

Wellside Surgery

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 comprehensive inspection at Wellside Surgery on 6 December 2016. The overall rating for the practice was good, with requires improvement for providing safe services. The full comprehensive report on the 6 December 2016 inspection can be found by selecting the 'all reports' link for Wellside Surgery on our website at www.cqc.org.uk.

We undertook a focused inspection on 4 July 2017 to check they had followed their action plan and to confirm they now met legal requirements in relation to the breach identified in our previous inspection on 6 December 2016. This report only covers our findings in relation to those requirements.

Overall the practice remains rated as good.

Our key findings from this inspection were as follows:

- Improvements had been made to the system used to ensure that all prescriptions were signed before medicines were dispensed to patients.

- The practice had implemented a revised schedule of annual health reviews for patients with mental health concerns.
- Learning points from significant events were recorded effectively to allow for appropriate reflection. Significant events were subject to a regular review process to highlight the occurrence of any themes.
- Improvements had been made to how near misses in the dispensary were recorded and reviewed.
- The practice had made changes to how notes from safeguarding meetings were recorded to show a clear track record of decision making processes and actions taken.
- Members of staff we spoke with were aware of the emergency medicines held in the practice.
- The practice had developed an effective system to review and disseminate guidance and updates from the National Institute of Health and Clinical Excellence.

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?

Our focused inspection on 4 July 2017 found that:

- Improvements had been made to the system used to ensure that all prescriptions were signed before medicines were dispensed to patients.
- Learning points from significant events were recorded effectively to allow for appropriate reflection. Significant events were subject to a regular review process to highlight the occurrence of any themes.
- Improvements had been made to how near misses in the dispensary were recorded and reviewed.
- The practice had made changes to how notes from safeguarding meetings were recorded to show a clear track record of decision making processes and actions taken.
- Members of staff we spoke with were aware of the emergency medicines held in the practice.

Good



Wellside Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This focused inspection was completed by a CQC inspector.

Background to Wellside Surgery

Wellside Surgery is situated in Sawtry, Cambridgeshire. The practice provides services for approximately 7,400 patients. It holds a General Medical Services contract with Cambridgeshire and Peterborough Clinical Commissioning Group.

According to information taken from Public Health England, the practice population has a smaller percentage of patients aged 20 to 35 and a higher proportion of patients aged 40 to 74 in comparison to the national average for practices in England. The practice has a lower level of deprivation compared to the local CCG and national averages. Income deprivation levels affecting older people and children are lower than the national average.

The practice clinical team consists of six GP partners, four practice nurses and a healthcare assistant. The clinical team are supported by a practice manager, a managerial assistant, and teams of reception, administration, secretarial and dispensary staff. The practice has a dispensary and can dispense medicines to patients registered with them who live more than one mile from a pharmacy.

The practice is open from 8am to 6pm and offers appointments from 8.30am to 12pm and from 3pm to 5pm

Monday to Friday. On alternate Mondays and Tuesdays the practice offers appointments between 6pm and 8pm. Out-of-hours care is provided by Herts Urgent Care via the NHS 111 service. Appointments with GPs and nurses can be booked four weeks in advance.

Why we carried out this inspection

We undertook a comprehensive inspection of Wellside Surgery on 6 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good, with requires improvement for providing safe services. The full comprehensive report following the inspection on 6 December 2016 can be found by selecting the 'all reports' link for Wellside Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Wellside Surgery on 4 July 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

During our visit we:

- Spoke with the practice manager and dispensary/reception team.
- Reviewed recent significant events and minutes of recent meetings where these had been discussed.
- Reviewed minutes of recent safeguarding meetings.
- Reviewed minutes of recent partners meetings where guidance and updates from the National Institute of Health and Clinical Excellence were discussed.

Detailed findings

- Discussed the process used to ensure that prescriptions were signed before medicines were dispensed to patients.
- Reviewed the process for recording near misses in the dispensary on the practice computer system.

Are services safe?

Our findings

At our previous inspection on 6 December 2016 we rated the practice as requires improvement for providing safe services.

- The practice had written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed. However, repeat prescriptions were not consistently signed by GPs before they were given to the patient. We saw that the practice kept the unsigned prescriptions in a dedicated safe location and that these were signed at the end of the day.
- Dispensing errors were logged, reviewed to monitor trends and appropriate actions were taken to prevent similar errors occurring. However, when near misses occurred (an event not causing harm, but has the potential to cause injury or ill health), the practice did not maintain records containing sufficient details to allow for effective review or learning from these events.
- There was a system in place for reporting and recording significant events but recording of learning points needed to be improved. A regular review process for significant events was not in place.
- The GPs attended safeguarding meetings and always shared information where necessary for other agencies. When we reviewed minutes from these meetings we noted that these did not consistently provide continuous recordings of the action points discussed at the meetings.
- All staff received annual basic life support training and emergency medicines were accessible to staff in a secure area of the practice, although one of the receptionists could not show us where these were kept, other staff were aware.

These arrangements had improved when we undertook a follow up inspection on 4 July 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

Specifically designed forms were available to staff to report significant events. The forms included an area for recording the learning points raised from the incident. These were reported to the practice manager and shared with the GP partners. Significant events were discussed as a standing agenda item at regular staff meetings. Furthermore, all significant events were discussed in six monthly significant event meetings to monitor for reoccurring themes.

Overview of safety systems and processes

The practice had made changes to how notes from safeguarding meetings were recorded to show a clear track record of decision making processes and actions taken. For example, action points were clearly recorded to highlight any areas for change or further development.

Medicines Management

During this inspection we found that an effective system had been implemented to ensure all prescriptions were signed before medicines were dispensed to patients. A schedule was in operation to ensure that the duty doctor signed both repeat and acute prescriptions as and when required.

Dispensary staff recorded significant events and described a comprehensive system for their analysis and review. Dispensary staff used an error log to record near misses, which enabled the identification of errors for the analysis of trends and to avoid reoccurrence. Regular dispensary meetings were held with the GP lead for medicines management, which enabled dispensary staff to openly discuss any issues that they wanted to raise.

Arrangements to deal with emergencies and major incidents

Members of staff we spoke with were aware of the emergency medicines held in the practice.