Woden Road Surgery

Quality Report

The Surgery
Wolverhampton
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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 at Woden Road Surgery on 15 August 2016. The overall rating for the practice was Good with Requires Improvement for providing safe services. The full comprehensive report on the August 2016 inspection can be found by selecting the 'all reports' link for Woden Road Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 28 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach in regulation that we identified at our previous inspection on 16 August 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

Our key findings were as follows:

- There was an open and transparent approach to safety and there was a system in place for reporting and recording significant events. The provider had reviewed how they shared the outcome and learning from significant events. Information was shared at monthly staff specific meetings. The sharing of information and learning could be further improved by periodically discussing all significant events that have occurred with the whole staff team.
- Risks to patients were assessed and well managed. Improvements had been made to the management of high risk medicines and recruitment procedures. Systems were in place for monitoring and review of prescriptions that had not been collected.

We also saw the following best practice recommendations we previously made in relation to providing safe, caring and responsive services had been actioned:

- The provider had introduced a system for checking the cleanliness of the patient facilities through out the day.
- Staff had attended fire safety, health and safety and basic life support training and to provide them with the skills needed to deal with unexpected emergencies.
- The provider had reviewed practices around maintaining confidentiality in the reception area. Notices were displayed to inform patients that they could request to speak with a member of staff in private if they wished to.

Summary of findings

- The provider had removed the book for recording complaints and concerns from the reception area. Patients wishing to raise concerns were encouraged to put their concerns in writing or offered the opportunity to speak with the business manager.
- Information about registering as a carer was displayed in the waiting room, in addition to information signposting carers to support services. The provider had increased the number of carers identified from 0.7% to 1.2% of the practice list.
- The provider had reviewed access to the building for patients with mobility difficulties. The external door was left open throughout the day, with notices asking patients not to close the door. A door bell to alert staff that a patient needed assistance was in place by the external door with a prominent notice informing patients to ring for assistance. The provider was in the process of obtaining quotes for the installation of an automatic door.

However, there were still areas of practice where the provider could make improvements.

The provider should:

- Consider periodically discussing all significant events that had occurred with the whole staff team.
- Consider discussing medicine and safety alerts at a central forum and recording actions taken on a central log.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Improvements had been made in the standard of cleanliness. The practice had introduced a system for checking the cleanliness of the patient facilities throughout the day and staff had received training in infection control.
- Improvements had been made to the management of high risk medicines and uncollected prescriptions.
- Staff had attended fire safety, health and safety and basic life support training to provide them with the skills to deal with unexpected emergencies.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

Consider periodically discussing all significant events that had occurred with the whole staff team.

Consider discussing medicine and safety alerts at a central forum and recording actions taken on a central log.

Woden Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist advisor.

Background to Woden Road Surgery

Woden Road Surgery is registered with the Care Quality Commission (CQC) as a partnership. The practice is close to main transport links for patients travelling by public transport. Parking is available for patients travelling by car. The practice is a two storey building with access for patients on the ground floor.

The practice team consists of four GP partners and two salaried GPs, three male and three females. The GPs are currently supported by two practice nurses and an assistant practitioner (healthcare assistant). Clinical staff are supported by a business manager, an office assistant, a medical secretary and six medical receptionists. The practice is a training practice for medical students, medical graduates and GP registrars.

The practice is open between 8.50am and 6.15pm Monday, Tuesday and Wednesday, 8.50am to 1pm on Thursday and Friday 8.50am to 6pm. The practice telephone lines are open at 8.30am. Appointments times with a GP are Monday to Friday 9am to 11am, Monday and Wednesday 3.30pm to 6pm, Tuesday 3pm to 6pm and Friday 3pm to 5.30pm. Appointments with a practice nurse are available Monday to Friday 9am to 11am, Monday, Tuesday and Wednesday 3.30pm to 6pm and Friday 3pm to 5.30pm. This practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to Wolverhampton Doctors on Call Limited when the practice is closed at lunchtime and on a Thursday afternoon. At all other times when the practice is closed, the patients are directed to the out of hours service Vocare via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 6,670 patients. It provides Directed Enhanced Services, such as childhood vaccinations and immunisations and minor surgery. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The level of income deprivation affecting children of 37.5% is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (35% compared to 16%).

Why we carried out this inspection

We undertook a comprehensive inspection of Woden Road Surgery on 16 August 2017 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 in August 2016 can be found by selecting the 'all reports' link for Woden Road Surgery on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Woden Road Surgery on 28 June 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

We carried out an announced focused inspection of Woden Road Surgery on 28 June 2017. During our visit we:

- Spoke with a range of staff including one of the GP partners, practice nurse, business manager and reception staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed significant event records.

