Bramblehaies Partnership

Quality Report

Bramblehaies Medical Practice
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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 effective?	Good

Summary of findings

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The five questions we ask and what we found

We always ask the following five questions of services.

Are services effective?

Good

The practice is now rated as good for effective having made improvements to ensure that standard operating procedures for pathology results and scanned correspondence have been reviewed and are being followed.

The practice rating for the effective key line of enquiry has been reviewed as part of this desktop review. We followed up the areas we were concerned about. Risks with regard to the handling of pathology results and scanned correspondence highlighted at the last inspection have now been addressed and improvements made.

Our findings at the last inspection were that systems were in place to ensure that all clinicians were up-to-date with both NICE guidelines and other locally agreed guidelines, which was influencing and improving practice and outcomes for their patients. We saw data that showed that the practice is performing highly in a number of areas when compared to neighbouring practices in the CCG.

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Detailed findings

Why we carried out this inspection

We carried out an inspection on 5 November 2014 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.

We have followed up to make sure the necessary changes have been made and found the provider is now meeting the fundamental standards included within this report. This report should be read in conjunction with the full inspection report. We have not revisited Bramblehaies Medical Practice as part of this review because the practice was able to demonstrate compliance without the need for an inspection.

How we carried out this inspection

We reviewed information sent to us by the practice. We have not revisited Bramblehaies Medical Practice as part of this review.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Working with colleagues and other services

Since the comprehensive inspection in November 2014, the practice sent us an action plan and provided evidence showing the improvements made. The improvements have shown that effective standard operating procedures are now in place and being followed

At the last inspection, we found that records were held on an electronic system for each patient including scanned copies of communications from hospitals. In November 2014, within 48 hours of the inspection, the practice submitted a revised code of conduct with shorter timescales and a revised protocol for GPs to view and process results and correspondence. For this desktop review, the practice sent us a log showing biweekly completed audits of patient records which monitored how results and correspondence was being handled across the entire team. The log of audits covered the period immediately after the inspection up until August 2015. This information demonstrated that any delayed actions within the IT task facility were explored and addressed with staff. Other record evidence reviewed demonstrated that staff had received training about the IT system and revised protocol and were being prompted to ensure that these changes were embedded in practise.

In November 2014, there were effective systems that the practice used to facilitate continuity of care and treatment for patients. For example, there was a shared system with the local out of hours provider to enable patient information to be shared in a secure and timely manner. GPs showed us the system, which allowed them to upload special notes directly onto this system. An example shared with us involved the care of a patient prescribed complex pain medication. Information was shared with the out of hours provider so that the medication was managed safely to avoid risks such as potential overdose. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. Electronic systems were also in place for making referrals to secondary care services.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency Department. The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information about this system was published on the practice website for patients and clearly explained the circumstances when information would be shared with other health or social care professionals.