Torrington Health Centre

Quality Report

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Devon
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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 focused inspection at Torrington Health Centre on 16 August 2016. This was to review the actions taken by the provider as a result of our issuing one legal requirement. In February 2016, the practice did not do all that is reasonably practicable to mitigate risk. This was specifically about the reporting and investigation of incidents involving medicines so that action was taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result. The practice sent us a plan showing how these issues would be addressed and we have monitored this with the practice. At this inspection, we reviewed the actions taken since the last inspection.

This report covers our findings in relation to the regulations and should be read in conjunction with the report published on 29 April 2016. This can be done by selecting the 'all reports' link for Torrington Health Centre on our website at www.cqc.org.uk

Overall the practice has been rated as GOOD following our findings, with the safe domain now rated as GOOD.

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

- The provider had introduced systems to ensure that incidents involving medicines were reported internally and to relevant external authorities/ bodies.
- A practice wide system for reviewing and investigating all incidents, including those arising in the dispensary had been implemented. Examples seen demonstrated that these were thoroughly investigated by competent staff. Actions had been taken to remedy the situation, prevent further occurrences and made sure that improvements were made as a result.

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 for safe services having improved the systems for reporting and investigating significant events.

Since the last inspection on 11 February 2016, the practice had set up systems to identify any potential risks so that these could be mitigated in a timely way. Staff understood their responsibilities to raise concerns, and to report incidents. The practice had provided training for dispensary staff to increase the recognition of, and reporting of all untoward events. Procedures in the dispensary for reporting errors and near misses as significant events were reviewed. Examples seen at this inspection demonstrated that the system was effective and events were now identified appropriately, investigated and learning shared to further improve patient safety.

Torrington Health Centre

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 second CQC inspector.

Background to Torrington Health Centre

Torrington Health Centre serves the whole of Torrington as well as its surrounding villages and has a branch surgery at The Old Stables, High Bickington. The patient list size is approximately 5,200 patients.

The practice staff includes three GP partners and two salaried GPs (two female and three male), two senior nurses (covering both surgeries) and two health care assistants as well as a practice manager, deputy practice manager, dispensers and reception staff. The GPs work as a group (there are three partners and two salaried GPs) and hold a contract with the Northern, Eastern and Western Devon Commissioning Group to deliver services to patients under the NHS.

Torrington Health Centre offers a full general practice service with a named GP responsible for each patient's overall care at the practice. The practice provides specialist clinics in travel, diabetes, epilepsy, asthma, coronary heart disease and minor surgery. There is an on-site dispensing service for patients living outside of a one mile radius of Torrington.

Opening times and appointment times at Torrington Health Centre are; Monday to Friday 8am until 6pm (closed between 12.15pm and 1.15pm). The dispensary opens from 8.30am until 12 midday and 2pm until 6pm Monday to Friday.

Opening times and appointment times at High Bickington Surgery are; Monday and Friday 4pm until 5.30pm and Tuesday, Wednesday and Thursday from 8.30am until 10am. When the practices are closed patients are directed to ring the 111 out of hours service.

Regulated activities are provided from the following two locations:

Torrington Health Centre, New Road, Torrington, Devon EX38 8EL.

Old Stables Surgery, High Bickington, Devon EX37 9AX.

We did not visit the branch surgery at High Bickington during this inspection.

Why we carried out this inspection

We carried out an inspection of Torrington Health Centre on 11 February 2016 and published a report setting out our judgements. We asked the provider to send us a report of the changes they would make to comply with the regulation they were not meeting. The report from 11 February 2016 is published on our website.

This was a focussed inspection to follow up the actions taken by the practice.

Detailed findings

How we carried out this inspection

We reviewed information sent to us by the practice. We carried out an announced focussed inspection carried out at short notice. We looked at management records and spoke with three staff, including dispensary staff.

Good

Are services safe?

Our findings

Safe track record and learning

In February 2016, there was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of incidents and there was a recording form available on the practice's computer system. However, there was a focus on reporting clinical incidents and the reporting of non-clinical significant events as learning opportunities was at times overlooked. For example, improvements from health and safety issues or business continuity concerns such as power cuts or fridge failures. The practice carried out a thorough analysis of the significant events reported. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

However, in February 2016 we found that these processes were not embedded in the dispensary. The dispensary did not have a supportive culture towards error reporting. Dispensing errors and near misses were not sufficiently recorded, acted upon, analysed, learnt from and shared within the practice dispensary. After the inspection, the practice sent us a plan showing how these concerns would be addressed and we have monitored this with the practice.

At this focussed inspection, we looked at the changes made by the practice. When we inspected on 16 August 2016, we found that the culture towards error reporting had changed. We looked at minutes of meetings held between April and July 2016 with GP partners, the dispensary team and all the staff at the practice. These minutes demonstrated that the practice had discussed and implemented an action plan to improve the culture and encourage reporting of significant events. Significant events were now a standing item at the GP partner meeting held every week. Minutes for a dispensary team meeting held on 21 April 2016 showed that the significant event procedures had been reviewed and these changes communicated to dispensary staff. The same messages were communicated to the entire practice staff at a meeting on 16 May 2016. Minutes showed staff were informed that there had been seven significant events reported since the last meeting. Staff were praised for raising these and encouraged to continue with this to promote shared learning and improvements at the practice.

Dispensary staff told us that they had received training which had increased their awareness of when to identify and report any significant events. A new system for error reporting had been implemented. The practice manager showed us data demonstrating that there had been an increase in significant event reports from dispensary staff. Practice data demonstrated that in 2015 there had been a total of 19 significant events. From January 2016 to August 2016 there had been 23 significant events reported, of which seven were administrative in nature. We reviewed safety records and saw there had been a thorough investigation with staff involved. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a significant event was reported regarding the prescribing and collection of a patient's prescription for a high risk medicine. Whilst the practice was not required to hold a register for this particular medicine, an additional safety net had been implemented providing an audit trail of when the medicine was dispensed and who collected it. Patients or their approved representative were now asked to sign a record on collection of this medicine. This demonstrated that safety improvements were made when dispensing errors and near misses were recorded, acted upon, analysed, learnt from and shared within the practice dispensary.

There were three other areas that we followed up at this inspection, which were highlighted as areas which should be improved under the safe key line of enquiry. These had all been reviewed by practice and improvements made. We looked a clinical room where there had been an unsecure oxygen cylinder. We saw that the oxygen cylinder was now secured to the wall promoting patient safety by reducing the potential risks of injury caused by it falling.

GP partners had taken over responsibility for monitoring the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. We saw this included carrying out dispensing reviews of the use of medicines (DRUMs). Data seen showed that since April 2016, the GPs had completed 161 DRUMs against the year target of 270 to be completed by March 2017.

Good

Are services safe?

Patient Group Directions (PGDs) were in place to allow nurses to administer medicines in line with legislation.

Since the last inspection, the practice manager verified that all of the PGDs had been reviewed to ensure that these were all ratified with the practice stamp and had been signed and dated by all staff following them.