Waterhouses Medical Practice

Quality Report

Waterfall Lane
Stoke On Trent
Staffordshire
ST10 3HY
Tel: 01538 308207
Website: www.waterhousesmedical.co.uk

Date of inspection visit: 5 October 2016
Date of publication: 19/10/2016

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Waterhouses Medical Practice on 21 June 2016. Three breaches of legal requirement were found. A warning notice was served for:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Requirement notices were served for :

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Summary of findings

- Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Waterhouses Medical Practice on our website at www.cqc.org.uk.

We undertook a focused follow up inspection on 5 October 2016 to check that the practice had taken urgent action to ensure they met the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. This report only covers our findings in relation to the warning notice. A follow up inspection will be carried out within six months to check that the practice had followed their action plan for the two requirement notices and to confirm they meet legal requirements.

Our key findings were as follows:

- There was a formal system in place to log, review, discuss and act on alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts, received into the practice.
- Opportunities to raise significant events were identified. There was an effective system in place for reporting and recording significant events.
- Effective systems had been put in place to mitigate risks to patients who took high risk medicines.
- There was a system in place to track prescriptions throughout the practice.
- An infection control audit had been completed and an action plan had been put in place to mitigate risks identified.
- Risks identified in the practice's legionella risk assessment and fire risk assessment had been mitigated.
- Hepatitis B immunisation records were available for most staff. Risk assessments were in place for two locum GPs whilst their hepatitis B status was confirmed.
- Emergency medicines were stored securely.

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

Waterhouses Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector and included a GP specialist adviser.

Background to Waterhouses Medical Practice

Waterhouses Medical Practice is registered with the Care Quality Commission (CQC) as a partnership provider in North Staffordshire. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice area is one of low deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. At the time of our inspection the practice had 3227 patients. Demographically the population is predominantly white British with a higher proportion of patients aged over 65 (21.1%) and 75 (9.4%) when compared with the national averages of 17.1% and 7.8% respectively. The percentage of patients with a long-standing health condition is 52% which is comparable with the local CCG average of 57% and national average of 54%.

The practice is open between 8am and 1pm and 2pm and 6pm Monday to Friday except for Thursday afternoons when it is closed. The practice closes at 1pm - 2pm but their telephone lines continue to be manned by a duty receptionist. Appointments are from 9am to 11.30am every morning and 3pm to 6pm daily (except Thursday afternoon). Telephone consultations are available after 11.30am and extended surgery hours are offered between 6.30pm and 8pm on Wednesday evenings. Pre-bookable appointments can be booked up to six weeks in advance and urgent appointments are available for that need them. The practice has opted out of providing cover to patients in the out-of-hours period and Thursday afternoons. During this time services are provided Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Why we carried out this inspection

This focused inspection was carried out under Section 60 of the Health and Social Care Act 2008 to follow up on our previous comprehensive inspection at Waterhouses Medical Practice in June 2016. At our previous inspection we identified breaches of Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action against Waterhouses Medical Practice by issuing a warning notice against Regulation 12 to tell them that services must be improved.

This inspection was to ensure that the provider had met the requirements and timescales of the warning notice issued to them against Regulation 12 under the Health and Social Care Act 2008.

Detailed findings

How we carried out this inspection

We carried out a focused follow up inspection on 5 October 2016. We reviewed policies, procedures and other information the practice provided during the inspection. We spoke with the GP partners, the practice manager, a practice nurse and a receptionist.

Are services safe?

Our findings

During our previous inspection in June 2016, we found that care and treatment was not being provided in a safe way for patients. This was because:

- There was no formal system in place to log, review, discuss and act on alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts, received into the practice.
- Opportunities to raise and analyse significant events were missed.
- There was a failure to mitigate risks to patients who took high risk medicines.
- There was no system in place to track prescriptions through the practice.
- Infection control audits had not been completed since 2013 and cleaning equipment was not stored appropriately.
- Some risks identified in the practice's legionella risk assessment and fire risk assessment had not been mitigated. Patient access through the emergency fire exit was inhibited due to the close proximity of bushes and a fence.
- Hepatitis B immunisation records were not available for all staff.
- Emergency medicines were not stored securely.

Safe track record and learning

Following our previous inspection in June 2016 the practice had made improvements and introduced a formalised system to act upon medicines and equipment alerts issued by external agencies.

