Quincy Rise Surgery

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Quincy Rise Surgery across two dates on 9 March and 4 April 2016. Breaches of legal requirements were found and after the comprehensive inspection we issued the following warning notices:

- A warning notice informing the practice that they were required to become compliant with specific areas of Regulation 12: safe care and treatment HSCA (RA) Regulations 2014, by 17 July 2016.
- An additional warning notice informing the practice that they were required to become compliant with Regulation 17: Good governance HSCA (RA) Regulations 2014, by 6 September 2016.

Summary of findings

The practice wrote to us in response to the warning notices to say what they would do to meet legal requirements in relation to Regulations 12 and 17

We carried out an announced focused inspection at Quincy Rise Surgery on 18 July 2016 to focus on the areas identified in the warning notice for Regulation 12of the HSCA (RA) Regulations 2014. This inspection was conducted to see if improvements had been made in line with the required completion date of 17 July 2016. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Quincy Rise Surgery on our website at www.cqc.org.uk.

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

- The arrangements for managing emergency medicines and vaccinations in the practice ensured that patients were kept safe. There were also contingency plans in place to support the practice in the event of a major incident and a break in the cold chain, and for the safe handling of vaccinations.
- The practice had made improvements in a number of areas by developing practice specific policies and ensuring key processes were embedded in the practice. Safety alerts were disseminated by the practice manager and records were kept to demonstrate action taken. There were effective arrangements in place for the management of risk which supported the safety of the premises, and we also saw areas where risks had been effectively mitigated.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

However we found that although some improvements had been made, improvements were not sufficient enough to ensure that patients were receiving medication reviews in line with care and treatment requirements. Overall, ineffective use of the practice's patient record system resulted in an inaccurate reflection of patient medication reviews. For example:

- We identified cases where poor record keeping and ineffective use of the patient record system had resulted in a lack of detail across some care plans, and medication reviews that had not been effectively coded.
- Additionally, we found that regular reviews had not always taken place in line with patients' medication changes and needs.

Therefore the practice has not fully met the requirements of the warning notice for Regulation 12: safe care and treatment HSCA (RA) Regulations 2014.

This service was placed in special measures in April 2016 and is due to be inspected again within six months of that date. When we re-inspect, we will also look at whether further progress has been made to complying with Regulation 12: safe care and treatment HSCA (RA) Regulations 2014; including specific areas for improvement such as record keeping, medicines management and clinical coding. During our re-inspection we will also see if improvements had been made in line with the warning notice which was issued for Regulation 17: Good governance HSCA (RA) Regulations 2014.

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?

- The arrangements for managing emergency medicines and vaccinations in the practice ensured that patients were kept safe. There were contingency plans in place to provide guidance and support in the event of a major incident and a break in the cold chain (to ensure the safe handling of vaccinations).
- We observed the premises to be visibly clean and tidy. There were effective arrangements in place for the management of safety risks in the premises and risks associated with infection control. Safety alerts were disseminated by the practice manager and records were kept to demonstrate action taken.

Are services effective?

- We identified cases where poor record keeping and ineffective use of the patient record system had resulted in a lack of detail across some care plans, and medication reviews that had not been effectively coded.
- Additionally, we found that medication reviews were not always part of patients' care and treatment assessments as required.
- Staff worked with multidisciplinary teams and engaged with health visitors to understand and meet the range and complexity of patients' needs.

Quincy Rise Surgery

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.

Background to Quincy Rise Surgery

Quincy Rise Surgery is a long established practice based in the Brierley Hill area of Dudley. There are approximately 3,200 patients of various ages registered and cared for at the practice. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The clinical team includes a lead GP, a GP partner, a salaried GP and two practice nurses. The lead GP and the practice manager form the practice management team and they are supported by a team of four receptionists.

The practice is open between 8am and 6pm Monday to Friday. Appointments are available between 9am 11:30am and then from 4pm to 6:30pm. There is a GP on call each morning from 8am to 9am and during the afternoons when appointments are closed. The practice offers extended hours from 6:30pm to 7:30pm on Tuesdays and Thursdays. There are also arrangements to ensure patients received urgent medical assistance when the practice is closed during the out-of-hours period.

