Fitzalan Medical Group

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	Inadequate
Are services safe?	Inadequate

Summary of findings

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Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Fitzalan Medical Group on 19 December 2017. The overall rating for the practice was inadequate. The full comprehensive report on the December 2017 inspection can be found by selecting the 'all reports' link for Fitzalan Medical Group on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 1 February 2018 to confirm that the practice was compliant with a warning notice issued following the December 2017 inspection. A warning notice was issued against regulation 12 (1) (safe care and treatment) and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report covers our findings in relation to the requirements against regulation 12 (1) (safe care and treatment).

The ratings remain unchanged from the December 2017 inspection as the purpose of the February 2018 inspection was to review compliance against the warning notice issued.

Our key findings were as follows:

- Systems for managing medicines had improved, including improvements to the safety of repeat prescribing practices.
- Medicines prescribed to patients were being regularly reviewed to support treatment, optimise their impact and improve safety.
- The practice had improved the monitoring processes to ensure that blood tests had been carried out prior to the prescription of high risk medicines.
- The practice had made improvements to the tracking of blank prescriptions and the safe storage of medicines. Patient group directions (PGDs) were appropriately authorised.
- Patient medicine and safety alerts were acted on, and the actions taken were recorded.
- There was improved monitoring of emergency medicines and a broader range of emergency medicines were available to address the types of emergencies the practice may face.
- There was improved monitoring of the vaccine fridges. Training for staff on this process had also been undertaken.
- There were improved checks and follow up for patients following abnormal blood results or action required from correspondence received.
- There was a clear infection control action plan that included risk assessments and timescales for action.

However, there were also areas of practice where the provider needs to make improvements.

- Patients on blood thinning medicines did not always have their blood test results reviewed prior to repeat medicines being prescribed.

Importantly, the provider must:

Summary of findings

- Ensure that care and treatment is provided in a safe way to patients.

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

Summary of findings

The six population groups and what we found

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

Older people	**Inadequate**
People with long term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Fitzalan Medical Group

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 adviser, a second CQC inspector and a member of the CQC medicines team.

Background to Fitzalan Medical Group

The practice is situated near the centre of Littlehampton, West Sussex, and provides general medical services to approximately 17,075 patients. The patient list was capped at the time of inspection. In October 2016 the practice took on 2,500 additional patients following the closure of a neighbouring practice. There are four GP partners (male and female) and seven salaried GPs (male and female). The practice also employs three paramedic practitioners, a nurse practitioner, seven practice nurses and three health care assistants.

Opening hours are Tuesdays, Thursdays and Fridays 8.00am to 6.30pm and Mondays and Wednesdays 8.00am to 8.00pm. The practice also provides nurse and health care assistant

appointments from 7.30am on Thursdays. The practice provides a wide range of services to patients, including asthma and diabetes clinics, chronic disease monitoring, cervical screening, childhood immunisations, family planning, smoking cessation and minor illness clinics. Ear, nose and throat and nephrology clinics were hosted by the practice.

The practice has a contract with NHS England to provide general medical services. The practice has a higher than national average percentage of its population over the age of 65. It also has a higher than local and national average percentage population with income deprivation affecting children and older people. The practice serves a high number of registered patients from Eastern Europe.

The practice provides a service to all of its patients at two locations :-

Fitzalan Road,

Littlehampton

BN17 5JR

and,

Wick Surgery

66 Clun Road

Littlehampton

BN17 7EB

Our inspection was undertaken on the practice premises at Fitzalan Road.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

Why we carried out this inspection

We undertook a comprehensive inspection of Fitzalan Medical Group on 19 December 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate.

Detailed findings

The full comprehensive report following the inspection on 19 December 2017 can be found by selecting the 'all reports' link for Fitzalan Medical Group on our website at www.cqc.org.uk.

We undertook a follow up warning notice focused inspection of Fitzalan Medical Group on 1 February 2018.

