, Disorder or Injury from Dartmouth Medical Centre.

We carried out this focused inspection on 27 March 2017 to review the actions the practice had taken following the Notice of Decision and focussed on the areas relevant to the notice only. As a result this there is no rating awarded following this inspection. Our key findings at this inspection were as follows:

- At the previous inspection, the GP was unable to confirm if alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA) had been acted on. The practice had introduced a system to ensure safety alerts including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned appropriately by clinical staff.
- At the inspection in January 2017 we found the patient record system in place did not demonstrate that contemporaneous patient records were held. We found that some handwritten consultations notes had not been added to the patient records. Those that had been attached to the electronic system were difficult to read or illegible. At this inspection a review of the system showed clinical notes continued to be handwritten, but a system had been put in place to ensure all consultation notes were scanned onto patients' records on a daily basis. A record of checks was held by the practice; however some of the notes remained illegible.
- At the first inspection we found that non clinical staff were adding medicines to patients' records on behalf of the GP partners. No checks were made by clinically trained staff to ensure medicines had been added correctly or that contraindications between medicines had been identified. We have since received assurances at the second inspection that all GPs take responsibility for ensuring accurate and appropriate records of medicines are in place.

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?

- During the inspection in January 2017 we found that patients were at risk of harm because effective systems were not in place or embedded to ensure the delivery of safe care and treatment. Specifically, the lack of contemporaneous patient records and the management of patients' medicines. At this inspection a review of the patient record system showed clinical notes continued to be handwritten, but a system had been put in place to ensure all consultation notes were scanned onto patients' records on a daily basis. A record of checks was held by the practice, but we found that the records we reviewed were illegible.
- At the first inspection we found that non clinical staff were adding medicines to patients' records on behalf of the GP partners. No checks were made by clinically trained staff to ensure medicines had been added correctly or that contraindications between medicines had been identified. We have since received assurances at the second inspection that all the GPs take responsibility for ensuring accurate and appropriate records of medicines are in place.
- In January 2017 during the inspection we found the practice had a new system to ensure safety alerts including those receive from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned, but on speaking with the GP we were unable to confirm that medicine alerts received (from the MHRA) were acted on appropriately. We found at the second inspection that the practice had introduced a system to ensure safety alerts including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned appropriately by clinical staff.

Dr R M, D R & J N Patel

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a specialist nurse adviser.

Background to Dr R M, D R & J N Patel

Dr RM and DR Patel's practice is located at Dartmouth Medical Centre, a purpose built building in West Bromwich, an area of the West Midlands, with a branch surgery at Central Clinic in Tipton, West Midlands. We did not inspect the branch surgery as part of this inspection. The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract. The practice also provides some enhanced services such as childhood vaccination and immunisation schemes.

The practice provides primary medical services to approximately 3,200 patients in the local community. The practice was led by three GP Partners, but one of the GP partners recently retired, and notification had been submitted to the CQC to advise them of a change to partnership. The current GP partners (1 male and 1 female) have the support of two practice nurses and three regular locums (2 male and 1 female). The non-clinical team consists of administrative and reception staff and a practice manager.

Based on data available from Public Health England, the levels of deprivation in the area served by the practice are below the national average and ranked at two out of ten, with ten being the least deprived.

The practice is open to patients between 8am and 6.30pm on Monday, Tuesday, Thursday and Friday and 8am and 1pm on Wednesday. When Dartmouth Medical Centre is closed on Wednesday afternoon, patients can access appointments at the branch surgery. Extended hours appointments are available 6.30pm to 8pm on Monday and 9am to 12pm Saturday. Telephone consultations are available if patients requested them; home visits were also available for patients who are unable to attend the surgery. When the practice is closed, primary medical services are provided by Primecare, an out of hours service provider and information about this is available on the practice website.

We had previously inspected the practice in January 2017 where we found that aspects of the services were not safe or suitable for the purpose of carrying on the regulated activities. This focused inspection was based on the registration of the current providers who are the only providers delivering regulated activity at the location Dartmouth Medical Centre. We found that the there are still aspects of the services that are not safe or suitable; however plans were in place for a new provider to offer the regulated activities in the near future.

Are services safe?

Our findings

At our previous inspection on 10 January 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of effective systems to reduce the risk of harm to patients were not in place or embedded to ensure the delivery of safe care and treatment were not adequate. A Notice of Decision was issued on 13 January 2017 under Section 31 of the Health and Social Care Act 2008 to impose conditions on the registration of the provider.

Some improvements had been made when we undertook a follow up inspection on 27 March 2017. We have not amended the rating as we only reviewed the Notice of Decision findings and the actions the practice had taken to reduce the risk to patients.

Safe track record and learning

In January 2017 during the inspection we found the practice had a new system to ensure safety alerts including those receive from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned, but on speaking with the GP we were unable to confirm that medicine alerts received (from the MHRA) were acted on appropriately. At the inspection on 27 March 2017 we received assurances that the new system has been embedded into the practice procedures and all clinicians acted on alerts received. We reviewed the system the practice had in place and found that folders had been set up with checklists that were completed once each alert had been reviewed and actioned by a clinician.

Overview of safety systems and processes

- The practice had an electronic system to store patient records and to show the actions which had been agreed to meet patients' care, treatment and monitoring needs. At the inspection carried out on 10 January 2017 we found key members of the clinical team were unable to use this system resulting in incomplete patient records. We reviewed ten patient records and found the handwritten documentation illegible. At this inspection on 27 March 2017 a review of the system showed clinical notes continued to be handwritten, but a system had been put in place to ensure all consultations were scanned onto patients' records on a daily basis and a daily audit was completed to ensure the handwritten notes were scanned onto each patient record. On the day of the second inspection, the records we reviewed showed the handwritten clinical notes were illegible.
- At the first inspection on 10 January 2017 we found that non clinical staff were adding medicines to patients' records on behalf of the GP partners. No checks were made by clinically trained staff to ensure medicines had been added correctly or that contraindications between medicines had been identified. We received assurances at the inspection on 27 March 2017 that all GPs take responsibility for ensuring accurate and appropriate records of medicines are in place and we found that the one GP identified at the previous inspection who was unable to use the clinical system, was now adding medicines to patients' records electronically with the support of administration staff.