Sheringham Medical Practice

Inspection 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 location	Good
Are services safe?	**Good**

Overall summary

We carried out an announced comprehensive inspection at Sheringham Medical Practice on 9 January 2018. The overall rating for the practice was good, with a requires improvement rating for providing safe services. We issued a requirement notice against regulation 17 as there were out of date emergency medicines and consumables in the practice and the process in place for the management of patient safety alerts was not effective.

We also identified areas the practice could improve including documentation relating to children who did not attend appointments, and the system for managing patients with diabetes during and following pregnancy.

The full comprehensive report on the January 2018 inspection can be found by selecting the 'all reports' link for Sheringham Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 9 August 2018 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 9 January 2018.

This report covers our findings in relation to those requirements and additional improvements made since our last inspection.

Overall the practice is now rated as good, with a good rating for providing safe services.

At this inspection we found:

- The practice had carried out a comprehensive review of safeguarding systems and processes and implemented changes to the way missed appointments are assessed and recorded for children and vulnerable patients.
- The practice had reviewed and implemented a robust new process for checking and recording emergency medicines and equipment.
- Processes for receiving, reviewing, acting on and monitoring safety alerts had been reviewed and improvements made.
- The process for managing diabetes during and after pregnancy had been thoroughly reviewed and systems put in place to improve identification, monitoring and recording of patients with diabetes during pregnancy and following pregnancy.

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

Please refer to the detailed report and the evidence tables for further information.

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and included a GP specialist adviser.

Background to Sheringham Medical Practice

Sheringham Medical Practice provides healthcare services to approximately 9,400 patients in Sheringham, Norfolk and outlying villages under a General Medical Service (GMS) contract. The practice is a dispensing practice, dispensing medicines to those patients requiring the service.

There are two GP partners who are supported by three salaried GPs. There are five nurse practitioners, three practice nurses and three healthcare assistants. A team of five dispensary trained staff support the dispensing of medicines. A team of 15 administration and reception staff support the practice manager and business manager. The business manager had applied to become a partner of the practice and this was in process at the time of the inspection.

The practice is a training practice for GP registrars (qualified doctors who are training to be GPs).

The practice is open between 8am and 6pm Monday to Friday. Extended hours are offered between 6.30pm and 8.30pm on a Monday. If the practice is closed, patients are asked to call the NHS111 service or to dial 999 in the event of a life-threatening emergency. Out of hours services are provided by Integrated Care 24 Ltd.

The practice has a lower number of patients aged 0 to 18 years and a higher number of patients aged over 65 years and over compared to the local and national average. The deprivation score is below the England average. Income deprivation affecting children and older people is below national averages. Male and female life expectancy in this area is in line with the England average at 80 years for men and 85 years for women.

Good

Are services safe?

At our previous inspection on 9 January 2018, we rated the practice as requires improvement for providing safe services as t here were out of date emergency medicines and consumables in the practice and process in place for the management of patient safety alerts was not effective . We also identified areas the practice could improve including documentation relating to children who did not attend appointments, and the system for managing patients with diabetes during and following pregnancy.

These arrangements had improved when we undertook a follow up inspection on 9 August 2018. The practice is now rated as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had carried out a comprehensive review of safeguarding systems and processes both internally and externally with a local safeguarding lead to ensure compliance with national clinical guidelines and a review of clinical reporting arrangements using the practice computer system.
- The practice considered and implemented regular clinical reporting and analysis of clinical record keeping for children. This ensured that records were updated to reflect children not attending appointments were risk assessed and appropriate action taken.
- The practice introduced a new protocol for managing missed appointments for all vulnerable patients and young people including missed practice and secondary care appointments. The new protocol included a template for clinicians to follow to maintain consistency.
- We reviewed ten clinical records and found the systems in place were effective.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing emergency medicines and equipment minimised risks.
- The practice business manager and team members responsible for the management of emergency medicines and equipment carried out a comprehensive and detailed review of the related systems, processes and protocols in place. The findings and proposed improvements were then reviewed, discussed and developed further during a nursing team away day. The review was then shared with and views sought from all practice staff who were also familiarised with the location and layout of the emergency equipment trolley.
- The nursing team introduced a detailed protocol and procedure which included two people checking stock and equipment and filling out a detailed recording template which was sent for further approval. The protocol included what to do when equipment and medicines were approaching expiry, including a review and risk assessment carried out by a GP and recorded on the template.
- All the medicines and equipment we checked were in date.

Lessons learned and improvements made

- The systems for receiving, reviewing and acting on patient safety alerts, including medicines and prescribing alerts, had been comprehensively reviewed. This was led by the lead GP partner and the business manager and involved a range of clinical and non-clinical staff. This review included identifying and reviewing past and present safety alerts and taking appropriate action. This information was used to populate a template for recording, monitoring and reviewing safety alerts and actions. Alerts and actions were discussed at regular monthly meetings and sooner where required.
- We reviewed actions taken by the practice shortly after our previous inspection which included writing to all patients involved in a safety alert relating to a high-risk medicine and inviting them for a review appointment to discuss their options. We also reviewed the practice tracker spreadsheet for other safety alerts and the action taken and found the practice had acted appropriately and in a timely way.

Please refer to the evidence tables for further information.