

Lucie Wedgwood Health Centre

Quality Report

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Date of inspection visit: 24 May 2017

Date of publication: 12/06/2017

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 Lucie Wedgwood Health Centre on 27 September 2016. The overall rating for the practice was Good with requires improvement in providing safe services. The full comprehensive report from the 27 September 2016 inspection can be found by selecting the 'all reports' link for Lucie Wedgwood Health centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 24 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 27 September 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as Good.

Our key findings were as follows:

- There was an effective system to ensure that patients who took medicines had a review by an appropriate clinician and consideration was given to the monitoring for side effects.

- There was a system for obtaining satisfactory information about any physical or mental health condition that staff members may have which are relevant to the role they undertook.
- The practice had recorded the action taken in response to all medicines and equipment alerts issued by external agencies.
- The practice had reviewed the oxygen therapy equipment in use to ensure it could be easily deployed within the practice as required.
- The practice had reviewed the method of storing and moving emergency medicines within the practice. The provider had obtained appropriate emergency medicine to treat possible complications associated with the insertion of specific intrauterine contraceptive devices.

We also saw the following best practice recommendations we previously made in relation to providing effective and responsive services had been actioned:

- Discussions and actions taken about changes in clinical practice, for example national guidance, were now recorded during clinical meetings held.

Summary of findings

- Patients were advised of the escalation process should they not be happy with the outcome of their written complaint.

However, there was still one area of practice where the provider could make improvements.

The provider should:

- Ensure the complaints procedure is readily accessible to patients.

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?

The practice is rated as good for providing safe services.

- There was an effective system to ensure that patients who took medicines had a review by an appropriate clinician and consideration was given to the monitoring for side effects.
- There was a system for obtaining satisfactory information about any physical or mental health condition that staff members may have.
- The practice had recorded the action taken in response to all medicines and equipment alerts issued by external agencies.
- The practice had reviewed the oxygen therapy equipment in use to ensure it could be easily deployed within the practice as required.
- The practice had reviewed the method of storing and moving emergency medicines within the practice. The provider had obtained appropriate emergency medicine to treat possible complications associated with the insertion of specific intrauterine contraceptive devices.

Good



Summary of findings

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure the complaints procedure is readily accessible to patients.

Lucie Wedgwood Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor.

Background to Lucie Wedgwood Health Centre

Lucie Wedgwood Health Centre is registered with the Care Quality Commission as a partnership provider. The practice currently holds a Personal Medical Services (PMS) contract with NHS England. A PMS contract is a locally agreed alternative to the standard General Medical Services (GMS) contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

The practice is situated within a health centre that also houses other NHS services; the location is close to the centre of Burslem. There is no car park attached to the practice, although limited time free parking is available at a local authority car park nearby.

At the time of our inspection the practice had 5,902 registered patients. The age range of patients registered at the practice broadly follows local and national averages. The demographic of the practice differs from others in some respects:

- The level of deprivation in the local area is significantly higher than local and national averages.

- Unemployment and the number of patients living with a long standing health condition are higher than local and national averages.

- The average life expectancy of people living in the local area is four years less for both males and females than national averages.

The practice staffing comprises of:

- Two male GP partners.
- One salaried male GP.
- One female locum GP.
- Two female practice nurses (one combines this role with that of a practice manager).
- One health care assistant.
- A team of secretaries, administrators and receptionists working a range of hours.

The practice is open: Monday 7:00am to 6pm, Tuesday 7.30am to 8pm, Wednesday 7.30am to 6pm, Thursday 7.30am to 5pm and Friday 7.00am to 6pm. The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Appointments can be made online, by telephone or face-to-face. The practice also offers video consultation appointments for patients over the age of ten, that do not require an immediate physical examination.

In preparation for the inspection we identified that the practice had changed their partnership, although

Detailed findings

applications to vary the CQC registration to reflect the changes had not been received. The provider has been prompted to submit the relevant applications at the earliest opportunity.

