Heathfield Surgery

Quality Report

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Heathfield
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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 of this practice on 3 February 2015. Breaches of Regulatory requirements were found during that inspection within the safe domain. After the comprehensive inspection, the practice sent to us an action plan detailing what they would do to meet the Regulatory responsibilities in relation to the following:

- To ensure that patients were informed regarding medicine dose changes following blood test results in line with national guidance.
- To review the management of the repeat prescribing system to ensure all staff are aware of the practice policy not to issue repeat prescriptions over the telephone.

We undertook this focused inspection on 19 April 2016 to check that the provider had followed their action plan and to confirm that they now met Regulatory requirements. 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 Heathfield Surgery on our website at www.cqc.org.uk.

This report should be read in conjunction with the last report from November 2015. Our key findings across the areas we inspected were as follows:-

- We saw that there was a robust system in place to inform patients of changes required in their medicines dose following blood tests.
- We found the required changes had been made in the standard operating procedure documenting the Controlled Drug Accountable Officer (CDAO) and the contact details for this person.
- Repeat prescriptions were now given to the practice via an online ordering system or repeat request slips. Telephone repeat prescription requests were undertaken by trained dispensary staff so as to reduce the risk of errors. Only patients who could not access other methods of repeat ordering were able to undertake telephone ordering.
- We saw that a system was now in place that monitored medicines reviews to prevent prescriptions being issued after the review date unless a review had been undertaken.

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.

- On our previous inspection on 3 February 2015, we found that occasional repeat prescriptions orders were taken over the telephone by dispensary staff. This was not undertaken in line with national guidelines from the national prescribing centre. On this inspection we found that this had been rectified. The majority of patients ordered their prescriptions using repeat slips or via email. Telephone ordering of prescriptions was undertaken only for people who could not access these methods of ordering. We saw that phone orders for repeat prescription requests were undertaken by trained dispensary staff to minimise any risk of error.
- In February 2015 we found that the surgery was not informing patients in writing about changes required to the dose of a particular medicine following a blood test. This was contrary to national guidelines from the National Patient Safety Agency. At this inspection we found that this had been rectified. The majority of patients were given this information in written form immediately after a blood test, to confirm dose changes. For patients who were unable to access the surgery, a telephone call from a trained member of staff was used to inform them of changes to dosage of the medicine following receipt of blood test results. A letter was also sent by post to the patient the same day to confirm the dose change
- At our last inspection we found that repeat prescriptions were sometimes issued even though patients had not received their medicines review. We reviewed a random selection of patient records and found that this was no longer the case. We also saw there were processes in place to prompt patients to make an appointment with the doctor when they were due for a medication review. Additionally dispensary staff contacted the doctor when a patient requested repeat medicines which were overdue for review.
- In February 2015 we found that the contact details of the Controlled Drugs Accountable Officer (CDAO) was not present in the standard operating procedures (SOPS) for the dispensary. At this inspection we found both contact details and contact forms for the CDAO were available with the SOPs.

Heathfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC pharmacy Inspector**.**

Background to Heathfield Surgery

The Heathfield Surgery is a semi-rural practice which offers general medical services to the population of Wealden area. The practice has a smaller branch surgery (The Firs Surgery) which we did not inspect. The practice is involved in the education and training of doctors and is also able to dispense medicines to it patients. There are approximately 12,513 registered patients.

The practice is run by seven partner GPs. The practice was also supported by a salaried GP, four practice nurses, two healthcare assistants, a team of receptionists, administrative staff and a practice manager.

The practice runs a number of services for it patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and holiday vaccinations and advice.

Services are provided from two locations:

The Heathfield Surgery

96-98 High Street

Heathfield

East Sussex

TN21 8JD

And also:

The Firs Surgery

Little London Road

Cross in Hand

TN21 0LT

However, we only inspected The Heathfield Surgery.

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice was a GP training practice and supported new registrar doctors in training. At the time of inspection there was one doctor who were receiving general practice training.

The practice population has a higher number of patients between 45 and 85 years of age than the national and local CCG average, with a significant higher proportion of 65-69 year old than the national average. There are a higher number of patients with a caring responsibility and the percentage of registered patients suffering deprivation (affecting both adults and children) is significantly lower than the average for England.

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

Why we carried out this inspection

We undertook an announced focused inspection of Heathfield Surgery on 19 April 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 3 February 2015 had been made. We inspected the practice against one of the five questions we ask about services: is the service Safe? This is because the service had not been meeting some legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 19 April 2016.

During our visit we:

• Spoke with staff working within the practice dispensary. We did not speak with patients who used the service at this inspection.

• Looked at records and information related to the safe management and control of medicines.

Good

Are services safe?

Our findings

Overview of safety systems and processes

We had previously found the registered provider did not protect patients against the risks associated with the unsafe use and management of medicines.Appropriate arrangements had not been in place for informing patients of changes to medicines and the repeat prescription policy had not always being adhered to. Additionally the process for ordering repeat prescriptions had not been undertaken in line with national guidelines.

On this inspection we found that these concerns had been rectified. The majority of patients now order their prescriptions using repeat slips or via email. Telephone ordering of prescriptions was undertaken only for patients who could not access these methods of ordering. We saw that phone orders for repeat prescription requests were undertaken by trained dispensary staff to minimise any risk of error.

We had previously found that the surgery was not following national guidelines on informing patients about changes required to the dose of a particular medicine following a blood test. We found that this had been rectified. The majority of patients were given this information in written form immediately after a blood test, to confirm dose changes. For patients who were unable to access the surgery, a telephone call from a trained member of staff was used to inform them of changes to dosage of the medicine following receipt of blood test results. A letter was also sent by post to the patient the same day to confirm the dose change.

At the last inspection we had found that repeat prescriptions were sometimes issued even though patients had not received their medicines review. We reviewed a random selection of patient records and found that this was no longer the case. We also saw there were processes in place to prompt patients to make an appointment with the doctor when they were due for a medicines review. We also saw that dispensary staff contacted the doctor when a patient requested repeat medicines which were overdue for review.

It had also been noted previously that the contact details of the Controlled Drugs Accountable Officer (CDAO) were not present in the standard operating procedures (SOPS) for the dispensary. At this inspection we found both contact details and contact forms for the CDAO were available with the SOPs.