We saw that the policy for safety alerts had been reviewed and updated to outline the process to be followed on receipt of an alert. The practice manager and one of the GP partners had been allocated the lead roles for the management of safety alerts. The practice manager cascaded safety alerts to all clinical staff via email. For any medicine alerts, the GP partner initiated a search to identify any patients prescribed the medicine. We saw evidence to support that all safety alerts and any required action was discussed at regular clinical meetings. Urgent safety alerts were discussed in between meetings as required.

Discussion of safety alerts was a standard agenda item at practice meetings, and this was confirmed by the minutes we saw. Safety alerts relating to the recall of specific medicines were actioned by the dispensary team.

The GP we spoke with during our inspection had a good knowledge of the most recent alerts. We looked at a recent safety alert for a specific medicine. We saw that the alert had been emailed out to all clinicians, that searches had been carried out and the required changes made.

Since our previous inspection, the practice had also made improvements in identifying, raising and analysing significant events.

We looked at four significant events that had been raised since our last inspection in June 2016. We saw that the practice had carried out a thorough analysis of these significant events and appropriate action had been taken to reduce the risk of incidents occurring again. We saw that the practice had a greater awareness of identifying significant events. For example, the practice had identified the need to raise a significant event following a complaint regarding incorrect information given to a patient. Analysis of the event had been carried out and learning was shared with the appropriate staff. Staff meetings had been introduced since our last inspection and we saw meeting minutes which demonstrated that significant events were a standard agenda item. The minutes demonstrated that learning had been shared with staff. Staff we spoke with demonstrated a good knowledge of how to raise concerns and the importance of doing so. An overarching review of significant events had been carried out to identify any patterns or trends.

Overview of safety systems and processes

Following our inspection in June 2016 the practice had made improvements and introduced effective systems to ensure the safe and proper management of patients prescribed high risk medicines.

The practice had developed a process for the management of disease modifying anti-rheumatic drugs (DMARDs). The practice had a shared care arrangement with three rheumatology clinics for patients receiving these medicines. We saw that systems had been modified to enable the practice to access patients' blood results before prescriptions were issued by the practice. Monthly audits had been undertaken by a GP partner to identify patients who were prescribed DMARDs and other high risk

Are services safe?

medicines. We saw that there were 22 patients prescribed high risk medicines and seven of these patients were slightly overdue the required blood screening. We saw that these seven patients had been contacted to advise them to book for blood tests in line with current guidance. Their repeat prescriptions had also been changed to prevent prescriptions being issued without the required safety checks. Reception staff knew to check whether up to date blood results were available before they processed repeat prescription requests. Where blood results were not available, reception staff alerted the GPs.

Since our previous inspection the practice had made improvements in tracking the use of prescriptions through the practice.

The practice had developed a policy that reflected national guidance for the tracking of prescriptions written by the practice. We saw that the system had been followed and was effective.

Improvements had also been made to the infection prevention and control measures in place at the practice.

We saw that an infection control audit had been carried out in August 2016 showing a compliance rate of 71%. An action plan had been put in place to ensure appropriate action was taken to mitigate identified risks and review dates for completion were included. We saw that all cleaning equipment was stored appropriately however the frequency of cleaning in the practice had not been increased from the two days noted at our previous inspection. The practice had been cleaned the day before our inspection and appeared visibly clean. All permanent staff had received the hepatitis B immunisation to reduce the risk of the transmission of this potential health care associated infection. However, evidence of hepatitis B immunisation was not available for two locum GPs that worked at the practice. We saw that risk assessments had been completed to mitigate any risks to patients whilst these results were obtained. We will check that these results are available at our next inspection.

Monitoring risks to patients

Following our inspection in June 2016 the practice had made improvements in mitigating risks identified in risk assessments.

We saw that previous issues identified in the legionella risk assessment had been mitigated. For example, monthly water temperature monitoring had been carried out and a shower removed where risks had been identified. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

At our previous inspection in June 2016, we saw that a fire risk assessment had not been carried out since 2013. We identified health and safety risks within the practice and reported our findings to the fire authority who took immediate action. At this inspection we saw that a fire risk assessment had been completed in July 2016. Where risks had been identified, the practice had taken appropriate action to mitigate them. For example, storage heaters used in the practice had been inspected and maintained by an approved electrician. We saw that previous concerns regarding the lack of access through the fire exit door had been rectified and concerns identified by the fire authority had been addressed to their satisfaction.

Arrangements to deal with emergencies and major incidents

Following our inspection in June 2016, the practice had made improvement in the management of emergency medicines.

At our previous inspection we saw that emergency medicines were stored on an open work surface in a corridor used by patients and workmen meaning they had easy access to them. At this inspection we saw that these medicines had been relocated to a secure area of the practice but they were easily accessible to staff.