Box Surgery

Quality Report

Box Surgery
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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

Are services safe?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

In March 2016 a comprehensive inspection of Box Surgery, Box, Wiltshire, was conducted. During that inspection we found concerns related to the management of blank prescription security and the systems to monitor this risk. A report setting out the findings of the inspection including the concerns was published in April 2016. Following the inspection the practice sent us an action plan detailing how they would improve on the areas of concern.

We carried out an announced focused inspection of Box Surgery on 22 June 2016 to ensure the changes the practice told us they would make had been implemented and to apply an updated rating.

We found the practice had made significant improvement since our last inspection on 16 March 2016. We have re-rated the practice overall as good. Specifically, they had made improvements to the provision of safe services. The ratings for the practice have been updated to reflect our findings.

At this inspection we found:

• Systems were in place to monitor and ensure the security of blank prescriptions.

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 was rated as requires improvement for providing safe services in March 2016 and was re-rated as part of this inspection.

Our last inspection in March 2016 identified a concern relating to the management and security of blank prescriptions. During the inspection in June 2016 we saw that the concerns had been addressed:

Box Surgery had reviewed their protocols and risks associated with the management and security of blank prescriptions and ensured the processes and procedures were now in place in line with national guidance.

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- 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.
- We found the processes and systems for prescription security and management were now in line with national guidance.

Risks to patients were assessed and well managed.

Box Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our follow up inspection was an announced visit by a CQC Lead Inspector.

Why we carried out this inspection

We carried out a comprehensive inspection on 16 March 2016 and published a report setting out our judgements. We undertook a focused follow up inspection on 22 June 2016 to check that the practice had taken the actions they told us they would make to comply with the regulations they were not meeting at the previous inspection.

We have followed up to make sure the necessary changes had been made and found the provider was now meeting the fundamental standards included within this report. The focused inspection also enabled us to update the ratings for the practice.

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

How we carried out this inspection

We undertook a focused follow up inspection at Box Surgery on 22 June 2016. This was carried out to check that the practice had completed a range of actions they told us they would take to comply with the regulations we found had been breached during an inspection in March 2016.

During our visit we:

- Spoke with the practice manager, checked two of the clinical rooms and tracked the process through the practice.
- Reviewed records relevant to the management of the blank prescription security.

Because this was a focused follow up inspection we looked at one of the five key questions we always ask:

• Is it safe?

Good

Are services safe?

Our findings

When we inspected in March 2016 we found the safety systems and processes were not robust in the security of blank prescriptions, specifically prescription pads were not locked within the printers or in a storage cupboard and the clinical rooms were not always locked throughout the day.

This was a breach of regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following publication of our report of the inspection, the practice provided a completed action plan which included the changes they would complete and implement for the practice. Subsequently they provided us with evidence of the changes in blank prescription security, including a detailed action plan and improvements made. We visited on 22 June 2016 to review these systems and ensure the improvements had been completed. On our follow up inspection we found:

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe which included:

- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The security of prescription pads had been revised and a robust system was in place. The practice had introduced new keys for all staff for the storage cupboard for the blank prescription pads. The practice had introduced a system to track the use of the prescriptions through the practice. We saw the updated protocol for handling, storing, recording and monitoring of blank prescriptions, and communications across the team where the processes had been discussed and shared and updated.