Dr Howells & Partners

Quality Report

Kintbury Surgery
Newbury Street
Kintbury
Berkshire
RG17 9UX
Tel: 01488 658294
Website: www.kintburyandwooltonhillsurgeries.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?	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 at Dr Howells & partners (at that time known as Dr West & partners) on 18 May 2016. At that time, the practice was rated overall as good. However, we identified a breach in regulation relating to the way in which medicines were managed which resulted in a rating of requires improvement for provision of safe services. Specifically we found that learning from dispensary errors was communicated inconsistently, medicines were dispensed to patients before GPs had signed and authorised prescriptions and some medicines held for use in an emergency were out of date.

The practice sent us an action plan setting out the changes they were making to address the breach in regulation.

We carried out a focused inspection on 21 December 2016 to ensure these changes had been implemented and that the service was meeting regulation they had previously breached. The ratings for the practice have been updated to reflect our findings. We found the practice had made improvements in safe provision of services since our last inspection on 18 May 2016 and they were now meeting the requirements of the regulation in breach.

Our key findings in the area we inspected were as follows:

- The practice had introduced an effective system for reporting and learning from dispensing errors and “near misses”. This followed an improvement process designed by the Royal Pharmaceutical Society.
- Repeat prescriptions were being signed by GPs before medicines were dispensed to patients from both the practice dispensaries.
- The practice had an effective system for monitoring the medicines held for use in an emergency.

We have updated the ratings for this practice to reflect these changes. The practice is now rated good for the provision of safe services.

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. The practice had made significant progress in addressing concerns identified at their previous inspection and at this inspection we found:

- Learning from dispensing errors was communicated to staff effectively. Staff were aware of errors and the actions they should take to avoid similar occurrences in the future.
- Processes for dispensing medicines from the practice dispensaries complied with legislation and guidance from professional bodies. Repeat prescriptions were signed before the medicines were collected by patients.
- Both medicines held in case of an emergency and those in GP bags were regularly checked to ensure they were in date and fit for use. An effective monitoring and checking system was in place.

At our earlier inspection we found:

- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients, that were not associated with medicines, were assessed and well managed.

Dr Howells & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

This focussed follow up inspection was undertaken by a CQC Lead Inspector.

Why we carried out this inspection

We carried out a comprehensive inspection on 18 May 2016 and published a report setting out our judgements. We asked the provider to send a report of the changes they would make to comply with the regulation they were not meeting. We undertook a focused follow up inspection on 21 December 2016 to make sure the necessary changes had been made and found the provider is now meeting the fundamental standards included within this report.

This report should be read in conjunction with the full inspection report.

How we carried out this inspection

Before visiting, we reviewed the action plan the practice had sent us detailing the changes they would make to become compliant with legislation. We carried out an announced focused inspection on 21 December 2016.

During the inspection we visited both sites from which the practice delivers regulated activities. Kintbury Surgery, Newbury Street, Kintbury, Berkshire, RG17 9UX and Woolton Hill Surgery, Trade Street, Woolton Hill, Berkshire, RG20 9UL and we:

- Spoke with one GP, the practice manager and two of the dispensing/administration team
- Reviewed records relevant to the management of the service.
- Carried out observations around the practice.
- Checked the arrangements for managing medicines safely.

To get to the heart of patients' experiences of care and treatment, we always ask the following question:

- Is it safe?

We did not revisit how well services were provided for specific groups of people because we had rated the overall provision of services as good at our last inspection. This applied to all population groups. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Good

Are services safe?

Our findings

When we inspected Dr Howells and partners (then known as Dr West and partners) in May 2016 we found the practice effectively managed the majority of risks to the safe provision of care and treatment. However, the inspection identified a breach in regulation relating to management of medicines including; inconsistent imparting of learning from incidents relating to dispensing, prescriptions not being signed prior to the dispensing of medicines to patients and out of date medicines held in the emergency medicines stock. The practice sent us an action plan setting out how they would make improvements in these areas. At this inspection we found significant improvements had been achieved.

Specifically in the areas of:

Safe track record and learning

When we inspected the practice in May 2016 we found that learning from near misses and dispensing errors was imparted inconsistently. At this inspection we found there was an effective system in place for reporting and recording errors and near misses relevant to the dispensing of medicines.

- Staff used a log, at both practice sites, to record all dispensing errors and near misses. The dispensary manager summarised the log entries to identify any trends in the errors reported. On a quarterly basis the errors were summarised into an auditing and review tool provided by the Royal Pharmaceutical Society called 'Near miss and error improvement tool'. This clearly recorded the learning from the incidents. Once collated, the summary was discussed by the practice formulary and clinical team, forwarded to all staff involved in dispensing and shared at the full practice team meetings. We reviewed minutes from both the formulary and clinical meeting (14 November 2016) and practice staff meeting (18 November 2016). These confirmed that the dispensing errors were discussed and learning shared. We spoke with two members of the dispensing/administration team. Both were able to describe the learning they had gained from previous dispensing errors and near misses.
- We noted the dispensing error rate was less than 0.5% per 1000 dispensed items across both dispensaries.

We saw an example of the learning from errors being followed up. The practice identified that there had been occasions when only part of a prescription was dispensed because insufficient stock was held in the dispensary to provide the full amount of medicine the patient required. When this happened a record of the shortfall in supply was not clearly recorded. This had resulted in the patient being given more than required when the stock was delivered. The practice introduced a labelling system that identified the exact amount of additional medicine required to fulfil the prescription. Overprovision of medicine was therefore avoided.

Overview of safety systems and processes

When we inspected the practice in May 2016 we found the majority of systems in place kept patients safe. However, the practice was enabling patients to collect medicines from the dispensaries before GPs had signed the repeat prescriptions to which the medicines related. This did not comply with Schedule 6 of the 2013 NHS Pharmaceutical Services Regulations and did not follow the current guidance from the Dispensing Doctors Association (DDA). At this inspection, we found the practice had made improvements to their repeat prescribing and dispensing systems. For example:

- When a patient requested a repeat prescription, staff prepared a label ready for the prescription and placed the prescription in a queue for GPs to authorise. Once the prescription was prepared GPs were required to sign the prescription form before the medicines on the prescription were prepared for the patient, or their representative to collect. Repeat prescription slips were kept in a clearly identifiable secure location awaiting signing. GPs checked and signed them at regular intervals during the day before the dispensers took the prescriptions to prepare the medicines for collection. The system we saw in operation complied with both the Human Medicines Regulations 2012 and guidance from the Dispensing Doctors Association (DDA).

Arrangements to deal with emergencies and major incidents

When we inspected the practice in May 2016 we found some emergency medicines held were out of date. The practice did not have an effective system in place to monitor the expiry dates of the emergency medicines held.

Good

Are services safe?

At this inspection we found the practice had made significant improvement in the arrangements in place to ensure emergency medicines were checked and were fit for purpose. Specifically we found:

- An emergency medicine log system had been introduced at both practice sites. These logs detailed the emergency medicines held at both sites for use in an emergency with their expiry dates clearly identified. We checked the emergency medicines at both sites and the medicines held corresponded with the logs. All 36 medicines we checked were within expiry date. Records we reviewed showed that staff checked these medicines on a monthly schedule and replaced any that were due to pass their expiry date.
- We also checked the emergency medicines GPs held in their bags to take out on home visits. The 14 medicines we checked in two GP bags were in date. There was a central record of the medicines the GPs held and this was cross checked by two members of staff against the contents of each bag.