Langley Corner Surgery

Quality Report

Ifield Green
Crawley
West Sussex
RH11 0NF
Tel: 01293 514340
Website: www.langleycornersurgery.co.uk

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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

Key findings

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Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Langley Corner Surgery on 16 February 2016 and a focused follow up inspection on 22 June 2017. The practice was rated good overall. However, we found that the practice continued to require improvement for the provision of safe services because breaches of regulation were identified. The full comprehensive reports on the inspections can be found by selecting the 'all reports' link for Langley Corner Surgery on our website at www.cqc.org.uk.

Specifically, we said they must:

- Ensure they record adequate details of investigations carried out on significant events to support the requirements of their duty of candour.
- Ensure the learning points from investigations into significant events were shared with all appropriate staff.

In addition we said the provider should:

- Ensure all staff receive training in Information Governance appropriate to their role.
- Ensure action plans produced as part of the infection control process, including waste management, are monitored to help identify when agreed actions have been completed.
- Ensure they have adequate systems for checking the emergency medicines in their branch practice.

After the previous focused inspection on 22 June 2017, the practice wrote to us to say what they would do to meet legal requirements. We undertook this focused inspection on 13 February 2018 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

Overall the practice continues to be rated as good and is now good in the safe domain.

Our key findings for this inspection were as follows:

- The practice had reviewed and updated their significant events policy and the incident recording form, which had been improved to include all details of the event through to learning points and a specific question regarding duty of candour. We saw examples where the practice had taken appropriate action under the duty of candour and had thoroughly recorded such events.
- Learning points from investigations were shared with all staff within a weekly practice meeting where all staff where expected to attend. Minutes were circulated to all staff following the meeting.
- We saw evidence that the practice had started a process to conduct six monthly reviews of all learning points and changes of policy, which was shared with all staff.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Langley Corner Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector.

Background to Langley Corner Surgery

Langley Corner Surgery is located in a residential area of Crawley and provides primary medical services to approximately 9,900 patients. The practice also provides care and treatment for the residents who are registered at the practice and who live in two nearby care homes, which serve individuals with a diagnosis of dementia or who have nursing care needs.

Services are provided from two locations, the main practice building at:

• Langley Corner Surgery, Ifield Green, Crawley, West Sussex, RH11 0NF.

And the branch surgery at:

• Ifield West Community Centre, Dobbins Place, Ifield, Crawley, RH11 0SZ

There are five GP partners and three salaried GP (three male, five female). The practice is registered as a GP training practice, supporting medical students and providing training opportunities for doctors seeking to become fully qualified GPs.

There are six female members of the nursing team; three practice nurses and three health care assistants. GPs and nurses are supported by the practice manager and a team of reception/administration staff.

Data available to the Care Quality Commission (CQC) shows the practice serves a higher than average number of patients who are aged 0 to 18 when compared to the national average. The number of patients aged 65 and over is also slightly above the national average. The number of registered patients suffering income deprivation is below the national average.

The main practice is open from Monday to Friday between 8:30am and 6:30pm.

Extended hours appointments are offered every Monday from 6:30pm to 8pm, and Tuesday to Friday from 7:30am to 8:30am. The Ifield West surgery is open every Monday from 2:30pm to 5:30pm, and Wednesday and Friday from 9:30am to 12:30pm. An emergency telephone service is provided between 1pm and 2pm.

Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hours service by calling the surgery or viewing the practice website.

The practice runs a number of services for its patients including; family planning, chronic disease management, minor surgery, health checks, smoking cessation, and holiday vaccines and advice.

Why we carried out this inspection

We undertook a comprehensive inspection of Langley Corner Surgery on 16 February 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall but required improvement for providing safe services. The full comprehensive report following the inspection can be found by selecting the 'all reports' link for Langley Corner Surgery on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Langley Corner Surgery on 22 June 2017 but found that improvements were still required for the safe domain. We therefore carried out a further follow up focused inspection on 13 February 2018 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.

Good

Are services safe?

Our findings

At our previous inspection on 22 June 2017, we rated the practice as requires improvement for providing safe services as we found that significant events were not always adequately recorded and shared with all staff.

These arrangements had significantly improved when we undertook a follow up inspection on 13 February 2018. The practice is now rated as good for providing safe services.

