Brundall Medical Partnership

Quality Report

The Dales, The Street, Brundall,
Norfolk.
NR13 5RP
Tel:01603 712255
Website: www.brundallmedicalcentre.nhs.uk

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced follow up inspection at Brundall Medical Partnership on 21 June 2016. Overall the practice is rated as good. This was to follow up on actions we asked the provider to take after our announced comprehensive inspection on 16 November 2015. During the inspection in November 2015, we identified:

- There was scope to improve the monitoring and auditing of fridge temperatures.
- There was scope to improve the arrangements for the security of medicines stored in the dispensary to ensure they are only accessible to authorised staff.
- Staff who undertake the checking of medicines in the dispensary were not appropriately trained, qualified and competent to undertake this role.
- There was scope to improve the protocols in place for the handling, analysis, audit and review of dispensing errors including discussion at dispensing team meetings. In addition there was scope to improve the systems in place to record near-miss dispensing errors to identify trends and ensure these are monitored and actions taken where necessary.
- There was scope to improve the protocols in place for the monitoring and auditing of the risks involved in receiving telephone repeat prescription requests, ensuring processes for producing repeat prescriptions are undertaken away from avoidable distractions to prevent errors.
- Cascading, sharing and learning from concerns and complaints to all staff required further improvement.
- Patients waiting for their appointments in some areas of the practice could not be clearly seen by reception staff to ensure patients whose health might deteriorate are overlooked by staff.
- There was scope to improve clinical audits undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Audit trails to demonstrate which MHRA (Medicines & Healthcare products Regulatory Agency) alerts and safety updates needed to be improved.

The practice manager provided us with evidence which showed the practice had put systems in place to improve these systems.

However there were areas of practice where the provider needs to make further improvements: Continue to risk assess and monitor patients waiting for their appointments in all areas of the practice to ensure patients whose health might deteriorate are not overlooked by staff

Summary of findings

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 had made improvements following our findings at inspection on 16 November 2015, we found that:

- Records of medicine refrigerator temperatures and the monitoring of medicine expiry dates were being appropriately completed.
- The practice had improved processes for assuring the competence of dispensary staff and had both undertaken and had planned future audits to assure the quality of its dispensing service.
- The practice had put systems and protocols in place for the handling, analysis, audit and review of dispensing errors including discussion at dispensing team meetings. There were improvements in recording and reviewing of near-miss dispensing errors to identify trends and ensure these were monitored and actions taken where necessary.
- There were improvements in practice in relation to receiving patient requests for repeat prescriptions, the security of the dispensary and procedures to ensure the accuracy of dispensing medicines and reporting errors.
- We saw that, where relevant, learning from concerns and complaints was shared with all staff.
- The practice had risk assessed and continued to monitor its systems in place to ensure patients waiting for their appointments could be seen by staff in all waiting areas of the practice should their health deteriorate.
- There were improvements in systems of clinical audit, including completed audit cycles. The practice had instigated an on-going programme of quality improvement cycles. These included an audit trail to demonstrate the implementation of safety updates and MHRA (Medicines & Healthcare products Regulatory Agency) alerts.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

Continue to risk assess and monitor patients waiting for their appointments in all areas of the practice to ensure patients whose health might deteriorate are not overlooked by staff.

Brundall Medical Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC pharmacist inspector. A desk based review was also completed by a CQC inspector.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We undertook a focused inspection on 21 June 2016 and a desk based review of evidence to confirm that the provider had undertaken and completed the actions identified at the previous inspection.

How we carried out this inspection

We reviewed the information received from the practice, spoke with the practice manager and requested additional information from the practice. We carried out a focused inspection on 21 June 2016. A desk based review was also completed by a CQC inspector.

Good

Are services safe?

Our findings

Overview of safety systems and processes

In November 2015 we identified that not all learning from concerns and complaints was shared or cascaded to all staff. The practice sent us information to show that where relevant, actions and learning points including policy or procedural changes were discussed with staff at team meetings. Actions or learning points were implemented immediately and staff were made aware of these actions. The practice had initiated a log of actions and these were reviewed by the practice management team.

During our inspection in November 2015 we saw there was scope to improve the programme of clinical audits undertaken in the practice, including completed clinical audit or quality improvement cycles. The practice sent us evidence to show that a programme of audits had been set up. These included dispensary audits , audits of cytology smears, consent of minor surgery and a number of medicine and Quality and Outcomes Framework (QOF) related audits. (QOF is a system intended to improve the quality of general practice and reward good practice).

In addition in November 2015 we saw there was scope to improve the monitoring of MHRA (Medicines & Healthcare products Regulatory Agency) alerts and safety updates to ensure these had been implemented. The practice manager sent us evidence to show the practice had implemented an action plan following the previous inspection and amended and updated the practice policy and monitoring sheets. We saw that these were manually updated with new alerts and were reviewed quarterly by the practice manager to ensure action was taken where required and none were overlooked.

During our inspection in November 2015 we noted there were waiting room areas in the practice that were not easily visible to staff. We saw that a patient, whose health was deteriorating while in the waiting room, was not visible to staff. We discussed this with the practice GPs and the practice manager who agreed they would be reviewing patient safety in this area. The practice sent us evidence to show that it had implemented a risk assessment of patient safety in this area and considered the risks to be low and satisfactorily managed. We saw that since the November inspection two risk assessments had been completed and the practice policy had been updated. The practice stated that due to insufficient capacity for patients in the main front waiting area, the layout of the practice building and time and operational delays for clinicians, due to the length of walk to the rear consultation and treatment rooms for frail and elderly patients, they would continue to closely monitor and risk assess the situation.

Medicines Management

The practice had implemented an action plan following the previous inspection and amended their written procedures where appropriate. There were improvements in practice in relation to receiving patient requests for repeat prescriptions, the security of the dispensary and procedures to ensure the accuracy of dispensing medicines and reporting errors. Records of medicine refrigerator temperatures and the monitoring of medicine expiry dates were being appropriately completed.

The practice had also improved processes for assuring the competence of dispensary staff and had both undertaken and planned future audits to assure the quality of its dispensing service.

This action ensured that patients were effectively protected against the risks associated with the management of medicines.