Ashlea 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 13 November 2014. Breaches of legal requirements were found during that inspection within the safe domain. After the comprehensive inspection, the practice sent to us an action plan detailing what they would do to meet the legal requirements in relation to the following:

- Record all significant events and ensure that regular review meetings are held and documented to demonstrate that the practice had learnt from these and that findings are shared with relevant staff.
- Record all care plans onto patient electronic records in a way that allows for the sharing of information.

Our previous report also highlighted areas where the practice should improve:-

- Record minutes of reception staff meetings
- Record when staff have read and understood policies and procedures including when these are updated
- Ensure newly recruited staff sign a health declaration.
- Ensure all staff is offering the chaperone services to all patients.
- Ensure all staff complete training on safeguarding vulnerable adults.

We undertook this focused inspection on 14 July 2015 to check that the provider had followed their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

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

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

- Significant events were a standing agenda item for discussion at the practice meeting held every three weeks.
- Minutes were kept of the significant events meeting discussions and reflective learning was recorded.
- All care plans were recorded into the patients' electronic notes.
- Where specific information was needed for the patient, for example medication information, this was printed from the patient electronic record to give to the patient.
- The practice had organised chaperone training for staff. All staff who undertook chaperone duties would be subject to a criminal record check via the Disclosure and Barring Service.
- Most staff had completed training on safeguarding vulnerable adults and dates were in place for those that were yet to take place.

Summary of findings

- We saw that minutes of reception staff meetings were being recorded.

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 Good for delivering Safe services

At our last inspection we found that significant events were not being centrally recorded and although they were discussed at daily meetings, the meetings were not minuted. There was no evidence that significant events were used by staff for continuous learning. At this inspection we found that significant events were a standing agenda item for discussion at the practice meeting held every three weeks. Minutes were kept of the meeting discussions and reflective learning was recorded. A partner GP and the practice manager reviewed all significant events to ensure that no trends were emerging and that any relevant information was passed to staff for continuous learning. All significant events were recorded centrally and were sent to the local clinical commissioning group each year.

We also found at our previous inspection that some hand written care plans had not been updated on to patient's electronic records. At this inspection we found that all care plans were recorded into the patients' electronic record. Where specific information was needed for the patient, for example medication information, this was printed from the patient electronic record to give to the patient.

Ashlea Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 13 November 2015 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

Breaches of legal requirements were found. As a result we undertook a focused inspection on 14 July 2015 to follow up on whether action had been taken to deal with the breaches.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At our previous inspection we reviewed the annual summary of significant events which had recorded two significant events which had taken place over the last 12 months. However, after talking with the GPs it was recognised that significant events were taking place but were not being recorded in the annual summary. GPs we spoke with told us of other significant events which had been discussed at the GPs daily meetings and were used in their re-validation. GPs we spoke with told us discussion ensured that appropriate learning took place. However, the daily meetings were not recorded so we were unable to see evidence that findings were communicated to all relevant staff to allow for learning to be shared.

At this inspection we found that significant events were being centrally recorded and discussed at the three weekly practice meeting. We saw these meetings were minuted and that reflective learning was captured in the significant event record. The practice manager and one of the partner GPs told us that following our last inspection a meeting was held with the GPs to discuss significant events and re-enforce how these needed to be centrally recorded and discussed. Significant events were now a standing item on the agenda for the practice meetings and we reviewed past minutes of meetings which confirmed this. We also saw evidence that GPs were ensuring that appropriate learning was also recorded and where appropriate disseminated to relevant staff. The GP partner we spoke with informed us that they and the practice manager reviewed all significant events as they arose to ensure that there were no trends emerging. The practice manager informed us that a meeting was planned in October 2015 to review all significant events from the last year.

Reliable safety systems and processes including safeguarding

At our previous inspection we found that some hand written care plans had not been routinely recorded in to patient electronic records. There was a concern that actions agreed by the patient may be missed by other nurses or GPs by not being electronically recorded.

At this inspection we found that all patient care plans were recorded into patients' records. The practice had found that there was a training requirement for some staff who had been hand writing information, for example medication information, from the patient electronic record to give to the patient rather than printing out the information. After our previous inspection, the practice ensured that all staff were made aware of the need to ensure all information for patients was recorded within the patient electronic record. We were shown how the patient electronic record allowed you to print out the required section which could then be given to patients as required. We reviewed five patient records and saw that information relating to the care of the patient was adequately recorded.