Stillmoor House Medical Practice

Quality Report

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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**	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Stillmoor House Medical Practice on 5 January 2016. This was to review the actions taken by the provider as a result of our issuing two legal requirements.

Overall the practice has been rated as GOOD following our findings.

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

- The provider had protected patients against the risks associated with unsafe use and management of medicines by means of making the appropriate arrangements for the safe keeping of medicines. This included the servicing of refrigerators used to store medicines, calibration of thermometers and use of additional digital thermometers to record internal temperatures for continued monitoring.
- Effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others had been implemented. These included the involvement of relevant staff in the discussion and learning from significant event analysis. Records showed subsequent actions were taken and how or with whom any learning was shared.

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

The practice is now rated as good for safe having improved systems and processes to reduce safety risks.

- Patients were protected against the risks associated with unsafe use and management of medicines by means of making the appropriate arrangements for the safe keeping of medicines. This included the introduction of servicing of refrigerators used to store medicines, calibration of thermometers and use of additional digital thermometers to record internal temperatures for continued monitoring.
- Effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others had been implemented. These included the analysis of significant events and involvement of relevant staff in the discussion and learning from these. Records showed subsequent actions were taken and how or with whom any learning was shared.

Our findings at the last inspection were that alerts were brought to the attention of staff appropriately so they could check and adjust their work accordingly. Good systems were in place to maintain a clean and hygienic service. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had management systems for safeguarding and review risks to children, young people and vulnerable adults.

Care Quality Commission

Stillmoor House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser.

Why we carried out this inspection

We carried out an inspection of Stillmoor House Medical Practice on 3 February 2015 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 regulations 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 comprehensive inspection report.

How we carried out this inspection

We reviewed information sent to us by the practice. We carried out a focussed inspection and looked at management records and spoke with eight staff.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At this inspection, we found that the practice had implemented a systematic approach towards analysing and identifying trends with reported incidents, events, accidents and complaints to ensure that risks were always mitigated for patients.

Immediately after the inspection, the practice reviewed the way it managed these and provided an updated written protocol. This included improvement of the process for significant events analysis (SEA), which promoted shared learning across the team. The SEA template had been reviewed to include additional prompts for staff. We discussed these with two GP partners who told us that training was on-going to ensure as much detail as possible was included so that a clear record of learning, actions taken and evidence of these being embedded into practice was made.

Additional funding had been obtained from the commissioners enabling the practice to close for a 2 hour period on the last Friday afternoon of the month, which was being used for training and discussion about learning from SEAs and complaints for example. During this time, a duty GP system was in place for patients to contact and information displayed throughout the waiting areas and on the practice website.

We randomly selected four significant events analysis records that had occurred since the last inspection and discussed these with nine staff across the practice. The majority of staff we spoke with had attended a recent meeting in November 2015, at which learning from SEAs and other events had been discussed. Staff showed us the minutes which had been circulated by email and those staff who had not been able to attend had seen them. Staff were able to confidently described the actions taken and able to demonstrate the changes made to their practice as a result of the learning from SEAs. For example, the practice had made changes to the way telephone messages were actioned and had set up a clearer system to differentiate routine and urgent messages. All blood results were now being reviewed by the duty GP on the day of receipt and promoted patient safety by being acted upon immediately. We were told that since the meeting in November 2015, three additional SEAs had been reported which the partners felt demonstrated a positive cultural shift.

Two GP partners told us about the significant investment made since the last inspection to support innovation and change the culture at the practice. External consultants had been working with the practice and lines of communication had been opened up across the team. Staff verified that there was a no blame culture and development was being encouraged. For example, a suggestions box for staff had been implemented enabling them to come up with solutions to improve the service for patients and working at the practice and to mitigate safety risks. A GP partner reviewed these regularly and met with a committee comprising of representatives from the administrative, nursing teams to discuss and agree actions for the suggestions. Recent suggestions being put into effect included purchasing printer label machines, which would make prescription labels clearer for patients and reduce the risk of these being misread.

Medicines management

The practice dispensary was inspected in February 2015. We found that medicines were managed safely with the exception of storage of medicines in refrigerators.

At this inspection, we looked at the arrangements for monitoring the temperature of refrigerators used to store medicines such as vaccinations. Records showed that all of the refrigerators used for this purpose had been serviced in April 2015. Certificates demonstrated that equipment used to monitor the internal temperature ranges in all four refrigerators had been calibrated since the last inspection.

The practice had reviewed its protocol for the storage of non-controlled medicines and vaccines, adding additional audit systems for checking that medicines were stored safely at the correct temperatures. Four staff showed us the records demonstrating that daily checks were done and all understood the reporting procedures should this fall outside of the safe temperature range in the protocol. Staff told us that since the inspection, digital thermometers had been purchased to monitor the internal temperatures of the refrigerators. The data from these was being downloaded and held on the practice computer system for further monitoring and audit by the practice manager.