This inspection was carried out to review compliance and action taken by the practice against a warning notice issued in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to confirm that the practice was now meeting legal requirements.

Inadequate

Are services safe?

Our findings

At our previous inspection on 19 December 2017, we rated the practice as inadequate for providing safe services as arrangements for the safe and appropriate use of medicines, cleanliness and infection control and safety systems and processes were not adequate.

These arrangements had improved when we undertook a follow up inspection on 1 February 2018. We found that the practice had taken action against all areas of the warning notice issued following the December 2017 inspection. However, the monitoring of patients receiving warfarin therapy still required improvement. The ratings remain unchanged from the December 2017 inspection as the purpose of the February 2018 inspection was to review compliance with the requirements of the warning notice.

Safety systems and processes

During our comprehensive inspection on 19 December 2017 we found that while infection control audits had been carried out, there was no clear action plan with timeframes for action to be taken.

On 1 February 2018 we found that the infection control audit had been reviewed and that a clear action plan was in place with dates for review. The practice had incorporated a risk matrix into the process so that action planning was prioritised based on the level of risk. Where an action was not able to be taken ways to mitigate the risk were identified.

Information to deliver safe care and treatment

During our comprehensive inspection on 19 December 2017 we found there was no formal or consistent system for ensuring abnormal blood results were acted on or that action was taken in response to correspondence received. Patients with abnormal results were contacted and asked to attend for appointments, however if they did not attend, follow up was dependent on the actions of individual practitioners as there was no practice wide system in place to ensure this happened.

On 1 February we found that the practice had improved their system for safety netting of abnormal blood results and actions required from correspondence. For example, we saw that GPs tasked reception staff to arrange appointments following the receipt of abnormal results or information from correspondence. Reception staff arranged appointments with patients and there was a system in place to ensure those that did not attend were followed up.

Safe and appropriate use of medicines

During our inspection on 19 December we found that the practice did not have reliable systems for appropriate and safe handling of medicines.

- There was no system in place for tracking blank prescriptions within the practice and the need for this was not included in the prescription security protocol for the practice. Boxes of prescriptions were regularly transferred to the branch practice without records of batch numbers being recorded. On 1 February we found that the system for tracking blank prescriptions had improved and that records of batch numbers were now recorded. We saw that prescriptions were stored securely in a locked filing cabinet in the dedicated prescriptions team office. We saw that the key was kept in a key lock in another room (the nurses' office) and that records of prescriptions coming in and being used were kept. Prescriptions pads (for handwritten prescriptions) were kept in a separate drawer; this was also locked, but records were not kept on their usage. The practice extended their audit processes to include the prescription pads during the course of our inspection.
- On 19 December we found that re-authorisation of repeat prescriptions was undertaken by clerical staff without having procedures in place to ensure medicines were safe and appropriate to continue. Repeat prescriptions were not being prepared in line with the practice's repeat prescription and medication review protocol, and we saw continued prescribing of repeat medicines despite outstanding monitoring or review and no evidence of clinical decision making. On 1 February 2018 we found that a new repeat prescriptions and medication review protocol had been written and introduced at the practice and that prescription re-authorisation was now only carried out by GPs. A new system had recently been introduced which involved the clerical prescriptions team using the electronic system to issue and track prescribing queries. This meant that if a repeat request was received for a medicine which had exceeded its authorised number of

repeats then a message was sent to the patient's own doctor or, if they were away, another available doctor. This was then answered or actioned by the doctor. We saw evidence of use of this new messaging system within the practice's workflow. A colour-coded system was in use to help identify whether the prescription has been authorised and/or issued. We saw that this was on the agenda of the clinical meeting the day after inspection to discuss and address teething problems with the new system.