Why we carried out this inspection

We previously undertook a comprehensive inspection of Lucie Wedgwood Health Centre on 27 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall with requires improvement for providing safe services. The full comprehensive report following the inspection on 27 September 2016 can be found by selecting the 'all reports' link for Lucie Wedgwood Health Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Lucie Wedgwood Health Centre on 24 May 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced focused inspection on 24 May 2017. During our inspection we:

- Spoke with a range of staff to include one GP, practice manager, the practice nurse, and a range of reception and administrative staff.
- Spoke with three patients who used the service to include the Patient Participation Group Chairperson.
- Reviewed health information obtained for two staff regarding any physical or mental health conditions.
- Reviewed arrangements for the safe management of medicines.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed protocols, minutes of meetings held and looked at information the practice used to deliver care and treatment.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

At our previous inspection on 27 September 2016, we rated the practice as requires improvement for providing safe services. This was because:

- The provider had not mitigated the risks of receiving unsafe care and treatment, as some patients who took anti-hypertensive medicines had not received monitoring to ensure they were not having side effects.
- The provider did not have a process for, and had not considered, the physical and mental health of an employee in line with the requirement of the role they were to undertake.

We also made some best practice recommendations. We asked the provider to:

- Record the action taken in response to medicines safety alerts.
- Review the oxygen therapy equipment in use to ensure it could be deployed within the practice as required.
- Review the method of storing and moving emergency medicines within the practice.

These arrangements had significantly improved when we undertook a follow up inspection on 24 May 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At the previous inspection we saw the practice had a process in place to act on medicines and equipment alerts issued by external agencies that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). Following an alert being received the practice checked to ensure that patients were not affected by the medicines or equipment involved. We saw that the practice did not always record the actions they had taken in response to alerts, although other evidence demonstrated they had taken action. During this inspection we saw the practice had improved their systems for obtaining and filing all alerts in addition to recording the action taken in response to medicine safety alerts received. We saw searches had been undertaken against the patient list for alerts received and the necessary action taken.

Overview of safety systems and process

At the previous inspection we saw that the way the practice monitored patients who took medicines used to help treat high blood pressure had not been fully effective. National guidance for patients who took the medicines suggested that regular monitoring of kidney function should take place. We also saw in the computer records that non-prescribing nursing staff had marked medicine reviews as being completed although the review did not record that blood monitoring had been considered. The practice sent us information after the inspection to demonstrate they had taken action in this area. At this inspection we found there was an effective system to ensure that patients who took medicines had a review with an appropriate clinician and consideration was given to the monitoring for side effects. We saw the practice had set up a search for patients and recalled patients, reviewed their anti-hypertensive medication and bloods were taken for monitoring. Monthly searches were carried out to ensure patients were reviewed and monitored at the required frequency.

At the previous inspection we found most of the required recruitment checks had been undertaken prior to new staff commencing employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, the practice had not obtained satisfactory information about any physical or mental health condition that may affect a staff member's capability relevant for their job role. At this inspection we saw the practice had incorporated a new employee questionnaire for obtaining information about any physical or mental health condition and these had been completed and copies retained on the two staff files we reviewed.

Arrangements to deal with emergencies and major incidents

At the previous inspection we saw the practice had arrangements in place to respond to emergencies and major incidents. We saw the practice had oxygen available to administer in an emergency. The oxygen cylinder was located in a central area of the practice although the cylinder was large and not easily portable. At this inspection we saw the practice had obtained a portable trolley for the oxygen cylinder for ease of movement across the practice.

At the previous inspection we saw emergency medicines were held to treat a range of sudden illness that may occur

Are services safe?

within a general practice. The medicines were stored securely although this was in a small open top basket with no lid to secure the contents. The practice did not have atropine available to treat a sudden drop in heart rate that can cause symptoms such as collapse and low blood pressure. The practice fitted coils and atropine was a medicine recommended to be immediately available due

to the increased risk of cervical shock when fitting coils. The practice submitted evidence the day after the previous inspection to demonstrate they had acquired atropine and we saw this during this inspection. We also saw the practice had also reviewed the method of storing and moving medicines within the practice and signage was available advising staff of the new location.