

Sherwood Rise Medical Centre

Quality Report

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Date of inspection visit: 8 January 2018

Date of publication: 30/01/2018

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

Inadequate



Are services safe?

Are services well-led?

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sherwood Rise Medical Centre on 22 and 30 August 2017. The overall rating for the practice was inadequate, and it was placed into special measures. Two warning notices were issued to the provider in response to identified breaches in regulations. The full comprehensive report on the August 2017 inspection can be found by selecting the 'all reports' link for Sherwood Rise Medical Centre on our website at www.cqc.org.uk.

The overall rating of inadequate will remain unchanged until we undertake a full comprehensive inspection of the practice within the six months of the publication date of the report from August 2017.

This inspection was an announced focused inspection carried out on 8 January 2018 to confirm that the practice had taken the required action to meet the legal requirements in relation to the breaches in regulations set out in the warning notices issued to the provider.

The warning notices were issued in respect of regulations related to safe care and treatment, and good governance. Specifically, the provider did not have an effective system in place to review and act on alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA); and in addition, the standards of record keeping were found to contain inaccurate or incomplete entries, and were not always kept up to date.

Our key findings were as follows:

- The practice had complied with the warning notices that we issued and had taken action to ensure they met with legal requirements.
- The process in place to review and act on MHRA alerts had improved significantly. A comprehensive alert log was maintained to summarise the receipt of incoming alerts, the follow up actions taken, and the outcomes this produced.
- We observed that alerts were reviewed by clinicians and supported by audits where necessary. Entries on individual patient records summarised any actions taken in response to the alert.
- The standards of record keeping had improved. We observed that entries into patient records were being recorded in greater detail. Entries were mostly made contemporaneously. If the notes were recorded retrospectively, this was clearly indicated within the entry.
- The practice had sought help to respond to our previous findings and we saw evidence of joint working with their Clinical Commissioning Group (CCG), the Local Medical Committee (LMC), NHS England and external consultants.

However, the provider should continue to make improvements in the following area:

- Review the arrangements to follow up on any actions that may be indicated when adverse test results have been received.

Summary of findings

- Ensure that when a medicine review has been documented in a patient's notes, the review has been completed in line with recommended guidance.

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

Sherwood Rise Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team consisted of a GP specialist advisor and a CQC Lead Inspector.

Background to Sherwood Rise Medical Centre

Sherwood Rise Medical Centre is a GP practice within NHS Nottingham City's Clinical Commissioning Group's area. It provides primary medical services to approximately 5,700 patients via a general medical services (GMS) contract.

The practice is located approximately one mile from Nottingham city centre and is easily accessible by public transport. The premises were built in 1986 and some community health services are based in a neighbouring property adjacent to the practice.

The practice age profile demonstrates higher numbers of younger people, and lower numbers of patients aged over 65 compared to local and national averages. The practice provides services to a locally diverse and multi-cultural population. The level of deprivation within the practice population is similar to the local average, but significantly above the national average with the practice falling into the second most deprived decile.

The clinical team is comprised of two GP partners (one full-time male, one part-time female), a long-term female locum GP working five sessions each week, one part-time

female practice nurse and one healthcare assistant. The clinical team is supported by a part-time practice manager, a part-time operational manager, six members of reception and administrative staff, and an apprentice.

The practice opens between 8am and 6.30pm Monday to Friday. GP consulting times are variable but are generally from 9am to 11.30am each morning and from 4pm to 6pm each afternoon.

Why we carried out this inspection

We undertook an announced comprehensive inspection of Sherwood Rise Medical Centre on 22 and 30 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice received an overall inadequate rating including inadequate ratings for providing safe and well-led services, and was placed into special measures. The practice was rated as requires improvement for caring, and good for providing effective and responsive services. The full comprehensive report following the August 2017 inspection can be found on our website www.cqc.org.uk

Two warning notices were issued to the provider further to identified breaches of regulations for not providing safe care and good governance.

We undertook a follow up focused inspection of Sherwood Rise Medical Centre on 8 January 2018. This inspection was carried out to review the actions taken by the practice to comply with the content of the warning notices issued following the August 2017 inspection and to confirm that the practice was now meeting legal requirements.

Are services safe?

Our findings

At our previous inspection on 22 and 30 August 2017, we rated the practice as inadequate for providing safe services.

The arrangements in respect of responding to alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) were not adequate. We issued a warning notice in respect of this issue, and found arrangements had significantly improved when we undertook a follow up inspection of the service on 8 January 2018.

- The practice had taken effective action to comply with the warning notice
- The practice maintained an alerts log which recorded all incoming MHRA alerts by date, any actions taken, and the outcomes that were achieved. This was colour coded to identify any alerts currently in progress.
- Where medicines may have impacted on patient care, an audit was undertaken and written up. This identified the number of patients affected and the actions taken to comply with the content of the MHRA alert.
- The audit recorded patients by an anonymised code to identify those patients who may be affected. This meant that records could be cross referenced to check any actions undertaken by the practice. We checked a number of patient records and found that these all contained reference to the alert and documented the follow up actions taken. These were in alignment with the information on the alerts log and the audit.
- We saw documented evidence that MHRA alerts were being discussed at clinical team meetings.
- At our previous inspection, we highlighted two specific MHRA alerts for which the practice was unable to provide assurance that the necessary follow up had been completed. At this inspection, we saw that these alerts had been reviewed and completed in full and could be clearly evidenced.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection on 22 and 30 August 2017, we rated the practice as inadequate for providing well-led services. The quality of recording entries into patients' notes keeping was found to be below recommended quality standards.

We issued a warning notice in respect of this issue, and found arrangements had significantly improved when we undertook a follow up inspection of the service on 8 January 2018.

- The practice had taken effective action to comply with the warning notice.
- External advice had been sought to provide mentorship and guidance to improve the quality of record keeping.
- We reviewed a number of entries in patient records which recorded consultations undertaken as home visits, scheduled care home visits, and GP appointments at the practice. We observed that the documentation was more detailed and accurate than we had found at our previous inspection.
- The location of where the consultation had taken place was being recorded appropriately.
- A laptop computer had been purchased to enable the GP to access patient records securely when visiting the care home. This also enabled the GP to record the consultation contemporaneously, rather than having to do this later at the practice. The laptop was first used on the day of our inspection, but we were able to see this working effectively whilst we at the practice.
- Although the quality of record keeping had improved, we did observe that follow up action (for example, when adverse test results had been received) was not always undertaken within an acceptable timescale. This was highlighted to the practice and it was suggested that two examples should be reviewed by the practice team as significant events. It was agreed that this would be followed up at the next comprehensive inspection which is due before the end period of the special measures.
- The practice had worked with their CCG, and had re-established links with the Local Medical Committee