Deepcar Medical Centre

Quality Report

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Deepcar Medical centre on 14 December 2016. The overall rating for the practice was good with requires improvement in safe. The full comprehensive report from 14 December 2016 can be found by selecting the 'all reports' link for Deepcar Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 9 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 14 December 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated good. Specifically, following the focused inspection we found the practice to be rated good for providing safe services.

Our key findings were as follows:

- The practice had implemented standard operating procedures for staff to follow in the dispensary to ensure all prescriptions were signed by a GP prior to medication being dispensed.
- Standard operating procedures in the dispensary had been reviewed and updated to include monitoring of uncollected dispensed medication.
- The practice had implemented a system to monitor and track blank prescriptions on receipt into the practice in accordance with NHS Protect Security of Prescriptions Guidance 2013.
- The practice had introduced a system of 'near miss' recording in the dispensary to identify trends and patterns in errors and to take action to prevent reoccurrence.
- The practice maintained a complete record of the immunity status of clinical staff as specified in the national Green Book (immunisations against infectious disease) guidance for healthcare staff.

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

Improvements had been made since our last inspection on 14 December 2016 and the practice is now rated good for providing safe services. Our key findings were as follows:

- The practice had implemented standard operating procedures for staff to follow in the dispensary to ensure all prescriptions were signed by a GP prior to medication being dispensed. All the prescriptions we reviewed where medication had already been dispensed were signed by a GP.
- Standard operating procedures in the dispensary had been reviewed and updated to include monitoring of uncollected dispensed medication. We reviewed all dispensed medication awaiting collection. These were within the time frame specified on the standard operating procedure.
- The practice had implemented a system to monitor and track blank prescriptions on receipt into the practice. There was a recording log of all blank prescriptions received into the practice and a recording log to track their movement within the practice.
- The practice had introduced a system of 'near miss' recording in the dispensary so the practice could identify trends and patterns in errors and take action to prevent reoccurrence. Staff we spoke with were aware of the procedure.
- The practice maintained a complete record of the immunity status of clinical staff as specified in the national Green Book (immunisations against infectious disease) guidance for healthcare staff.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

People whose circumstances may make them vulnerable

Outstanding ☆

As the practice is now rated as good for safe services the overall rating for the care of people whose circumstances may make them vulnerable is now rated as outstanding. Our findings from the inspection on 14 December 2016 were as follows:

- The practice had worked proactively with other social care providers by identifying patients who required extra social support and had referred to other agencies on the patient's behalf. For example, Age UK, the local social café and the Sheffield Drinkwell Agewell support group. The practice also hosted a community support worker who would advise and signpost patients to services. For example, information on housing and social care or support to join local social activities. The staff we spoke with proactively referred patients to this service and told us of specific instances where they had referred patients who had approached them directly for help. For example, the receptionist had referred a patient with no access to food and who was going to be made homeless to the community support worker who was able to assist with food vouchers and accommodation.
- The practice had hosted in recent months two coffee mornings at the practice which had been well attended by patients, carers and members of the patient participation group to support local charities. They had used these events to specifically invite patients who were carers and patients who may be vulnerable or isolated. Practice staff baked cakes and provided snacks for the events. Entertainment was also provided through quizzes, bingo and raffles. Support services including representatives from charities and the community support worker were invited to attend to provide advice and signposting to services. For example, the local social café held at the local church. The practice manager told us they received very positive feedback from patients and carers on how it had supported them to engage with others in similar situations and also to find out about support groups and what is happening in the local community.

Deepcar Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector

Background to Deepcar Medical Centre

Deepcar Medical Centre is located in a purpose built health centre in Deepcar, Sheffield and accepts patients from Deepcar, the surrounding semi-rural area and several small rural outlying villages. Public Health England data shows the practice population is similar to others in the Clinical Commissioning Group (CCG) area with a slightly higher than average number of patients aged over 45 years old compared to the England average. The practice catchment area has been identified as one of the seventh least deprived areas nationally.

The practice provides Primary Medical Services (PMS) under a contract with NHS England for 5,160 patients in the NHS Sheffield CCG area. It also offers a range of enhanced services such as anticoagulation monitoring and childhood vaccination and immunisations.

