Clay Cross Medical Centre

Quality Report

Bridge Street
Clay Cross
Chesterfield
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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?

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Clay Cross Medical Centre on 2 November 2016 and 10 November 2016. The overall rating for the practice was inadequate. The full comprehensive report from November 2016 can be found by selecting the 'all reports' link for Clay Cross Medical on our website at www.cqc.org.uk.

The overall rating of inadequate will remain unchanged until we undertake a further full comprehensive inspection of the practice within the six months of the publication date of the report from November 2016.

This inspection was a focused inspection carried out on 31 January 2017 to confirm that the practice had taken the required action to meet the legal requirements in relation to the breaches in regulation set out in a warning notice issued to the provider. The warning notice was issued in respect of a breach of regulation related to safe care and treatment; specifically the practice was failing to ensure appropriate action was being taken to mitigate risks in respect of the prescribing of contraindicated medicines.

Our key findings were as follows:

- The practice had complied with the warning notice we issued and had taken the action needed to comply with legal requirements.
- Audits of patient records had been undertaken to identify any affected patients and appropriate action had been taken to address any identified issues.
- Searches of the practice's patient record system demonstrated action had been taken to address identified areas of concern in respect of the prescribing of contraindicated medicines.
- Improvements had been made to the system for the receipt and management of alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

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

Clay Cross Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team included two CQC inspectors.

Background to Clay Cross Medical Centre

Services are provided from a main practice located at Bridge Street, Clay Cross, Derbyshire S45 9NG. The practice had a branch surgery located at Queen Victoria Road, Tupton, S42 6TD. We did not visit the branch practice as part of our inspection.

The level of deprivation within the practice population is slightly above the national average with the practice. Income deprivation affecting children is below the national average and income deprivation affecting older people is slightly above the national average.

The clinical team comprises two GP partners (one male, one female), one salaried GP (male), a clinical pharmacist, an advanced nurse practitioner, two practice nurses and two healthcare assistants. The clinical team is supported by a practice manager, a deputy practice manager and a team of reception and administrative staff.

The main practice is open between 8am and 6.30pm Monday to Friday. Appointments at this practice are from 8.30am to 11.30am every morning and from 3pm to 5.30pm daily. Extended hours appointments are available on Tuesdays from 6.30pm to 7.45pm.

The practice does not provide out-of-hours services to the patients registered there. During the evenings and at weekends an out-of-hours service is provided by Derbyshire Health United. Contact is via the NHS 111 telephone number.

Why we carried out this inspection

We undertook an announced comprehensive inspection of Clay Cross Medical Centre on 2 November 2016 and 10 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection in November 2016 can be found by selecting the 'all reports' link for Clay Cross Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Clay Cross Medical Centre on 31 January 2017. This inspection was carried out to ensure the practice had complied with the warning notice issued on 16 December 2016 and to confirm that the practice was now meeting legal requirements.

Are services safe?

Our findings

At our previous inspection in November 2016, we rated the practice as inadequate for providing safe services due to issues identified in the following areas:

- Process for reporting and recording significant events were not being operated effectively. Staff were not clear about the process for reporting incidents, near misses and concerns. Although the practice carried out some investigations when there were unintended or unexpected safety incidents, lessons learned were not always communicated and so safety was not improved.
- Patients were at risk of harm because systems and processes were not implemented in a way which kept them safe. For example, there was no clear process in place to deal with medicines alerts. The practice did not have effective systems in place to respond to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Systems to store and monitor the stock levels of controlled drugs were not operated effectively within the practice.

Following our inspection in November 2016, we issued the practice with a warning notice in respect of the prescribing of contraindicated medicines with no clear recorded rationale.

Our findings from our inspection of 31 January 2017 indicated that the practice had taken action to comply with the warning notice:

- The practice had undertaken searches of the patient record system of patients being prescribed contraindicated medicines including patients being prescribed a high dose of simvastatin (with amlodipine (used to treat high blood pressure) and patients being prescribed spironolactone (and ACE/A2RBs (often used to treat high blood pressure).
- Evidence indicated prescribing had been reviewed for each of these patients and prescribing altered where required. A recall system for patients being prescribed higher risk combinations of medicines was in place. Meeting minutes demonstrated that these findings had been discussed at a clinical staff meeting.
- We sampled recorded related to patients affected by alerts received from the MHRA had alerts added to their patient record and were receiving appropriate monitoring.
- Arrangements for the receipt and management of alerts had been improved. The advanced nurse practitioner had taken over the responsibility for the receipt and management of MHRA alerts and a new policy for the receipt of all alerts had been developed. Evidence indicated that the new policy had procedures had been discussed with relevant staff.
- A spreadsheet had been created and was stored on the shared drive to log receipt of all alerts received by the practice. This would also enable the practice to record action taken in respect of alerts.