Peartree Surgery

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Peartree Surgery on 26 January 2017. This inspection was undertaken to follow up on a Warning Notice we issued to the provider and the registered manager in relation to:

- Regulation 12; Safe Care and Treatment with regards to areas of unmanaged risk to patients receiving high risk medicines, medicines which require monitoring and the management of clinical documentation including pathology results and discharge letters.

The practice received an overall rating of inadequate at our inspection on 19 October 2016. We issued a warning notice and this report only covers our findings in relation to the areas identified in the warning notice as requiring improvement during our inspection in October 2016. You can read the full report from our last comprehensive inspection in October 2016, by selecting the 'all reports' link for Peartree Surgery on our website at www.cqc.org.uk.

The areas identified as requiring improvement in the warning notice were as follows:

- We found that the system for checking the monitoring of high risk medicines was not effective.

Summary of findings

- We found some patients receiving medicines that required monitoring had not received the appropriate checks.
- We found systems and processes in place for the safe and effective management of clinical documentation was not adequate.

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

- The practice had complied with the warning notice we issued and had taken the action required to comply with legal requirements.
- There was a safe and effective system in place for the management of patients receiving medicines that require monitoring, including high risk medicines.
- The practice had an effective system in place for the safe and timely management of clinical documentation including pathology results and discharge letters.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Peartree Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Peartree Surgery

Peartree Surgery provides primary medical services, including minor surgery, to approximately 22,000 patients in Welwyn Garden City, Hertfordshire. Services are provided on a General Medical Services (GMS) contract (a nationally agreed contract). The practice operates across three premises. Peartree Surgery is the main surgery and was purpose built in 1993. All patient consultations are held on the ground floor. There is an on-site pharmacy which has been operating since 2012.

Moorswalk Surgery is a branch surgery located approximately two miles away from the main surgery and Hollybush Lane Surgery is a branch surgery located approximately one mile away from the main surgery.

The practice serves a slightly higher than average population of those aged between 0 to 9 years and a slightly lower than average population of those aged between 65 to 79 years. The population is 88% White British (2011 Census data). The area served is less deprived compared to England as a whole.

The practice team consists of seven GP Partners and two salaried GPs; four of which are male and five are female.

There are three long term locums. There are two nurse practitioners, who are both qualified to prescribe certain medicines, six practice nurses and one health care assistant.

The non-clinical team is made up of a practice manager, deputy practice manager and 29 members of the administration and reception team.

Peartree Surgery is a training practice and has been approved to train doctors who are undertaking further training (from four months up to one year depending on where they are in their educational process) to become general practitioners.

Peartree Surgery and Moorswalk Surgery are open to patients between 8am and 6:30pm Mondays to Fridays. Appointments with a GP are available from approximately 8.30am to 12pm and from 3pm to 6.30pm daily. Emergency appointments are available daily. A telephone consultation service is also available for those who need urgent advice. The practice offers extended opening hours at the main practice between 6.30pm and 8pm three evenings each week, and on Saturdays from 8am to 11am on a fortnightly basis.

Home visits are available to those patients who are unable to attend the surgery and the Out of Hours service is provided by Hertfordshire Urgent Care and can be accessed via the NHS 111 service. Information about this is available in the practice, on the practice website and on the practice telephone line.

Why we carried out this inspection

We carried out an announced focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection

Detailed findings

was carried out to check that improvements had been made to meet legal requirements in respect of safe care and treatment following our comprehensive inspection on 19 October 2016.

How we carried out this inspection

After our comprehensive inspection on 19 October 2016, we issued a warning notice to the provider and informed them they must become compliant within the law by 12 January 2017. We carried out an announced focused inspection on 26 January 2017.

Are services safe?

Our findings

Our focused inspection on 26 January 2017 found that the practice had taken proactive steps to address the areas in relation to safe care and treatment as set out in the Warning Notice issued to the practice.

When we inspected the practice in October 2016 we found patients receiving medicines that require monitoring, including high risk medicines were at risk of harm because these patients were not being monitored appropriately and some of these patients had not received the required checks.

We checked the prescribing processes in place for patients receiving high risk medicines. The system for checking the monitoring of high risk medicines was not effective. We completed a search on the number of patients receiving methotrexate, a medicine used to treat cancer, rheumatoid arthritis and certain other clinical conditions. At the time of inspection we identified 106 patients on methotrexate. We looked at five patient records, including the hospital laboratory system and found three of these patients did not have an up to date full blood count (FBC) on their computer record. One of these patients last FBC was in February 2016 and this patient was issued their last repeat prescription in September 2016. Another patient was issued a repeat prescription for methotrexate in October 2016 and their last FBC was competed in April 2016. One patient was issued a repeat prescription for methotrexate in October 2016 and their last FBC was competed in July 2016.

Following our inspection in October 2016 the practice was asked to run searches on their clinical system and patients who had not received the appropriate monitoring were identified. These were in relation to patients receiving lithium and ACE inhibitors.

During our inspection in October 2016 we found the management of clinical records from secondary care services was not adequate. Results from the hospital and records from the Out of Hours service were not always acted on in a timely way.

