The James Cochrane Practice

Quality Report

Helme Chase Surgery,
Burton Road,
Kendal,
Cumbria,
LA9 7HR
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Website: www.jamescochranepractice.co.uk

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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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The James Cochrane Practice on 15 September 2016. The overall rating for the practice was good, although the practice was rated as requires improvement for safety. The full comprehensive report on the September 2016 inspection can be found by selecting the 'all reports' link for The James Cochrane Practice on our website at www.cqc.org.uk.

This inspection was an unannounced focused inspection carried out on 23 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach in regulation that we identified in our previous inspection on 15 September 2016. This report covers our findings in relation to those requirements.

Overall the practice is rated as good, however the practice remains rated as requires improvement for safety. The practice had not addressed all issues raised at the last inspection, and we found further areas of concern.

Our key findings were as follows:

- Although some improvements had been made to management systems, the arrangements for checking temperatures in medicine refrigerators, uncollected prescriptions, the management of controlled stationery, including prescriptions, and the signing of Patient Group Directions by a prescriber were not in accord with expected standards and did not minimise the associated risks.
- There were standard operating procedures in place in relation to medicines management.
- The practice had risk assessed their dispensing procedures and taken the decision to close the dispensary at the Maude Street surgery.
- Appropriate arrangements were now in place for checking emergency medicines and equipment, controlled drugs, and the expiry dates of medicines.
- Action had been taken to ensure patients who were due a medication review were seen.

There were areas of practice where the provider must make improvements:

- Ensure that the procedures put in place to monitor medicine refrigerator temperatures and uncollected prescriptions are adhered to.

Summary of findings

- Ensure that Patient Group Directions are signed by an appropriate prescriber.
- Ensure the process for managing controlled stationary at the practice includes tracking the use of handwritten prescription pads at Helme Chase, and recording blank computer prescriptions which are transferred between Helme Chase and Maude Street.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. We found some improvements had been made since the previous inspection in September 2016, however there were still concerns which needed to be addressed.

- Although a new system had been implemented to check prescriptions which had not been collected, we found there were still uncollected prescriptions dating back over eight weeks.
- The practice had introduced a centralised electronic system to record all medicines refrigerator temperatures. However, we saw that action was not taken on occasions when the temperatures were out of range, and on some occasions temperatures had not been recorded daily.
- At our last inspection, we found some Patient Group Directions (PGDs) had not been authorised by a responsible person at the practice. At this inspection, we reviewed the PGDs which were in use and found four had not been appropriately authorised.
- Blank computer prescription forms and handwritten pads were kept securely, however there was no process in place to track the use of handwritten pads at Helme Chase, and staff did not always keep records of blank computer prescriptions which had been transferred between Helme Chase and Maude Street.
- Appropriate arrangements were now in place for checking emergency medicines and equipment, controlled drugs, and the expiry dates of medicines.
- Action had been taken to ensure patients who were due a medication review were seen. We saw evidence that showed a 45% reduction in the number of patients who were overdue a medicines review between January 2017 and May 2017.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that the procedures put in place to monitor medicine refrigerator temperatures and uncollected prescriptions are adhered to.
- Ensure that Patient Group Directions are signed by an appropriate prescriber.
- Ensure the process for managing controlled stationary at the practice includes tracking the use of handwritten prescription pads at Helme Chase, and recording blank computer prescriptions which are transferred between Helme Chase and Maude Street.

The James Cochrane Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC pharmacist specialist and included a CQC medicines inspector.

Background to The James Cochrane Practice

The James Cochrane Practice provides primary medical services to the town of Kendal and the surrounding areas to approximately a seven mile radius. The practice provides services from two locations:

- Helme Chase Surgery, Burton Road, Kendal, Cumbria, LA9 7HR,
- Maude Street Surgery, Maude Street, Kendal,Cumbria,LA9 4QE,

The practice dispenses medicines from Helme Chase Surgery. This means under certain criteria they can supply eligible patients with medicines directly.

Helme Chase surgery is located in converted residential premises in a residential area of Kendal. The branch surgery at Maude Street is closer to the town centre of Kendal and is located in purpose built premises. There is step free access at the front of both buildings and a bell for patients to attract attention if they need assistance. Some patient facilities at Helme Chase are on the first floor; however there are also several consulting rooms downstairs. There is patient parking including disabled spaces at the Helme Chase. There is roadside parking at the Maude Street branch and arrangements can be made for patients who require disabled access to park in the staff car park at Maude Street.

The practice has seven GP partners and three salaried GPs. Two are female and five are male. Some GPs are part time, the whole time equivalent is 7.87 or 63 sessions per week. There are two nurse practitioners, three specialist nurses, three practice nurses and nine healthcare assistants. There is a practice manager, operations manager, information technology manager, patient service manager and an office manager. There are eight dispensary staff which includes two managers. There are eighteen reception and administration staff.

The practice provides services to approximately 16,580 patients of all ages. The practice is commissioned to provide services within a Personal Medical Services (PMS) contract with NHS England.

The practice is part of Morecambe Bay clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the ninth least deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice has lower levels of patients between the ages of 20 to 44, when compared to national averages.

