Dudley Urgent Care Centre

Quality Report

Dudley Urgent Care Centre
Russells Hall Hospital
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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 previously carried out an announced comprehensive inspection of Dudley Urgent Care Centre on 28 June 2016. The overall rating for the practice was good with requires improvement for providing a safe service. The full comprehensive report on the 28 June 2016 inspection can be found by selecting the 'all reports' link for Dudley Urgent Care Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 10 October 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the areas identified at our previous inspection on 28 June 2016. This report covers our findings in relation to those requirements.

Our key findings were as follows:

- A system had been implemented to ensure that learning from significant events was communicated to all staff as well as to external stakeholders and healthcare professionals.
- The reporting process for significant events had been improved to make it more readily available to all staff.
- The lead nurse was the appointed lead for infection prevention and control. External auditors were used to monitor standards and best practice.
- A formalised process had been implemented to ensure that controlled medicines required for a palliative care patient during the out of hour's period were easily accessible to staff.

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 rated as good for providing safe services.

- A system had been implemented to ensure that learning from significant events. A total of 13 incidents had been reported since January 2017. Details of incidents, together with learning outcomes, were made available to all staff. We saw that events were reported and learning shared with external stakeholders and healthcare professionals including the NHS 111 service provider and the Clinical Commissioning Group (CCG).
- The reporting process for significant events had been improved to make it more readily available to all staff. All staff including locum GPs and nurses had access to a standard reporting form.
- The lead nurse was the appointed lead for infection prevention and control. Internal audits were carried out every three months and external auditors were used to monitor standards and promote best practice.
- A formalised process had been implemented with the hospital pharmacy based on the same site to ensure that controlled medicines required for a palliative care patient during the out of hour's period were easily accessible to staff.

Dudley Urgent Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and included a second inspector.

Background to Dudley Urgent Care Centre

Dudley Urgent Care Centre is situated in Russells Hall Hospital which is based in the Dudley area of the West Midlands. The service provides urgent care and out-of-hour GP services for its member practices.

Data provided by the service indicated that between April 2015 and April 2016 approximately 12,420 calls were streamed in the Out of Hours service and approximately 85,580 cases were dealt with across the urgent care and Out of Hours service.

The Urgent Care Centre offers non-emergency care for walk-in patients with minor illnesses and injuries that need urgent attention. These services are available to patients 24 hours a day, seven days a week. Patients can attend the Urgent Care Centre directly which is accessed through the Emergency Department at the hospital. Patients can also be referred to the Urgent Care Centre by the NHS 111 service. NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately met their needs.

The out of hour's service is available for registered patients from all member practices within the Dudley Clinical Commissioning Group (CCG) area. The department for out of hour's care is also situated at the Urgent Care Centre.

This service is operational on evenings from 6:30pm through to mornings until 8am and for 24 hours during weekends and bank holidays. Patients access the out of hour's service through the NHS 111 telephone number.

The service has approximately 70 staff some of which are directly employed with the organisation. GPs work for the service on a self-employed basis. The local management team consists of an urgent care lead (director), an education and nurse lead, a GP lead and a service manager. The clinical team consists of male and female GPs, advanced nurse practitioners and health care assistants. The service is supported by a team of 19 non-clinical staff members who cover a mixture of reception, administration, IT and driving duties.

The service also provides training opportunities in the out of hour's period for GP registrars, pre-registration nurses and undergraduate pharmacy students.

Why we carried out this inspection

We previously undertook a comprehensive inspection of Dudley Urgent Care Centre on 28 June 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 in providing a safe service. The full comprehensive report following the inspection on 27 July 2016 can be found by selecting the 'all reports' link for Dudley Urgent Care Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Dudley Urgent Care Centre on 10 October 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

Detailed findings

the practice 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.

How we carried out this inspection

Before our inspection we reviewed a range of information we held about the practice.

During our inspection we:

- Spoke with the GP lead, the nurse lead and the service manager.
- Checked documents that contained records of safety checks carried out.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

At our previous inspection on 28 June 2016, we rated the practice as requires improvement for providing safe services. This was because:

- Significant events, although discussed, had not always been shared widely enough to minimise the risk of reoccurrence.
- Formal reporting processes were not fully embedded in the service so that staff felt confident to formally report concerns when things go wrong.
- There was no lead in place to manage infection control concerns and promote best practice infection control standards.
- Key processes were not formalised and easily accessible to staff in the event that controlled medicines were required for a palliative care patient during the out of hour's period.

We found arrangements had significantly improved when we undertook a follow up inspection of the service on 10 October 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and processes

During the June 2016 inspection we found that significant events were verbally reported to a member of the management team but staff did not readily have access to a template for recording an event. The provider had recognised that the system did not promote the recording of events by individuals due to the diversity of working hours required to staff a 24 hour, seven day a week operation. A significant event template had been made available electronically to all staff and was placed on each home screen for ease of access. We saw that 13 incidents had been recorded between January 2017 and September 2017; these included any complaints that were recorded as significant events. We saw that members of staff had completed forms individually and others had reported events to the lead nurse who subsequently completed a significant event written record. An electronic list of all recorded events was available to each staff member together with a summary of the discussions and shared learning. The complexity of the shift patterns made it difficult to hold full staff meetings but a monthly staff newsletter had been introduced to improve communication and outline key themes from shared learning. In addition the provider planned to introduce an electronic system for reporting and sharing significant events.

The provider had established communication with external stakeholders and associated healthcare professionals to develop a network of shared learning. There was a standard form completed to report any inappropriate referrals to the NHS 111 service. We were told that any concerns over clinical competency or malpractice were reported to the General Medical Council if it involved a GP or to the Nurse and Midwifery Council if it involved a nurse. The provider was engaged with the Urgent Care Alliance (UCA) a group of providers based in the West Midlands who held monthly meetings for general discussion and quality improvement.

The lead nurse was the appointed lead for infection prevention and control (IPC), and had received training specific to the role and ongoing support from IPC leads within Russells Hall Hospital Trust. Regular internal monitoring systems were in place. For example; hand hygiene audits were carried monthly and internal audits to monitor all IPC standards were carried out every three months. In addition, external auditors were used to monitor standards and promote best practice. The most recent audit had been carried out in September 2017. There had been two minor actions for improvements, both had been completed.

The provider had reviewed arrangements for access to controlled medicines that could be required for patients nearing the end of life. A formalised process had been implemented with the hospital pharmacy based on the same site to ensure that controlled medicines required for a palliative care patient during the out of hour's period were easily accessible to staff. Staff had telephone access to one of the hospital on-call pharmacists, based at the hospital, and available 24 hours a day, seven days a week and 365 days a year.