Owlthorpe Medical Centre

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	Good
Are services safe?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Owlthorpe Medical Centre on 6 September 2016. The overall rating for the practice was good with requires improvement in safe. The full comprehensive report from 6 September 2016 can be found by selecting the 'all reports' link for Owlthorpe Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 24 April 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach in regulations that we identified in our previous inspection on 6 September 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated good. Specifically, following the focused inspection we found the practice to be rated good for providing safe services.

Our key findings were as follows:

- The practice had implemented a system to track and monitor the movement of blank prescriptions within the practice in line with the NHS Protect Safety of Prescriptions Forms Guidance.
- Patient Group Directives (PGD's) had been signed by the practice nurses and the authorising representative of the practice allowing the practice nurses to administer medicines in line with legislation.
- A fire drill had been carried out on 20 April 2017. A diarised system to ensure this was completed annually had been implemented.
- A system to check the emergency oxygen cylinder and the defibrillator weekly had been implemented to ensure emergency equipment was in good working order.
- Clinical and full staff meetings had been formalised. A rota of meetings had been scheduled throughout the year and minutes of these meetings were produced and available to all 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

Improvements had been made since our last inspection on 6 September 2016 and the practice is now rated good for providing safe services. Our key findings were as follows:

- The practice had implemented a system to track and monitor the movement of blank prescriptions within the practice. The practice had trialled two different systems for monitoring blank prescriptions within the practice. An audit was scheduled for May 2017 to review the effectiveness of the system.
- Patient Group Directives (PGD's) had been signed by the practice nurses and the authorising representative of the practice allowing the practice nurses to administer medicines in line with legislation.
- A fire drill had been carried out on 20 April 2017. A diarised system to ensure this was completed annually had been implemented.
- A system to check the emergency oxygen cylinder and the defibrillator weekly had been implemented to ensure emergency equipment was in good working order. These checks were recorded on a monitoring log sheet.
- Clinical and full staff meetings had been formalised. A rota of meetings had been scheduled throughout the year and minutes of these meetings were produced and available to all staff.

Owlthorpe Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector.

Background to Owlthorpe Medical Centre

Owlthorpe Medical Centre is located in a purpose built health centre in Owlthorpe and accepts patients from the surrounding area. Public Health England data shows the practice population has a higher than average number of patients aged over 50 years of age compared to the England average. The practice catchment area has been identified as one of the eighth least deprived areas nationally.

The practice provides Primary Medical Services (PMS) under a contract with NHS England for 4643 patients in the NHS Sheffield Clinical Commissioning Group (CCG) area. It also offers a range of enhanced services such as childhood vaccination and immunisations.

Owlthorpe Medical Centre has three female GP partners and two male salaried GPs, two practice nurses, three healthcare assistants, a practice manager and an experienced team of reception and administration staff. The practice is a training practice for student nurses.

The practice is open 8am to 6pm Monday to Friday with the exception of Thursdays when the practice closes at 4pm. The GP Collaborative provides cover when the practice is closed from 4pm on a Thursday afternoon. Extended hours are offered on a Tuesday and Wednesday morning 7.30am to 8am and Wednesday evenings until 7pm. Morning and afternoon appointments are offered daily Monday to Friday.

When the practice is closed between 6.30pm and 8am patients are directed to contact the NHS 111 service. The Sheffield GP Collaborative provides cover when the practice is closed between 8am and 6.30pm. For example, at lunchtime. Patients are informed of this when they telephone the practice number.

As part of the Care Quality Commission (Registration) Regulations 2009: Regulation 15, we noted the GP partners registered with the Care Quality Commission as the partnership did not reflect the GP partners at the practice. The practice manager told us application forms were currently being progressed through CQC to include the new GP partner. We also noted at the inspection on 6 September 2016 that the regulated activities the practice were undertaking did not reflect the registration. The practice manager confirmed at the inspection on 24 April 2017 that the practice were not currently undertaking this regulated activity and an application form was in the process of being submitted to CQC.

Why we carried out this inspection

We undertook a comprehensive inspection of Owlthorpe Medical Centre on 6 September 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 safe. This is because the service was not meeting one legal requirement and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations. Specifically Regulation

Detailed findings

17 Good Governance. The full comprehensive report following the inspection on 6 September 2016 can be found by selecting the 'all reports' link for Owlthorpe Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Owlthorpe Medical Centre on 24 April 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

Before completing the focused inspection we reviewed a range of information we hold about the practice including the action plan submitted by the practice following the comprehensive inspection. We carried out a focused inspection on 24 April 2017. During our visit we spoke with the practice manager, one of the reception staff, reviewed management documents and observed practice procedures.

To get to the heart of patients' experiences of care and treatment, we asked the question: Is it safe?

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 6 September 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of tracking and monitoring blank prescriptions was not adequate and there were areas that required improvement with regard to fire safety, medicines management and risk assessment of staff who performed chaperone duties.

These arrangements had improved when we undertook a follow up inspection on 24 April 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

We saw evidence blank prescriptions were stored securely and a recording log had been implemented to monitor and track their movement within the practice. Staff we spoke with had a clear understanding of the procedure. The practice had trialled two different systems for monitoring blank prescriptions within the practice. An audit was scheduled for May 2017 to review the effectiveness of the system.

Patient group directives had been signed by the nurses and the authorising representative of the practice allowing the practice nurses to administer medicines in line with legislation. The practice had implemented a new system to ensure these were signed within an appropriate time frame when received.

The practice manager told us that following discussion at a clinical meeting the GPs had agreed reception staff would no longer act as chaperones. Nursing and healthcare assistant staff would act as chaperones. All had received chaperone training and had a Disclosure and Barring Service (DBS) check in place. (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 policy had been updated to reflect this.

The practice had implemented a rota system of meetings. Full staff meetings and clinical meetings were held monthly. Staff were invited to add items for discussion to the full staff meeting agenda and minutes of these meetings were shared with staff on the notice board.

Monitoring risks to patients

The practice had undertaken a fire drill on 20 April 2017 and there was a diarised note to do this annually. The fire risk assessment had last been reviewed in January 2017 and maintenance checks of the alarm system were completed weekly.

Arrangements to deal with emergencies and major incidents

The practice had implemented a system to check the oxygen cylinder and the defibrillator weekly, to ensure they were in good working order. These checks were recorded on a monitoring log sheet.