Hook Surgery

Quality Report

Merritt Medical Centre
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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
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Hook Surgery on 8 June 2016. Breaches of legal requirements were found. After the comprehensive inspection, the practice submitted an action plan, outlining what they would do to meet the legal requirements in relation to the breaches of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the comprehensive inspection we found that the practice had failed to do all that was reasonably practicable to ensure that sufficient safeguards were in place when prescribing medicines, this included the bulk prescribing of high-risk medicines such as Warfarin, and the lack of formal guidelines for prescribing by the nurse practitioner; that they did not have processes in place to ensure that the temperature of the vaccines refrigerator was monitored on a daily basis and had failed to keep comprehensive records of action taken when the temperature had gone outside of the optimum range; that they did not do all that as reasonably practicable to ensure that patients who failed to collect prescriptions were followed-up; and that they did not have sufficiently robust processes in place to ensure that there was clinical oversight of all hospital correspondence received.

We also found areas where the practice should make improvements. We found that the practice had been recording significant events, but that their records did not always contain sufficient detail; the practice provided training to its staff but processes in place to identify when refresher training was due had not been maintained; at the time of the initial inspection, the practice's Patient Participation Group had been recently restructured and the new group was in the process of becoming fully established; the practice had identified 13 carers, which represented less than 1% of their patient population.

We undertook this focussed inspection on 9 December 2016 to check that the practice had followed their plan and to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hook Surgery on our website at www.cqc.org.uk.

Overall the practice was rated as good following the comprehensive inspection. They were rated as requires improvement for providing safe services. Following the focussed inspection we found the practice to be good for providing safe services.

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

- There was an effective system in place of reporting and recording significant events.
- The practice's arrangements for prescribing medicines was in line with guidelines and up to date policies were in place.
- Prescription sheets and pads were stored safely and records were kept of stocks held.

Summary of findings

- The practice recorded the temperature of their medicines fridges daily; however, their temperature log did not record full details of action taken when fridge temperatures went out of the optimum range.
- All clinical letters were reviewed by GPs.
- All staff were up to date with mandatory training sessions and processes were in place to flag when training was due.
- The patient participation group continued to meet regularly.
- The practice had identified 13 carers at the time of the initial inspection; however, they felt that this was not a true representation of their carers register and that there had been an error in their data collection. At the time of the follow-up inspection they re-interrogated their patient records system, and we saw evidence that they had 115 carers on their register, which represented 2% of their patient list.

The practice should take action to address the following area:

- They should ensure that full details are recorded of action taken when medicines fridge temperatures go out of the optimum range.

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

- There was a system in place of reporting and recording significant events, and examples viewed showed that records of incidents contained an appropriate level of detail.
- The practice's arrangements for prescribing medicines was in line with guidelines and up to date policies were in place.
- We saw evidence that the practice had processes in place to ensure that medicines and prescription sheets and pads were stored safely.
- The practice had amended their process for reviewing incoming post to ensure that all clinical letters were seen by GPs.

Are services effective? Good

Are services caring? Good

Are services responsive to people's needs? Good

Are services well-led? Good

Hook Surgery

Detailed findings

Why we carried out this inspection

We undertook a focussed desk-based inspection of Hook Surgery on 9 December 2016. This is because the service had been identified as not meeting one of the legal requirements associated with the Health and Social Care Act 2008. From April 2015 the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, a breach of regulation 12 (Safe care and treatment) was identified.

During the comprehensive inspection carried out on 8 June 2016, we found that the practice had failed to do all that was reasonably practicable to ensure that sufficient safeguards were in place when prescribing medicines, this included the bulk prescribing of high-risk medicines such as Warfarin,and the lack of formal guidelines for prescribing by the nurse practitioner; that they did not have processes in place to ensure that the temperature of the vaccines refrigerator was monitored on a daily basis and had failed to keep comprehensive records of action taken when the temperature had gone outside of the optimum range; that they did not do all that was reasonably practicable to ensure that patients who failed to collect prescriptions were followed-up; and that they did not have sufficiently robust processes in place to ensure that there was clinical oversight of all hospital correspondence received. We also identified areas where improvements should be made, which included ensuring the they keep complete records of significant events; ensuring that they maintained processes to identify when staff training is due; ensuring that they involve patients and seek patients' opinions of the services provided, including developing the Patient Participation Group; and reviewing how patients with caring responsibilities are identified and recorded on the clinical system.

