The Woodland 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**
Are services well-led?	**Good**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focussed follow up inspection on 3 November 2016 to follow up on concerns we found at The Woodland Medical Practice on 25 February 2016. The inspection in November 2016 was to ensure that improvement had been made following our inspection in February 2016 when breaches of regulations had been identified. The inspection in February 2016 found breaches of regulation and rated the practice as requires improvement overall, specifically in safe and well-led services.

At the inspection on 3 November 2016 we found that overall the practice had implemented changes and that the service was meeting the requirements of the regulations. The ratings for the practice have been updated to reflect our findings following the improvements made since our last inspection in February 2016; the practice is now rated as good overall.

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

- The practice had in place and followed appropriate policies and guidance such as a cold chain policy and protocol.
- The policies were practice specific and reflective of the requirements of the practice to enable them to carry out their roles in a safe and effective manner including resetting fridge temperatures on a daily basis.
- The practice had robust systems and processes in place for safeguarding children, including implementation of and adherence to the practice's 'Safeguarding Children Action Plan'.
- The practice had robust systems in place for monitoring patients and the quality of care, including the implementation of and adherence to the practice's 'improvement plan for GSF meetings' and their 'shared care prescribing' plan.

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 providing safe services.

Our last inspection in February 2016 identified concerns relating to safeguarding and the cold chain process.

At this inspection we saw the concerns had been addressed:

- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Arrangements for maintaining the cold chain were robust.

Are services well-led?

Good

The practice is now rated as good for providing well-led services.

Our last inspection in February 2016 identified concerns relating to multi-disciplinary meetings and a lack of oversight and awareness regarding safeguarding children.

At this inspection we saw the concerns had been addressed

- Multi-disciplinary meetings were taking place quarterly for safeguarding and palliative meetings.
- The practice had a good awareness of safeguarding and had developed the policy and protocol for the identification of patients at risk.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Population group	Rating
Older people The practice is rated as good for the care of older people.	Good
People with long term conditions The practice is rated as good for the care of people with long term conditions.	Good
Families, children and young people The practice is rated as good for the care of families, children and young people.	Good
Working age people (including those recently retired and students) The practice is rated as good for the care of working age people (including those recently retired and students).	Good
People whose circumstances may make them vulnerable The practice is rated as good for the care of people whose circumstances may make them vulnerable.	Good
People experiencing poor mental health (including people with dementia) The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).	Good

The Woodland 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 advisor.

Why we carried out this inspection

We undertook an announced focussed inspection on 3 November 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection in February 2016 had been made. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting.

The focused inspection of this service was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection is planned to check whether the provider has made the necessary improvements and is meeting the legal requirements in relation to the regulations associated with the Health and Social Care Act 2008.

We have followed up to make sure the necessary changes have been made and found the provider is now meeting the regulations associated with the Health and Social Care Act 2008 included within this report.

This report should be read in conjunction with the full inspection report.

We inspected the practice against two of the five key questions we ask about services:

- Is the service safe?
- Is the service well led?.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 November 2016. During our visit we:

- Spoke with a range of staff.
- Requested information in relation to policies and procedures.
- Reviewed information given to us by the practice, including policies and procedures.
- Reviewed documents relating to safeguarding.

Good

Are services safe?

Our findings

When we inspected in February 2016 we identified concerns relating to safeguarding and the cold chain process.

At this inspection we found the practice had made significant improvements to address the concerns previously identified.

Overview of safety systems and processes

At the inspection in February 2016 we found that the arrangements for safeguarding children were not robust. There was not a clear system in place for monitoring children considered to be at risk. The practice had a register of 63 children coded as being a cause for concern but the lead GP for safeguarding was not aware of any of these children. There were three fridges in the practice used for the storage of vaccines. However we found that although the fridge temperatures were recorded on a daily basis the thermometer was not being reset in line with national guidance. The thermometer was not being regularly calibrated as was required if there was no secondary thermometer in use. We were informed subsequent to our visit that a secondary thermometer had been purchased. The practice had a protocol for refrigeration failure but it was not robust. It did not provide staff with sufficient guidance on what action to take in the event of a potential failure. There was no cold chain policy available on the day of our visit.

At this inspection we saw that there was a robust system for safeguarding children. The practice had identified children considered to be at risk and were holding meetings with health visitors at the practice quarterly to discuss any concerns. All staff we spoke with were aware of the safeguarding process and escalation process if they had any concerns. The practice had followed up children that had not attended hospital appointments. However this was not always documented fully in the patients notes.

The practice had implemented the new cold chain policy. Daily checks were performed on all fridges and we saw that these were recorded. The fridges were being reset in line with national guidance. The practice cold chain policy was detailed with named staff responsible for actions. The policy gave detailed guidance on what action to take in the event of a failure. The policy included telephone numbers of suppliers if there was a need to contact them. The practice had also developed a fridge protocol which gave guidance on all fridges in the practice on how to defrost and clean them and general health and safety.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Governance arrangements

At the inspection in February 2016 there was a lack of guidance or a policy regarding the maintenance of the cold chain within the practice. There was no structured or robust approach for dealing with safeguarding children or high risk medication prescribing. We found that there were limited structured multi-disciplinary team meetings taking place. For example relating to palliative care and safeguarding children.

At this inspection we saw detailed and practice specific policies for the cold chain, fridge management and the safeguarding process. Children at risk of safeguarding had been highlighted and coded as appropriate and multi-disciplinary meetings had commenced with health visitors attending to discuss children at risk of safeguarding.

Processes were in place for handling repeat prescriptions which included the review of high risk medicines.

Palliative meetings were also in place and held quarterly and the practice were now completing after death reviews to ensure appropriate care was provided and to see if there was any learning to be gained.