The Helme Chase surgery is open from 8am until 7.30pm Monday to Friday. The Maude Street surgery is open from 8am to 5pm Monday to Friday.

Consulting times with the GPs and nurses range from 8am to 12 noon, and 2pm until 7.20pm at Helme Chase, and 4.50pm at Maude Street.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Cumbria Health on Call (CHOC).

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of The James Cochrane Practice on 15 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. The full comprehensive report following the inspection on June 2016 can be found by selecting the 'all reports' link for The James Cochrane Practice on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of The James Cochrane Practice on 23 May 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

We carried out an unannounced inspection on 23 May 2017. We visited the practice's surgery Helme Chase. We spoke with the practice manager and members of the dispensary team team. We reviewed documentation related to medicines management in the practice, as well as assorted practice policies and standard operating procedures.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 15 September 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of medicines management were not satisfactory.

When we undertook a follow up inspection on 23 May 2017 we found some improvements had been made, however there were still concerns which needed to be addressed. Therefore, the practice remains rated as requires improvement for providing safe services.

Overview of safety systems and processes

When we inspected the practice in September 2016 some of the systems, processes and practices in place to ensure the safe management of medicines required improvement.

At this inspection, we found some improvements had been made, but other areas still required improvement.

- Since our last inspection, the practice had risk assessed their dispensing procedures and taken the decision to close the dispensary at Maude Street. Patients could still collect medicines from this site or have them delivered to their own home if they chose to do so.
- When we last inspected we found the practice had standard operating procedures (these are written instructions about how to safely dispense medicines) that were readily accessible and covered all aspects of the dispensing process. However, these had not been signed by all staff working in the dispensary to confirm they had been read and understood. In addition, the records we were shown by the dispensary manager indicated some SOPs were past their date of review. Following our inspection, the practice sent us evidence that dispensary SOPs had been reviewed, updated and signed.
- At our previous inspection, we found staff did not always record when they carried out medicines expiry date checks. At this inspection, we found a new process was in place and staff routinely recorded each month when checks were carried out.
- 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. At our last inspection, we found staff did not carry out regular balance checks of controlled drugs. During this inspection, we reviewed controlled drugs registers and found regular checks had been carried out and accurate records maintained.
- In September 2016 we found several repeat prescriptions at Maude Street which had not been signed by a doctor. We also found acute (one-off) prescriptions which had been given out to patients and had not been signed by the doctor within a reasonable time period. At this inspection we were told the dispensing process had been reviewed. Dispensary staff told us about the procedure for getting prescriptions signed before they were dispensed. We checked dispensed prescriptions awaiting collection and found they had all been signed by an appropriate practitioner.
- At our previous inspection, we found some patients had not had a medicines review, and repeat prescriptions had been issued past their review dates. The lead GP for the dispensary told us the practice had used a tool provided by the Cumbria CCG medicines management team to review repeat medicines processes. Following our inspection, the practice provided us with audits showing a reduction in the number of patients overdue a medicines review between January 2017 and May 2017.
- Staff told us that prescriptions which had not been collected should be removed after eight weeks and brought to the attention of the patients' usual GP. We were told that following our last inspection a new process of monthly checks had been implemented, however we found four uncollected prescriptions dating back over eight weeks, one of which had been dispensed in January 2017.
- At our previous inspection, we found the temperatures of medicines refrigerators at both sites were not always recorded in accordance with national guidance. During this inspection we checked to see what improvements had been made. The practice had introduced a centralised electronic system to record all medicines refrigerator temperatures. We reviewed records; these showed temperatures for the dispensary refrigerator were outside the recommended range for storing medicines on nine occasions between 1 April 2017 and 22 May 2017. Staff had not recorded taking any action in response and the dispensary manager was not aware

Requires improvement

Are services safe?

there had been a problem with the refrigerator. In addition, we found staff had not recorded temperatures for other refrigerators every day as recommended in national guidance.

- Vaccines were administered by nurses and health care assistants using directions which had been produced in accordance with legal requirements and national guidance. At our last inspection, we found some Patient Group Directions (PGDs) had not been authorised for use by a responsible person at the practice. At this inspection, we reviewed the PGDs which were in use and found four had not been appropriately authorised.
- At our previous inspection, we identified concerns about the management of controlled stationery at the practice. During this inspection we found blank computer prescription forms and handwritten pads were kept securely, however there was no process in place to track the use of handwritten pads at Helme Chase. In addition, staff did not always keep records of blank computer prescriptions which had been transferred between Helme Chase and Maude Street.
- In September 2016, we found staff did not always follow the procedure for checking emergency medicines and equipment. At this inspection, there were sufficient supplies of emergency medicines, oxygen, and defibrillators with adult pads. We reviewed records and found staff had carried out regular checks to make sure these were fit for use.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were a lack of systems and processes in place to assess, monitor and improve the quality and safety of the service provided. Systems to monitor the temperature of medicines refrigerators were not being adhered to. Patient Group Directions were not signed by an appropriate prescriber. There was no process in place to track the use of some handwritten prescription pads, or to record blank computer prescriptions which are transferred between practice sites. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.