Ivy Grove Surgery

Quality Report

Steeple Drive, Ripley Derbyshire DE5 3TH
Tel: 01773 514130
Website: www.www.ivy.gs

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Ivy Grove Surgery on 18 January 2016. The overall rating for the practice including are services safe was good. The full report dated 18 January 2016 can be found by selecting the 'all reports' link for Ivy Grove Surgery on our website at www.cqc.org.uk.

We carried out this focused announced inspection on 6 June 2017 in response to information we received from the Coroner concerning a serious incident. We visited Ivy Grove Surgery as part of this inspection to check that the practice had taken action to improve safety relating to the management of controlled drugs (medicines that require extra checks because of their potential for misuse), and ensure that significant events were appropriately reported and managed.

We reviewed the practice against part of one of the five questions we ask about services: are services safe. We found that the practice had carried out an action plan to address the above issues to improve patient safety. The evidence supported that the previous inspection rating of good for are services safe was still accurate.

Our key findings were as follows:

- The practice had carried out an action plan to improve patient safety relating to the management of controlled drugs.
- There was an open culture to reporting safety incidents and near misses.
- The practice had taken action to ensure that significant events including serious incidents were appropriately reported, recorded and acted on to minimise the risk of further occurrences.
- Following the inspection, the significant events policy was updated to detail all processes followed in practice. We received assurances that all staff had been made aware of this.

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 carried out an action plan to improve patient safety relating to the management of controlled drugs.
- There was an open culture to reporting safety incidents and near misses.
- The practice had taken action to ensure that significant events including serious incidents were appropriately reported, recorded and acted on to minimise the risk of further incidents.
- Lessons were shared with staff and improvements where made where required to provide care and treatment in a safe way.
- Following the inspection, the significant events policy was updated to detail all processes followed in practice. We received assurances that all staff would be made aware of this.

Ivy Grove Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a member of the CQC medicines team.

Background to Ivy Grove Surgery

Ivy Grove Surgery provides primary care medical services to approximately 11,000 patients via a Personal Medical Services (PMS) contract. The practice is situated on the outskirts of Ripley town centre in Derbyshire at Steeple Drive, Ripley, DE5 3TH.

The practice is located in purpose built premises, which are shared with another GP practice, along with the adjoining car park. All patient services are provided on the ground floor of the building, whilst the upper floor is used for administration.

The practice is run by a partnership of seven GPs. The provider's current certificate of registration issued by the Care Quality Commission includes four partners. Three new partners were in the process of submitting applications to be added to the provider's registration.

The practice team includes administrative staff, a practice manager, deputy practice manager, three practice nurses, two health care assistants and seven GPs (five male, two female) all of which are partners. Ivy Grove Surgery is a teaching practice for medical students.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available throughout the day from 8am to 5.50pm daily. Extended hours surgeries are available on Wednesday evenings.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Healthcare United via the NHS 111 telephone service.

Why we carried out this inspection

We undertook a focused inspection of Ivy Grove Surgery on 6 June 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out in response to information we received from the Coroner, to check that the practice had taken action to improve safety relating to the management of controlled drugs, and ensure that significant events were appropriately reported and managed.

How we carried out this inspection

Before our inspection, we reviewed various information that we hold about the practice. We visited the practice on 6 June 2017 as part of this focused inspection.

- We spoke with the practice manager, two GP partners and administrative staff.
- We checked various records including a sample of the personal care or treatment records of patients.
- We checked that further systems had been put in place to improve safety relating to the management of controlled drugs.
- We also checked that significant events including serious incidents were appropriately reported, recorded and acted on to prevent further occurrences.

Good

Are services safe?

Our findings

The practice is rated as good for providing safe services.

We previously carried out an announced comprehensive inspection at Ivy Grove Surgery on 18 January 2016. The overall rating for the practice including are safe services was good.

We carried out this focused inspection on 6 June 2017 in response to information we received from the Coroner concerning the management of controlled drugs (medicines that require extra checks because of their potential for misuse), and the reporting of a serious incident.

