Waltham Road Medical Centre

Quality Report

The Medical Centre,
4a, Waltham Rd,
Gillingham, Kent,
ME8 6XQ
Tel: 01634 231074
Website: none

Date of inspection visit: not visited
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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 a desktop review of Waltham Road Medical Centre on the 21 August 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe services.

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

At our inspection of 11 December 2014 we found the practice had a system for reporting, recording and monitoring significant events, incidents and accidents, but it did not always operate well. At our desk top review on 21 August we saw that there was a new significant events policy. This had led to more events being reported by staff. The events had been discussed and action taken to reduce the risk of similar events happening in the future.

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 is rated as good providing safe services.

At our previous comprehensive inspection on the 11 December 2014 the practice had been rated as requires improvement for providing safe services as there were areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However there was no common understanding of what constituted a significant event so there was no consistency in reporting them. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

At our follow up desktop review on the 21 August 2015, the practice provided records and information to demonstrate that the requirements had been met. We found that action had been taken to improve safety by identifying and reporting significant events. The practice had implemented a new significant event policy. This had been read by all staff and discussed at staff meetings. Staff had reported events since the implementation of the new policy. The number of events raised by staff had increased significantly. The events had been discussed at staff meeting and action taken where appropriate.

Waltham Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector.

Background to Waltham Road Medical Centre

The Waltham Road Medical Centre is a GP practice located in an urban area of Gillingham, Kent and provides care for approximately 1,600 patients. The practice has more than twice the national average of patients over 75 and over 85 years of age. The number of people in the area who claim disability allowance is significantly higher than the national average.

There are two GP partners, one male and one female. There is a female practice nurse. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from the central surgery at

The Medical Centre,

4a, Waltham Rd,

Gillingham, Kent,

ME8 6XQ.

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out- of- hours care.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 11 December 2014 as part of our regulatory functions. At the inspection we found that there was a breach of Regulation 10 (1) (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This inspection was planned to check whether the changes that the provider has made mean the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We undertook a desktop review on 21 August 2015 to follow up on the action that had been taken to deal with the breach. We had a telephone interview with the practice manager. We reviewed and assessed correspondence from the provider for example, reading the minutes of staff meetings, policies and reports of significant events.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At our inspection of 11 December we found the practice had a system for reporting, recording and monitoring significant events, incidents and accidents, but it did not always operate well. There had been two reported significant event over the previous year. They had been reported in a comprehensive and timely way. Records demonstrated the action taken by the practice following the incident. However, we found three occurrences that could have been classified as significant events. They were all medical emergencies. In each case the situation was dealt with efficiently and effectively but none were recorded as significant events. We found that there was no policy to guide staff on what was a significant event or incident, therefore there was no common understanding of how to identify and report a significant event or incident.

At our desk top review on 21 August we found that the practice manager had taken advice from the local clinical commissioning group about how to manage significant events. There was a new significant events policy. This had been read by all staff and discussed at staff meetings. Staff had reported six events since the implementation of the new policy. These ranged from staff absence, through problems with the building maintenance to incorrect processing of patient's clinical results. These had been discussed at staff meetings and action taken where appropriate.