- On 19 December 2017 we found that medicines were not being regularly reviewed, to support the patient with their treatment, optimise the impact of their medicines and ensure they were still safe. There was a backlog of more than 2,800 medicine reviews. On 1 February 2018 we saw that very few patients at the practice were still overdue a review of their medicines. We reviewed records of three recently completed clinical medicine reviews and saw that these had been carried out appropriately. One GP partner described a process for prioritising medicine reviews in the future as well as the future development of a medicines review template
- On 19 December 2017 we found that appropriate therapeutic monitoring of patients prescribed high risk medicines was not being carried out consistently. We saw that patients prescribed medicines requiring regular monitoring, were not always being monitored to ensure the medicine was still safe. On 1 February we found that monitoring of high risk medicines had improved in some areas. We saw evidence that recall searches had been run weekly for high risk medicines and the prescribing team manager would check that those patients had blood tests completed. However, we found that patients prescribed warfarin (a blood thinning medicine) were not consistently having their blood test results reviewed clinically prior to prescribing. GPs we spoke with told us that the blood results were not available through their electronic patient record system. However, during the course of the inspection it became apparent that these results were available through another system within the practice, but that the clinicians were unaware and not reviewing these results before prescribing warfarin.
- On 19 December 2017 we saw that national patient and medicine safety alerts were received by the practice and we were told these were cascaded to clinical staff by the practice manager to relevant staff. However, we found there was no system in place to ensure or record action taken as a result of the alert or a record to indicate that no action had been required. On 1 February 2018 we saw that information about alerts was retained on a spreadsheet with information about action and discussions/cascade of information was recorded. For example, we saw a record that the practice had checked their oxygen cylinders following an alert and had amended their policy to ensure all staff were aware of the process for checking the oxygen flow from the cylinder.
- On 19 December we found that emergency medicines within the practice did not include those for use in the event of a patient experiencing an epileptic seizure, acute pain, heart failure or croup. There was no risk assessment relating to this to identify which types of emergency medicines were required, and those that were not, based on the risks within the practice. Monitoring of emergency medicines and equipment was inconsistently recorded. On 1 February we found that the practice had made changes to their emergency medicine stock to include medicines for epileptic seizures, acute pain, heart failure and croup. They had made improvements to monitoring and were in the process of carrying out risk assessments relating to the use of emergency medicines and the type of situations that may occur.
- On the 19 December 2017 we found that the vaccine fridge at Wick Surgery was not checked on a daily basis when the surgery was open and temperature records showed a number of gaps in temperature recordings. On 1 February 2018 we found that the practice had implemented a system where administrative staff at Wick Surgery checked the temperature of the vaccine fridge on a daily basis. They had received training on how to do this and we viewed records to demonstrate that the daily checks were in place. On the 19 December 2017 we found that temperature records of vaccine fridges at Fitzalan Road showed that one of the fridges had a maximum temperature record that was sometimes out of the recommended range, although nursing staff had sought advice from the fridge manufacturer to assure themselves that the actual temperature had been maintained within the recommended range. We were told that the issue was because not all nurses were familiar with a new fridge thermometer and how to read it correctly. This had been identified as a training need although had not been addressed at the time of inspection. On 1 February

we were told that the practice had been in touch with the fridge manufacturer who had carried out a health check on the fridge and had discovered that the practice had been given the wrong fridge instructions. The correct instructions were seen to be in place at the time of our focused inspection and all relevant staff had received training on the appropriate method for recording the fridge temperature.

- On 19 December 2017 we found that patient group directions (PGDs) had not been appropriately authorised as they did not detail the name of the practice in which they were adopted. On 1 February we saw that all PGDs included the name of the practice recorded clearly.
- On 19 December 2017 we found that medicines were not always stored securely. A set of drawers used to store stock medicines was found to be unlocked with the key left in the lock. On 1 February we found that all stock medicines had been moved into a lockable office with a key code and that medicines were stored securely.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** **Blood test results for patients prescribed blood thinning medicines were not always reviewed clinically prior to repeat prescribing of the medicine.** Regulation 12 (1)