We found that the practice had carried out an action plan to address the above issues to improve patient safety. The evidence supported that the previous inspection rating of good for are services safe was still accurate. Our findings were as follows:

Safe track record and learning

- We reviewed how significant events were managed and the process for sharing learning with staff. We checked various records of incidents dating from January 2016 to June 2017, including minutes of meetings where events were discussed.
- We found that improvements had been made to ensure that significant events including serious incidents were promptly reported, recorded and acted on to minimise further occurrences. For example, the practice had identified that following un-expected deaths of patients referred to the Coroner, they did not routinely receive information relating to cause of death, which could potentially be important in helping them to improve their service. The practice had therefore introduced a process to ensure this information was requested from the Coroner.
- All patient un-expected deaths were also reviewed at regular clinical meetings to further improve safety and share learning where appropriate.
- Records of significant events were well documented, detailing action taken to prevent further incidents, and lessons learned where appropriate.
- One of the GPs was the clinical lead for significant events. Minutes of meetings showed that all senior staff had been reminded of their responsibilities to report serious incidents to the relevant external agencies and authorities.
- Records showed that significant events were standard agenda items at weekly clinical meetings. Minutes of meetings were also circulated to all clinical staff and non-clinical staff where appropriate, to ensure that individuals unable to attend were aware of incidents and changes made.
- Concise minutes of meetings were kept, which showed that lessons were shared with the staff team and wider to ensure action was taken to improve patient safety. For example, the practice had identified a delay in obtaining a patient's particular pathology result, and had contacted the hospital pathology department to discuss ways to reduce such delays in the future.
- We followed up several significant events to check that required actions and improvements had been made in practice to prevent further occurrences, and found that this was the case.
- The records showed that the practice had taken appropriate action to help prevent the risk of harm to patients where possible. For example, the duty GP had immediately seen a patient in response to deterioration in their mental health and risks to their safety, and referred them to the local crisis mental health team for urgent help. The welfare of the patient resulted in a serious incident. Discussions with staff and records showed that the practice had made changes to further help keep patients safe, including updating the depression assessment tool used to assess patients wellbeing.
- Whilst the records showed that significant events and serious incidents were effectively managed, the policy required updating as it did not detail all the processes followed in practice. Also, not all staff we spoke with were aware and had access to the policy. Following the inspection, we received a copy of the updated policy, which detailed the processes in place. We also received assurances that all staff had been made aware of this.
- A new incident reporting form had been produced for use by all members of staff for all significant events. This

was being implemented and included a section to record where an incident had been reported to various relevant external agencies, where appropriate. It did not include a section to record if the patient had been informed of a safety incident that had led to potential or actual harm to their wellbeing, and if an apology had been received. Senior staff agreed to review this.

- To aid communication and the management of concerns the complaints manager kept a spread sheet detailing the progress of complaints and coroners' requests for reports. This enabled clinicians to see what deadlines were in place and what progress was being made. Regular monthly meetings where scheduled to discuss coroners' cases and complaints.

Overview of safety systems and processes

- We found that the practice had carried out an action plan to improve patient safety relating to the management of controlled drugs (CDs).
- An updated standard operating procedure for the prescribing of controlled drugs was in place and we saw that it was accessible to all prescribers. The policy had been shared with NHS England (NHSE) and Southern Derbyshire Clinical Commissioning Group (SDCCG).
- One of the GPs was the clinical lead for the management of medicines including CDs. Processes had been introduced to ensure regular audit of prescribing of CDs and this was supported by SDCCG medicines management team. A recent audit had investigated whether full information was being received when external clinicians (e.g. hospital doctors and nurses) made recommendations to alter patients treatment. No concerns had been identified however the practice had put systems in place to ensure all necessary information was available to the prescriber, before a medicine could be prescribed.
- The internal peer review process for GPs now included the peer review of difficult prescribing decisions and patients on high doses of CDs. This was due to be discussed at a forthcoming clinical meeting.
- The practice were aware of their responsibility to report medicine incidents involving controlled drugs to the local accountable officer and we saw evidence of this having been done.
- A flow chart had been developed for reporting controlled drug incidents, which was displayed in the consulting rooms, and non-clinical areas. This directed staff to external agencies they needed to notify including the Coroner's office, where appropriate.
- To further strengthen their management of controlled drugs, and mitigate the risk of prescriptions going missing, the practice had introduced a system for tracking prescriptions as they left the surgery. A recent audit of this showed that the system was being used effectively by the clinicians.
- The GPs confirmed that improvements had been made with involvement of relevant agencies including EMIS Health and the National Patient Safety Agency to adapt their electronic prescribing systems to be more informative and safe. For example, concentrated solutions of high strength CD medicines were less accessible on the list of medicines, and clearer safety alerts were in place.
- SDCCG medicines management team had recently funded a prescribing decision support software package known as OptimiseRx. This links with the EMIS computer system at the practice, and is used both to direct prescribers to preferred choices (on either clinical or cost effectiveness grounds) and to provide safety warnings. The new system was introduced at the practice at the beginning of May 2017. The GPs said that they found the new system beneficial.
- As part of the practice's action plan to improve patient safety relating to the management of CDs we saw that the practice had written to local pharmacies to remind them to contact the practice, if there were any issues or concerns in relation to a controlled drug prescription.