

Scots Gap Medical Group

Quality Report

The Surgery
Scots Gap
Morpeth
Northumberland
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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

Are services safe?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 9 October 2014. A breach of legal requirements was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines.

We undertook this focused inspection on 30 November 2015 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. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Scots Gap Medical Group on our website at www.cqc.org.uk

Our key findings were as follows:

- Patients were protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, handling, using and dispensing of medicines used for the purposes of the regulated activity

However, there was also an area of practise where the provider needs to make improvements.

The provider should:

- Monitor the new process of signing repeat prescriptions before they are issued to patients. This is in order to demonstrate these improvements become embedded into practise in the long term.

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 practice is rated as good for providing safe services.

At this visit we checked to ensure medicines were handled safely.

There had been concerns at the previous inspection about the way that medicines were managed. At this inspection we saw that improvements had been made to address the issues.

Good



Summary of findings

What people who use the service say

We did not speak with any patients during this focused inspection.

Areas for improvement

Action the service **SHOULD** take to improve

- Monitor the new process of signing repeat prescriptions before they are issued to patients. This is in order to demonstrate these improvements become embedded into practise in the long term.

Scots Gap Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC pharmacist inspector carried out this focused inspection.

Background to Scots Gap Medical Group

The practice is located in Scots Gap, around 11 miles to the west of Morpeth in Northumberland. Services are provided from the main base in Scots Gap and the branch surgery in Stamfordham, around 13 miles away. The practice covers the area from Elsdon in the north to Stamfordham in the south, and east to west Mitford to Ridsdale. The practice provides services from these two addresses and we visited both during this inspection:

- Main site: The Surgery, Scots Gap, Morpeth, Northumberland NE61 4EG
- Branch surgery: 16 Grange Road, Stamfordham, Northumberland NE18 0PF

The practice at Scots Gap is based on the ground floor, with staff offices and facilities on the first floor. It also offers on-site parking, a WC, step-free access and a dispensary that provides medicines for patients who do not live near a pharmacy. The practice provides services to around 1,850 patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice.

The practice has two GP partners (one male, one female), a practice nurse, a practice manager, two administrators and five staff with reception and dispensing duties.

The service for patients requiring urgent medical attention out of hours is provided by the 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We undertook an announced focused inspection of Scots Gap Medical Group on 30 November 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 9 October 2014 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 was not meeting some legal requirements.

How we carried out this inspection

We carried out an announced visit on 30 November 2015. We spoke with staff from the practice who were involved with or had responsibility for the management of medicines. We looked at records the practice maintained in relation to the provision of services. We visited both surgeries during our inspection.

Are services safe?

Our findings

Medicines Management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe.

- Medicines were dispensed for patients who did not live near a pharmacy and this was appropriately managed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.
- Staff showed us the standard operating procedures for managing medicines (these are written instructions about how to safely dispense medicines) and we saw evidence that these were regularly reviewed to reflect current practice. We observed medicines being dispensed and saw arrangements were in place to minimise dispensing errors. Medicine errors which had been supplied to patients were recorded and reviewed to reduce the risk of errors being repeated.
- Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.
- There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example,

how repeat medicine past the date of review were managed. This had improved since our last visit and helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

- Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. However at the time of our visit there was no system in place to ensure that GPs checked and signed repeat prescriptions before the medicines were dispensed and issued to patients. Overall this meant that patients did not receive medicines safely because GPs did not have the opportunity to do a clinical check before they were dispensed. The practice has since reviewed this process and introduced a system where all prescriptions are reviewed and signed by the GP before dispensing. The provider should monitor the new process of signing repeat prescriptions before they are issued to patients. This is in order to demonstrate these improvements become embedded into practise in the long term.
- There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.
- Blank prescription forms were handled in accordance with national guidance and kept securely at all times.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.