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 15 August 2016, we rated the practice as requires improvement for providing safe services. This was because:

- Adequate arrangements were not in place for the proper and safe management of medicines.
- Not all appropriate employment checks had been completed for all staff employed.

Improvements were also required around the time taken to share the outcome of significant events, the cleanliness of patient facilities and staff training to deal with unexpected emergencies.

These arrangements had significantly improved when we undertook a follow up inspection on 28 June 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of seven documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports and minutes of meetings where significant events were discussed. The practice had carried out a thorough analysis of the significant events.
- We saw that improvements had been made to the time taken to share the outcome and learning from significant events. Staff told us that significant events were discussed at the monthly staff specific meetings. They told us the discussions were open and transparent, which enabled learning from the incident to take place. We found the sharing of information and learning could be further improved by periodically discussing all significant events that have occurred with the whole staff team.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient had requested that a prescription for a specific medication was to be collected in person rather than sent to the pharmacy via the electronic system. The prescription had been generated ready for collection but had inadvertently been sent to the pharmacy with other prescriptions collected by their representative. Following this incident all prescriptions for collection in person were stored separately from prescriptions for general collection.
- The business manager received medicine and safety alerts and disseminated these to relevant staff. There was evidence to support that these had been appropriately actioned. We saw that alerts had been seen, read and acted upon by appropriate staff. The GP spoken with demonstrated a good knowledge of recent alerts received at the practice. The process could be further strengthened by discussing alerts at a central forum and recording actions taken on a central log.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP partners was the lead member of staff for safeguarding. From the one documented example we reviewed we found detailed clinical notes, interaction with other agencies, a holistic approach to care, appropriate referral and active review of the case.
- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. Although regular meetings did not take place to discuss any child or families at risk, staff told us they were able to contact the health visitors to discuss any concerns. The practice nurses told us they routinely discussed children who did not attend for their immunisations with the health visitors.

Good

Are services safe?

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three and practice nurses to level two.
- The practice told us they had introduced a system to follow up children who did not attend hospital appointments. Letters notifying the practice of non attendance were passed to the administration team, who tried to make contact with the family. The practice also ran periodic searches of children on the safeguarding register to check their notes for any non attendance at hospital or the practice.
- A notice in the consulting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We saw improvements had been made in the standard of cleanliness. We observed the premises to be clean and tidy. The practice had introduced a system for checking the cleanliness of the patient facilities through out the day. There were cleaning schedules and the practice told us the cleaning company carried out monitoring visits. The practice told us they had requested copies of these reports.
- The practice nurses were the infection prevention and control (IPC) clinical leads. There was an IPC protocol in place. We saw that since the last inspection all staff had received up to date training. Annual IPC audits were undertaken by an external company. The most recent audit had been carried in May 2017 and the practice was waiting to receive the report.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- We found that improvements had been made to the management of high risk medicines and uncollected prescriptions.
- The practice had introduced a process for ensuring high risk medicines were monitored and that patients had regular reviews and blood monitoring. We reviewed the notes for six patients prescribed two different high risk medicines. We saw that the prescribing was in line with current guidelines and there was evidence of up to date monitoring of blood results.
- A system had been introduced for monitoring the destruction of uncollected prescriptions. Reception staff sorted out any prescriptions that had not been collected within the previous three months. These were given back to the prescribing GP for review and agreement to destroy. Reception staff recorded the information in the patient notes, and noted down how many prescriptions had been destroyed. When prescriptions for controlled medicines (medicines that require extra checks and special storage because of their potential misuse) were destroyed, the prescription number was also recorded.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. These were available to view at the time of this inspection and we saw they had been signed by the practice nurses and a GP partner.

The practice had not recruited any new staff since the previous inspection. We reviewed the staff file that was looked at during the previous inspection and found that all of the outstanding information (the references) had now been obtained. We looked at the file for the locum GP used by the practice and found that appropriate information such as the Disclosure and Barring Service (DBS) check, immunity status, evidence of qualifications and inclusion on the performers list, and ongoing training was available.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. The most recent fire drill had been carried out in June 2017.
- The practice did not have a fire alarm system but used a tannoy system to alert staff and patients to an emergency. Since the last inspection the practice had

introduced a system to check the carbon monoxide and smoke detectors on a monthly basis, to ensure they were in good working order. The fire risk assessment had been updated in September 2016.

- We saw that since the previous inspection staff had been attended fire safety training in October 2016. Staff had also attended health and safety training.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Clinical staff received annual basic life support training and non clinical staff received updated every two or three years. Emergency medicines were available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We noted that although two oxygen cylinders were available, one of the cylinders was less than 50% full.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.