Safety systems and processes

At this inspection we found that the practice manager maintained a training matrix and was able to see the staff training and the dates these were completed. The system easily showed when training was overdue and a reminder was sent to the staff member four weeks before the required update. We found that all staff had completed Information Governance training. All staff had access to on line training which covered all of their mandatory training.

The practice told us that since our last inspection the infection control lead had been allocated the actions arising from audits to ensure completion. We saw from three recent audits that all actions had been completed, or were part of long term planning. Two weeks prior to this inspection the practice had commissioned a waste audit but had not yet received a report.

At the previous inspection we found that the practice system for checking the emergency medicines available in their branch surgery was inconsistent. At this inspection we saw evidence that the practice nurses now used a log book of medicines at the practice, which included medicines that were kept in a box used for the branch surgery and those in doctors' bags. Medicines that had been used were logged to ensure they were replaced. We also saw they had updated the Emergency Drugs policy and had conducted a risk assessment for each medicine.

Lessons learned and improvements made

At the previous inspection we found that the practice did not record adequate details of investigations carried out. This included that no evidence was found to demonstrate the practice had considered what action they might be required to take or had taken under their 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). We also found that the practice had not taken adequate action to ensure that learning points were shared with all appropriate staff.

At this inspection:

- We saw that the practice had reviewed and updated their significant events policy. They had created a policy database, which enabled all staff to easily access all policies and showed when they were due for review. They had also updated their incident recording form to include all details of the event through to learning points. The form now supported the recording of notifiable incidents under the duty of candour, with the addition of a specific question to document whether there was a possible issue of duty of candour. The form included a definition of a notifiable safety incident to assist staff. Staff were directed to discuss with the senior partner or practice manager immediately if such an event occurred.
- Staff told us they would inform their line manager of any incidents and there was a recording form available on the practice's computer system. They told us they were a lot more involved with the process since our last inspection, for example they were encouraged to raise new significant events and enjoyed taking part in the learning discussions. Staff and management told us they felt the new process had improved working practices between non-clinical and clinical staff.
- The practice told us they carried out a thorough analysis of significant events that were fully discussed in a weekly practice meeting. They had opened this meeting to all staff, who were expected to attend. They told us the practice closed, with an emergency line used, for the meeting to ensure all staff were given opportunity to attend. We saw that significant events were a standing agenda item and any actions arising from such events were reviewed at each meeting to ensure completion. All minutes were held electronically and hard copy to enable staff who were not present to review the discussion. They told us they sent the minutes to all staff via a notification on their computer system by the Monday following the meeting. We saw evidence that the minutes of the most recent meeting on 9 February 2018 had been circulated in this manner.

Good

Are services safe?

- New significant events were added to a waiting list on the system with a summary of the event and this was monitored by the senior partner. This meant they could be actioned and added to the agenda for the forthcoming practice meeting. The senior partner had overall responsibility for ensuring that all significant events were recorded, investigated, and acted on in a timely manner.
- The practice maintained a separate register of completed significant events, which included summarised details of the actual event, the discussion learning points and actions taken. During the inspection the practice identified that their processes could be streamlined further by including new or in progress significant events onto the register. We reviewed three significant events that the practice had recorded since our last inspection. We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, 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 also reviewed the most recent practice meeting minutes, where we saw these had been discussed in order to share learning amongst all practice staff.
- We saw examples where the practice had taken appropriate action under the duty of candour and had thoroughly recorded such events. For example, a patient was prescribed medicine during a review by the practice during a home visit and was later admitted to hospital where the medicine was continued. As a result the amount of medicine taken was over the safe limit and the patient suffered a serious complication. We saw that the practice recorded this as a significant event, had sent a letter of apology to the patient, and thoroughly investigated what had happened. As a result, the practice updated the appropriate review form on their practice computer with additional risk information and included an information leaflet to be given to patients at the time of prescribing this medicine. The practice also conducted a search of all patients prescribed this medicine and ensured they had been given appropriate information about the risks. Additionally, the senior partner visited the patient to explain what had happened and what action was taken to improve safety at the practice. This event was also discussed with staff for learning, with guidance on home visits in these circumstances, in their practice meeting. The practice updated the hospital with the actions they have taken following the significant event investigation.
- Following our last inspection the practice told us they would conduct six monthly reviews of all learning points and changes of policy. The summaries would then be circulated to all staff. At this inspection we saw the practice had conducted their first review as of February 2018. They felt it had been a useful tool to ensure all actions had been completed and to reflect on changes at the practice.