This inspection was carried-out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 8 June 2016 had been made. We inspected the practice against one of the five questions we ask about services: is the service safe.

Good

Are services safe?

Our findings

Safe track record and learning

During the initial inspection in June 2016 we found that there was a system in place for reporting and recording significant events, but that incidents were not always recorded in sufficient detail.

For the follow-up inspection we asked the practice to provide copies of records of the significant events that had occurred between 8 June 2016 and 9 December 2016. The practice provided evidence of four incidents, and we found these all contained sufficient detail about the incident and the action taken by the practice.

Overview of safety systems and processes

During the initial inspection we found that the practice's process for the repeat prescribing of Warfarin was not sufficiently robust to keep patients safe. The practice's process was to take blood samples of patients taking Warfarin and send the sample along with the patient's log book to the local hospital. The hospital would test the blood and return the log book directly to the patient with a record of the Warfarin dose they should take. The practice would bulk-prescribe Warfarin to patients in 1mg and 3mg tables with instructions that the patient should take the dose advised by the hospital. This process carried risks that patients could take the wrong dose of this medicine because their prescription did not state the dose that they should be taking. This was a particularly unsafe system for vulnerable people who were unable to calculate the dose they should take.

Following the inspection, the practice amended their Warfarin prescribing policy and a copy was provided to us. The amended policy set out instructions regarding the information that a prescriber must view before issuing a prescription for Warfarin. It also outlined the safety netting arrangements in place for ensuring that vulnerable patients were supported in taking this medicine.

During the initial inspection we found that the nurse practitioner was prescribing medicines, but her role was not covered by the practice's prescribing policy.

For the follow-up inspection, the practice provided us with an updated version of their prescribing policy, which showed that the nurse practitioner's role had been included, and that the remit of her prescribing role had been defined.

During the initial inspection we found that there were some days when the temperature of vaccines fridges had not been recorded. We also noted some occasions where the temperature was outside of optimal range, but no record had been made of the action that had been taken as a result.

The practice told us that following the inspection, they had created a buddy system for recording fridge temperatures to ensure that temperatures were checked every day that the practice was open. We viewed their fridge temperature logs, which confirmed that fridge temperatures were checked daily. We noted some instances where fridge temperatures had gone outside of the optimum range and were told that this was due to a fault with the fridge. The practice told us that they moved all stock from this fridge to another as soon as the fault was identified; however, this action was not recorded on their fridge temperature log.

During the initial inspection we found that blank prescription forms and pads were securely stored but that there was no system in place to monitor their use. We observed a large stock of prescription pads in the names of GPs who no longer worked at the practice. We also found examples of prescriptions which had not been collected by patients, some of which had been issued several months previously.

For the follow-up inspection, the practice provided us with evidence that they had put in place a log of serial numbers for prescription sheets and pads received by the practice. They also confirmed that the prescription pads for GPs who no longer worked at the practice had been returned to Primary Care Services England for destruction. Following the initial inspection, the practice had put in place a new protocol relating to uncollected prescriptions, this outlined that where a prescription had not been collected by the patient within one month of its issue the patient should be contacted to discuss whether the item prescribed was still required. The outcome of the discussion would then be reported to a GP, who would authorise destruction of the prescription if appropriate. We saw minutes of a meeting where this protocol had been shared with reception staff.

Good

Are services safe?

During the initial inspection we found that the process in place for reviewing letters received by the practice was not robust. We were told that a member of administrative staff opened the post and that all letters were then passed to a GP for review apart from those regarding a patient's attendance at Accident and Emergency which were marked as "no further action needed" and any letters notifying the practice that a patient had failed to attend a hospital appointment; these letters would be scanned and saved to the patient's records, which meant that it would potentially not be seen by a GP unless they had cause to review the patient's notes. We judged this process to be unsafe, as it relied too heavily on the judgement of a member of staff who was not clinically trained to determine whether an issue needed urgent review by a GP and risked significant information being overlooked.

Following the initial inspection, the practice confirmed that all letters would now be sent to GPs for review.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Good

Are services caring?

Our findings

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Are services well-led?

Good

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

Our findings