Cradley Surgery

Inspection report

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Date of inspection visit: 07/09/2020
Date of publication: 06/10/2020

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 location	Good
Are services safe?	**Good**

Overall summary

We carried out an announced comprehensive inspection at Cradley Surgery on 8 March 2019 as part of our inspection programme. The overall rating for the practice was Good. The full comprehensive report on the March 2019 inspection can be found on our website at .

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what type of inspection was necessary and proportionate, this was therefore a desk-based review.

On 7 September 2020 we carried out a desk-based review to confirm that the practice had carried out their plan to meet the legal requirements in relations to the breaches of regulation we identified at our previous inspection on 8 March 2019. This report covers our findings in relation to those requirements and additional improvements made since our last inspection.

We found that improvements had been made and the provider was no longer in breach of the regulations and we have amended the rating for this practice accordingly. The practice is now rated as Good for the provision of safe services. We previously rated the practice as Good for providing effective, caring, responsive and well-led services.

During this desk-based review we looked at a range of documents submitted by the practice to demonstrate how they met the requirement notices. This included:

- Risk assessments
- Medicines and Healthcare products Regulatory Agency (MHRA) alerts processes
- Disclosure and Barring (DBS)/recruitment checks
- Records to confirm improvements made.

During the desk-based review we looked at the following question:

Are services safe?

We found that this service was providing a safe service in accordance with the relevant regulations and had demonstrated they had acted on the required improvements and had implemented the following:

- Risk assessments for the medicine delivery service had been completed. All procedures had been updated and included continued assessment of the delivery service.
- Computer prescription paper had been moved from the shelves in the dispensary to a lockable cupboard with an appropriate monitoring process put in place. The procedure had been added to the dispensary operating procedures.
- Although no discrepancies had been found at the time of the inspection, there were no regular stock reconciliation checks carried out on controlled drugs. Quarterly stock balance checks were now carried out. The additional procedure of a quarterly balance stock on the small controlled drugs cabinet had also been added to the dispensary operating procedures.
- A key safe had been installed to ensure the key to the controlled drugs cabinet was stored securely. Access to the key box was coded and the dispensary team and the doctors were the only personnel aware of the code.
- Improvements to the management of MRHA alerts had been made. Reports were received by email by the practice manager who then directed these to the appropriate departments. The email was flagged, and a record of receipt and action taken was recorded. There were plans to further revise the system, but changes had been put on hold as a result of the Covid pandemic.
- Disclosure and Barring Service (DBS) risk assessments for staff who did not have DBS checks had now been completed.

Action had been taken for areas where the provider had been advised they **should** make

improvements.

- All non-clinical staff had completed level two safeguarding training in accordance with the revised guidance issued in January 2019.
- A full evacuation as part of the routine fire drill had been planned but was cancelled due to the COVID pandemic. The provider assured us that re-arrangements would be made as soon as it became possible.
- Ongoing efforts were made to reactivate the Patient Participation Group and included encouragement and recruitment of COVID volunteers.
- The provider confirmed that continued review of the decision not to offer an electronic prescription service (EPS) was an ongoing consideration. This service was made more difficult due to WIFI availability/reliability in their rural location. Currently 97% of patients received

Overall summary

medicines from the practice dispensary so EPS would only be relevant to a very small proportion of patients. However, improved WIFI when it became available would enable this option.

During the inspection in March 2019 further areas were identified where improvements should be made. These were:

- The vaccine refrigerator was overfull, which meant that air could not circulate freely to ensure that vaccines were not compromised. The provider had reviewed the refrigerator fill levels to ensure that vaccines were not compromised through overfilling.
- There was no safeguarding register; alerts were added to patients' medical records as necessary. The provider had reviewed their processes and considered that their approach was appropriate for the practice. They held a child safeguarding register, an adult safeguarding register, a looked after child register, a homelessness register, and a vulnerable family register. Information was accessible as required and all information documented on patient records.
- Four out of the seven incidents recorded in the last year related to the dispensary. We did not see evidence at the last inspection that trends had been analysed at practice level. We saw that action had been taken to try to prevent a recurrence of errors in the dispensary. Dispensary staff recorded 'near misses' on a separate log rather than raising as a significant event. We saw that 28 near misses had been recorded in January and February 2019. The provider confirmed that the dispensary manager reviewed and assessed each incident as they occurred. Discussions were held with each person involved, with further discussion at the full practice meeting as learning points. The dispensary manager reviewed all incidents to determine possible patterns. No patterns had been identified to date.

Details of our findings and the evidence supporting our ratings are set out in the evidence table.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was carried out by a CQC Lead Inspector.

Background to Cradley Surgery

Cradley Surgery is a rural practice in Cradley, near Malvern in Worcestershire. The surgery is in a residential area and provides pharmaceutical services to those patients who live more than one mile (1.6km) from their nearest pharmacy premises. The practice currently dispenses to 95% of their patients.

The provider is registered with CQC to deliver the Regulated Activities: diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury.

Cradley Surgery is situated within the Herefordshire Clinical Commissioning Group (CCG) and provides services to 3,325 patients under the terms of a general medical services (GMS) contract. This is a contract between general practices and NHS England for delivering services to the local community.

There is one female GP (the sole provider) and a male salaried GP. The practice employs a locum GP on a regular basis. The GPs are supported by a practice manager, a dispensary manager, two practice nurses, a health care assistant and administration and dispensary staff. The practice is part of the East Locality in Herefordshire.

The practice does not provide out of hours services. Patients are advised to contact 111 for urgent GP access outside of normal GP working hours. When patients dial 111 they get advice from the Out of Hours service which is commissioned by the CCG.