Deepcar Medical Centre has four GP partners (one female, three male), one female salaried GP, two practice nurses, one health care assistant, a practice manager and an experienced team of reception and administration staff. The practice is a teaching practice for foundation year medical students.

The practice is open 8.30am to 6.30pm Monday to Friday. Extended hours are offered 9.30am to 11.30am on Saturday mornings. Morning and afternoon appointments are offered daily Monday to Friday with the exception of Thursday afternoons when there are no appointments.

When the practice is closed between 6.30pm and 8am patients are directed to contact the NHS 111 service. The Sheffield GP Collaborative provides cover when the practice is closed during the hours of 8am and 6.30pm. For example, at lunchtime between 1pm and 2pm. Patients are informed of this when they telephone the practice number.

Why we carried out this inspection

We undertook a comprehensive inspection of Deepcar Medical Centre on 14 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good with requires improvement in safe. This is because the service was not meeting a legal requirement and regulation associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations. Specifically Regulation 12 safe care and treatment. The full comprehensive report following the inspection on 14 December 2016 can be found by selecting the 'all reports' link for Deepcar Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Deepcar Medical Centre on 9 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.

Detailed findings

How we carried out this inspection

Before completing the focused inspection we reviewed a range of information we hold about the practice including the action plan submitted by the practice following the comprehensive inspection. We carried out a focused inspection on 9 May 2017. During our visit we spoke with the practice manager, one of the dispensary staff, reviewed management documents and observed practice procedures.

To get to the heart of patients' experiences of care and treatment, we asked the question: Is it safe?

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

At our previous inspection on 14 December 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of medicines management within the dispensary were not adequate.

These arrangements had improved when we undertook a follow up inspection on 9 May 2017. The practice is now rated as good for providing safe services.

Overview of safety systems and process

Arrangements for managing medicines in the dispensary had been reviewed. The practice had updated the dispensary standard operating procedures (SOPS) to include a prescription signing and monitoring of uncollected dispensed medication SOP. (SOPS are written instructions about how to safely dispense medicines). Staff working in the dispensary had signed to say that they had read and understood the updated SOPS. At the inspection on 14 December 2016 we saw evidence of six prescriptions where medication had been collected by the patient and the prescription had not been signed by a GP dating between 2nd and 13th December 2016. At the focused follow up inspection, all the prescriptions we reviewed dating from 18 April 2017 to 9 May 2017 where medication had already been dispensed were signed by a GP.

The practice had implemented a SOP for monitoring of medicines which had been dispensed and not collected. At the inspection on 14 December 2016 we found evidence of several uncollected dispensed medications that had not been collected, dating back to 20 September 2016. At this inspection we reviewed all the dispensed medication awaiting collection. These dated back to 29 April 2017 which was within the two month period stated in the SOP. Dispensary staff we spoke with were aware of the new procedure as specified in the SOP.

The practice action plan recorded the practice manager had met with staff to update them on the SOPS and there was a system in place to regularly monitor these SOPS were adhered to.

At the inspection on 14 December 2016 the practice did not have a system to record the receipt of blank prescriptions into the practice. At this inspection we observed the procedure to have been updated. There was a recording log of all blank prescriptions received into the practice and a recording log to track their movement within the practice.

At the inspection on 14 December 2016 the practice had a system in place for recording significant events involving medicines and had adequately acted to investigate these incidents. However, they did not keep a 'near miss' recording log (a record of errors that had been identified before medicines had left the dispensary) to identify trends and patterns in errors and to take action to prevent reoccurrence. At this inspection the practice had implemented a SOP for this and a recording log which was kept in the dispensary for staff to complete. Staff had signed to confirm they had read the SOP and staff we spoke with were aware of the recording log and where to access it. The practice manager confirmed any incidents recorded on the log sheet would be discussed at the staff meeting to assist staff learning. There had been no near miss incidents reported since our inspection on 14 December 2016.

At the inspection on 14 December 2016 the practice did not maintain a complete record of the immunity status of clinical staff. At this inspection we saw evidence that the practice now maintained a complete record of the immunity status of clinical staff as specified in the national Green Book (immunisations against infectious disease) guidance for healthcare staff.