Why we carried out this inspection

We carried out an announced focused inspection at Quincy Rise Surgery on 18 July 2016 to focus on the areas identified in the warning notice for Regulation 12: safe care and treatment HSCA (RA) Regulations 2014, which was served on 6 May 2016. This inspection was conducted to see if improvements had been made in line with the required completion date of 17 July 2016. This report only covers our findings in relation to those requirements.

How we carried out this inspection

The inspection team:-

- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced focussed inspection on 18 July 2016.
- Spoke with staff and observed the premises.
- Reviewed a range of practice records.
- Reviewed some of the practice's policies and procedures.

Are services safe?

Our findings

We saw that since our comprehensive inspection in March and April 2016, the practice had improved the process for the management of safety alerts. During our comprehensive inspection we found that although safety alerts were disseminated to the clinicians, the staff we spoke with were unable to demonstrate how the practice had taken action on specific alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA).

During our focussed inspection in July 2016 we saw that the practice manager and clinical staff had since signed up to receive relevant alerts including patient safety alerts, medicines and medical device alerts. Alerts were disseminated by the practice manager, and records were printed and signed to demonstrate that relevant staff had read and understood them. We saw that the practice had recently implemented a robust system which enabled the practice manager to record and monitor alerts as well as actions taken. Staff we spoke with were able to discuss recent alerts, provide supporting records, and demonstrate how clinical searches were conducted to determine if any actions were required and if any specific patients needed to be contacted for an appointment.

Overview of safety systems and processes

- There were systems and supporting policies in place for repeat prescribing and a system in place for the prescribing of high risk medicines. During our inspection we reviewed the practices system of monitoring specific high risk medicines such as methotrexate. Methotrexate is a type of drug known as a disease-modifying anti-rheumatic drug (DMARD). We looked at a sample of cases where patients had been prescribed methotrexate. We found that staff had identified that some of these patients had not had the relevant monitoring blood tests performed within the last two months and staff assured us that they were arranging to call these patients in. We identified that the problems the practice had with coding the dates for medication reviews made it difficult to identify those patients needing blood tests without repeated searches of the patient population on the practice IT system. This raised the possibility of patients continuing on methotrexate beyond the recommended monitoring intervals.
- Additionally, we identified one patient on specific medication to help with inflammation and pain. The specific medicine is prescribed by hospital specialists only, and other commonly prescribed medicines can cause significant interactions with this medication. Although the information about the medication was in letters from the hospital specialist, the medication had not been added to the patient's medication record by the practice. There was therefore a risk of significant interactions with other prescribed medications.
- The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. During our comprehensive inspection in March and April 2016 we noticed that some of the PGDs had not been signed by a GP to demonstrate that they had been authorised in line with legal requirements and national guidance. We checked a sample of PGD records as part of our focussed visit in July 2016 and saw that they were up to date and had been signed by a GP. Prescription stationery was securely stored and there was a system in place to track and monitor the use of the prescription pads used for home visits.
- During our comprehensive inspection, we identified that although vaccination fridges were well ventilated and secure; staff were not effectively following guidance by Public Health England about correct record keeping for the cold chain. During our focussed inspection, we saw that effective record keeping had been applied to monitor the cold chain. Records demonstrated that fridge temperatures were monitored and managed in line with guidance by Public Health England. There was also a policy and contingency plan in place to support the effective management of the cold chain for storage and handling of vaccinations.
- During our inspection we observed the premises to be visibly clean and tidy.

Monitoring risks to patients

During our comprehensive inspection in March and April 2016 we identified a number of gaps in the management of risks associated with health, safety, fire and infection control. Additionally, we found that the practice did not

Are services safe?

always have policies in place to support the overall management of health and safety. During our focussed inspection in July 2016, we found that the practice had worked to improve this area, and there were a number of procedures in place for monitoring and managing risks to patients' and staff safety. For example:

- Policy management had significantly improved; there were a number of practice specific policies in place including a health and safety policy.
- The practice had risk assessments in place to monitor the safety of the premises. We saw that risks such as working from heights had been mitigated by removing high shelving in the reception area so that reception staff no longer needed to use steps to access specific items.
- Risk assessments were also in place which covered fire risk and risks associated with infection control such as the control of substances hazardous to health and legionella.