We checked the management of clinical documentation. We were told all out of hours documents were scanned into the practice's electronic mail inbox and allocated to the GPs. At the time of inspection there were approximately 400 documents in the practice inbox, it was unclear if all of these had been reviewed and passed on to clinicians for action. Some of these clinical records included discharge letters from consultants and letters regarding information about appointment dates. We found 17 had been allocated to a doctor who left the practice on 30 September 2016. We also found one which had been allocated to a doctor who had been on maternity leave since May 2016.

We checked the management of pathology results and we found that there were 124 results prior to 14 October 2016 which had not been acted on. These pathology results dated back to 9 September 2016.

Overview of safety systems and processes

During our focused inspection on 26 January 2017, we found the practice had a safe and effective system in place for the management of patients receiving medicines that require monitoring, including high risk medicines.

The practice had a high risk drug monitoring and repeat prescribing policy in place which included a high risk drug monitoring quick reference guide for staff members. The practice had also created a medicines management policy which clearly documented individual roles and responsibilities. The practice had reviewed and updated their system for clinical coding and this enabled the practice to easily and accurately identify patients that were due the required checks prior to medicines being re-authorised and issued.

We checked the prescribing processes in place for patients receiving methotrexate (a medicine used to treat cancer, rheumatoid arthritis or certain other conditions). At the time of inspection there were 72 patients on methotrexate. (Patients on methotrexate require a blood test on a three monthly basis to check their full blood count). The practice had eight patients on methotrexate who were due a FBC. We looked at five of these patient records and found all five had been last prescribed methotrexate with an up to date record of their FBC.

We checked the prescribing processes in place for patients receiving levothyroxine (a medicine used to treat thyroid hormone deficiency). At the time of inspection there were 689 patients on levothyroxine. 670 patients had received the required checks and 19 patients were due to receive the required checks. The practice had safety alerts on the clinical system which prevented staff members from issuing

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a repeat prescription without the patient receiving the required checks. All of these patients had been contacted and blood tests had been requested. We checked three patient records and found evidence to confirm this.

We checked the prescribing processes in place for patients receiving lithium (a medicine used to treat mood disorders). At the time of inspection there were 21 patients receiving lithium. All 21 patients had received the required checks and the practice had a fail-safe system in place which prevented staff members from issuing a repeat prescription to patients who had not received the required checks.

We checked the clinical system and identified 1,488 patients receiving ACE inhibitors. We found 35 patients were due for their blood test. The practice had a system in place which restricted the re-authorisation and issuing of this medicine until an up-to-date blood test had been completed. All of these patients had been sent a letter from the practice requesting a blood test.

We checked the prescribing processes in place for patients receiving a combination of angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs). These medicines are often used to treat high blood pressure, heart and kidney problems. At the time of inspection there were 74 patients receiving both ACE and ARBs. All 74 patients had received the required checks and the practice had a fail-safe system in place which prevented staff members from issuing a repeat prescription to patients without an up-to-date blood test result.

The practice had implemented fail-safe protocols to ensure safe prescribing and this included safety alerts and restrictions within the clinical system. The practice had implemented clear instructions on the clinical system for the clinician to contact the patient before prescribing medicines and this included a standard letter which was issued to patients.

The practice had implemented a system of clinical coding which enabled the practice to complete accurate system searches and to ensure safe and effective monitoring was in place for patients receiving medicines that require monitoring, including high risk medicines.

During our inspection we checked the systems and processes in place for the safe and timely management of clinical documentation including pathology results and discharge letters. We found the practice had a safe and effective system in place.

During our inspection we reviewed the process for pathology results and on review of the systems we found all pathology results received into the practice had either been acted on or were in the process of being acted on within the 72 timeframe stated within the practice's protocol for pathology results.

Scanned documents received were acted on as required. At the time of inspection the practice had a number of documents which had been looked at and were waiting further processing. All scanned documents we looked at had been acted on or were in the process of being acted on within the practice's timescales.The practice had a policy in place for the management of scanned documents and pathology results which the practice had been reviewed with all GPs and administration staff members. This policy was also included in the practice's GP locum pack and clearly outlined the roles and responsibilities for the safe and timely managemed of scanned documents.

The practice had a schedule of audits in place to ensure a review of the sytems and processes in place could take place on a regular basis. The practice had completed an audit of pathology results and scanned documents in January 2017 and the results showed 89 out of 95 (94%) of the results received on 5 December 2016 had been filed within 72 hours of receipt. Five results had been filed on 9 December and one result was filed on 12 December 2016. The practice had scheduled a re-audit to take place in July 2017.

The practice had reviewed and updated their system and processes for the management of prescription requests. All prescription requests were assigned as a task to the prescription team on the practice's computer system. The practice told us that if the medicine required re-authorisation or if the request was for acute medicine then this would be tasked to a GP. Acute medicine is a general (internal) medicine concerned with the immediate and early specialist management of adult patients who present to, or from within, hospitals as urgencies or emergencies. The practice's medicines management policy clearly outlined the process and timescales for managing

prescription requests. At the time of inspection there were 37 prescription requests, including eight online requests. All of these requests had been submitted within the previous 48 hours.

The practice told us that all of the administration staff involved in processing prescription requests had received training with the GP lead for medicines management. During our inspection we spoke with two members of the administration team involved in processing prescription requests. Both of these staff members demonstrated knowledge and awareness in relation to the safe and effective management of prescription requests. Both of these staff members confirmed that they had received training on the new fail-safe protocols and alerts and understood the process for managing prescription requests, including requests for acute medicine. We saw evidence to confirm this.