Arrangements to deal with emergencies and major incidents

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

The practice had an emergency trolley which included emergency medicines, a defibrillator and oxygen with adult and children's masks. The emergency trolley and its contents were easily accessible to staff in a secure areas of the practice and the medicines we checked were all in date. Records were kept to demonstrate that the emergency equipment and the emergency medicines were regularly monitored.

- During our comprehensive inspection in March and April 2016 we found that the practice had not assessed the risk arising from the absence of a specific emergency medicine associated with minor surgery and the fitting of specific birth control devices.
- However, during our focussed inspection in July 2016 we found that the practice had a stock of the specific emergency medicine in question.

Since our comprehensive inspection, the practice had developed a comprehensive business continuity plan. We reviewed this as part of our focussed inspection visit and fount that major incidents were covered as part of the plan; such as power failure or building damage. The plan included emergency contact numbers, and we saw that staff had access to hard copies and electronic copies of the plan if needed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found that clinical staff had access to best practice guidance from the National Institute for Health and Care Excellence patients'. However needs were not always assessed in line with relevant and current evidence based guidance and standards. For example, we identified gaps in record keeping to demonstrate that patients had received adequate medication reviews. This was also identified as an area which required improvement during our comprehensive inspection in March and April 2016.

Management, monitoring and improving outcomes for people

During our focussed inspection in July 2016, we identified further cases of poor record keeping This was identified as an area which required improvement during our comprehensive inspection in March and April 2016. During our focussed inspection we found ineffective use of the patient record system and a number of examples where medication reviews had not been effectively coded.

- We reviewed several records about patients on the practice's learning disability register. In these cases we found that care plans were well structured and detailed, but medication reviews were not always effectively coded. For instance, we saw that one patient's medication review had been appropriately coded in May 2013 but that a medication review carried out in June 2016 had not been appropriately coded on the system. Shortly after our inspection the practice confirmed that this had been rectified on the system and that the medication review was correctly coded.
- We saw further examples of where medication reviews had taken place but had not been effectively coded and these included reviews for patients with long term conditions and patients with epilepsy who were on repeat medication.
- We also found that staff were not following a process on the system to ensure that medication review dates were printed on the patients' prescriptions; informing patients, carers and pharmacists of when a review was due.

We found that poor record keeping was an ongoing theme since we identified areas for improvement during our comprehensive inspection in March and April 2016. During our focussed inspection we identified further areas of record keeping which required improvement. For example:

- We found that two patients prescribed continuous combined oral contraception did not have an adequate record of blood pressure checks. One person had a first prescription for combined oral contraception issued and no blood pressure check was visible on the clinical record. A second patient had had a blood pressure check but this was recorded as a free text comment rather than as a coded clinical entry.
- On reviewing a home visit consultation, we found that medication prescribed had been added as a comment in the consultation record rather than recorded in the relevant area of the medication record. However when we reviewed further home visits we found that that the medication prescribed was recorded in the appropriate area of medication record; this highlighted inconsistencies in the recording process.
- We also found that in some circumstances specific consultations were not clearly added to the patient's record such as documenting when a telephone consultation had taken place.

Inconsistencies in coding and poor record keeping also indicated that the practice's reports and supporting data was not necessarily a true reflection of the practice's performance for areas such as medication reviews. Overall, this posed the risk of other clinicians such as locum GPs having to work with unclear records when dealing with complex patients.

We also found some areas which indicated that regular reviews had not taken place in line with patients' medication changes and needs. For example, we saw that a review had not taken place in over 12 months for a patient who was on antidepressant medication.

During our focussed inspection we discussed our findings with regards to record keeping and inconsistencies with coding on the practices patient record system. The lead GP assured us that the team were working on reviewing a total of 324 patients who required medication reviews. The

Are services effective?

(for example, treatment is effective)

practice was receiving support from the clinical commissioning group (CCG) who had recognised that there were problems with coding and had identified potential training needs specific to the patient record system.

Coordinating patient care and information sharing

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. During our comprehensive inspection visit in March and April 2016 we found that a multi-disciplinary team (MDT) meeting had not taken place since January 2016. During our focussed inspection we saw minutes of multi-disciplinary meetings which had taken place on a monthly basis between March and July 2016, with regular representation from other health and social care services. Vulnerable patients and patients with complex needs were regularly discussed during the meetings. We saw that discussions took place to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital.