Beech House, Shebbear Surgery

Quality Report

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Shebbear
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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an inspection of Beech House, Shebbear Surgery on 13 December 2016. This review was performed to check on the progress of actions taken following an inspection we made in July 2015. In July 2015 the practice did not have safe systems in place for the safe management and storage of medicines. We requested an action plan following the inspection in May 2015 which detailed the steps they would take to meet their breach of regulation.

The practice has not been rated following this inspection. A comprehensive inspection is planned for the near future.

This report covers our findings in relation to the requirements and should be read in conjunction with the report published in October 2015. This can be done by selecting the 'all reports' link for Beech House, Shebbear Surgery on our website at www.cqc.org.uk

Our key findings across all the areas we inspected were as follows:

During our latest inspection on 13 December 2016 we found the provider had started to make the necessary improvements with medicines management within the dispensary.

- Systems were in place to ensure all prescriptions, including those for controlled drugs were signed before they were dispensed to the patient.
- Systems were in place to monitor patients that were taking high risk medicines.
- All staff dispensing medicines had commenced or received appropriate training.
- Systems were in place to record the balance of controlled drugs being received into the dispensary and being dispensed.

However, other aspects of the practice had not improved and were poorer than previously identified.

- Emergency equipment and medicines were available; however, some of the emergency medicines and many other medicines found in the consulting room were found to be out of date.
- Minimum and maximum refrigerator temperatures were not being recorded in a timely way as to ensure safe storage of medicines.
- Medicines were not stored securely, including those returned from patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, the documentation was not always in sufficient detail.
- Blood and urine samples were not sent for testing in a safe time scale.
- Controlled drugs were not always stored or disposed of in accordance with legislation.
- Governance arrangements were not effective in providing an oversight of practice performance, patient safety or the performance of staff.
- Leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively and at times were out of touch with what was happening during day-to-day service delivery.

The areas where the provider must make improvement are:

- Ensure that all medicines in the practice are in date and stored securely.
- Ensure that patient returned medicines are stored securely and safely disposed of according to The Hazardous Waste (England and Wales) Regulations 2005.
- Ensure that controlled drugs are prescribed, dispensed, stored, recorded and disposed of according to The Misuse of Drugs Regulations 2001 and The Misuse of Drugs (Safe Custody) Regulations 1973.

Summary of findings

- Ensure systems and processes are in place to provide effective governance, including quality assurance and auditing systems or processes.
- Ensure that blank prescription stationary is stored securely at all times and the use of prescriptions monitored in accordance with NHS Protect guidance.

The areas where the provider should make improvements are:

- Review how competency assessment is considered for dispensary staff
- Ensure consistent and accurate information is provided regarding opening times and appointment times

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?

Since the inspection in May 2015 the practice had started to improve the systems, processes and practices in place to keep people safe. For example;

- Systems had been put in place to ensure all prescriptions for controlled drugs were signed before they were dispensed to the patient.
- Systems were now in place to monitor patients that were taking high risk medicines.
- All the staff working in the dispensary dispensing medication had commenced training.
- Systems were in place to record the balance of controlled drugs being received into the dispensary and being dispensed.
- 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.
- Risks to patients were assessed and well managed.

However, at this inspection we found;

- Emergency equipment and medicines were available; however, some of the emergency medicines and many other medicines found in the consulting room were found to be out of date.
- Minimum and maximum refrigerator temperatures were not being recorded in a timely way to ensure safe storage of medicines.
- Rooms storing medicines and liquid nitrogen, used in minor surgery, were not kept in locked rooms for safety and security.
- Unused, patient returned and some out of date medicines, including controlled drugs, were found in a consulting room and not stored securely or disposed of in line with legislation.
- Prescription forms were not monitored or stored safely when consulting rooms were not in use.

Summary of findings

Are services well-led?

The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care. This included a lack of arrangements to monitor and improve quality. For example

- There was no effective system for identifying, capturing and managing issues and risks.
- Governance of infection control policies including replacing dignity curtains.
- Governance arrangements to ensure staff awareness of medicines protocol in regard of cold storage of vaccines is effectively communicated.
- Governance arrangements to review overall complaints management process as policy out of date.
- Practice specific policies and information for patients were not always current, accurate or kept under review.
- Leaders do not have the necessary experience, knowledge, capacity or capability to lead effectively and at times were out of touch with what was happening during day-to-day service delivery.

Summary of findings

What people who use the service say

We spoke with eight patients during the inspection and one representative from the patient participation group (PPG). All nine patients said they were satisfied with the care, said it was easy to get through to the practice by phone and did not experience any difficulty in obtaining appointments. They told us they were involved in their care and treatment and thought staff were approachable, committed and caring. Two patients commented about lengthy waiting times on arrival at the practice for their appointment, but also stated they valued the time GPs spent with them discussing their problems.

The representative of the PPG told us some patients of the Shebbear practice were unhappy with the name change to Hatherleigh Medical Centre as they had not been informed prior to the change and it had caused some of confusion with the older patients.

Areas for improvement

Action the service MUST take to improve

- Ensure that all medicines in the practice are in date and stored securely.
- Ensure that patient returned medicines are stored securely and safely disposed of according to The Hazardous Waste (England and Wales) Regulations 2005.
- Ensure that controlled drugs are prescribed, dispensed, stored, recorded and disposed of according to The Misuse of Drugs Regulations 2001 and The Misuse of Drugs (Safe Custody) Regulations 1973.
- Ensure systems and processes are in place to provide effective governance, including quality assurance and auditing systems or processes.
- Ensure that blank prescription stationary is stored securely at all times and the use of prescriptions monitored in accordance with NHS Protect guidance.

Action the service SHOULD take to improve

- Review how competency assessment is considered for dispensary staff
- Ensure consistent and accurate information is provided regarding opening times and appointment times

Beech House, Shebbear Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector, and a CQC pharmacy inspector.

Background to Beech House, Shebbear Surgery

The Beech House, Shebbear Surgery was previously inspected on the 16 July 2015. Our inspection on 13 December 2016 was a focussed inspection to check if areas identified as requires improvement had been actioned.

The practice is owned by two partners, the main GP and a practice nurse, who also manages the practice. They took over neighbouring Hatherleigh Medical practice as the registered providers in October 2015. Both practices provide a service to approximately 3540 patients. 2150 of these use the services at Hatherleigh and 1300 at Shebbear. The providers have one NHS contract to deliver primary care services to the two registered locations. The partners work as a GP and nurse at the practice, and also work at and manage this second GP practice.

The Beech House practice is situated in the rural village of Shebbear in North Devon. At the time of our inspection there were approximately 1,300 patients registered at the Shebbear Surgery. The practices population is in the sixth decile for deprivation, which is on a scale of one to ten. The lower the decile the more deprived an area is compared to the national average. The practice population ethnic profile is predominantly White British. The practice has a slightly higher elderly population than the national averages with 28% of the practice list aged over 65 years. The average male life expectancy for the practice area is 83 years which is higher than the national average of 79 years; female life expectancy is 84 years which is higher than the national average of 83 years.

There is a principle male GP supported by three locum GPs, one male and two female. The GP holds managerial and financial responsibility for running the business. The team are supported by the practice manager who is also the practice nurse prescriber, a practice nurse, a healthcare assistant/phlebotomist (Phlebotomists are people trained to take blood samples) and additional administration and reception staff.

The practice also has a dispensary overseen by a pharmacist.

The practice website and a sign outside the practice advertises the practice as being open Monday to Friday from 8.30am until 6pm with a 1pm to 2pm session for lunch when calls are transferred to an answer machine with information about how to contact the out of hours provider. Appointments are available between 9am and 1pm or 2pm and 5pm. However, NHS choices advertise the practice as being open on Monday, Wednesday and Friday between 9am and 6pm with a 1pm to 2pm session for lunch and open 7.30am to 1pm on a Tuesday and 7.30am to 5pm with an hour's lunch. On Tuesday 13 December, the day of our inspection, the practice closed at 1pm

Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Detailed findings

The practice have a Primary Medical Services (PMS) contract with NHS England.

This report relates to regulated activities from the site at Beech House, Shebbear, Beaworthy, Devon. EX21 5RU.

Why we carried out this inspection

We carried out an inspection of the Beech House Shebbear Surgery on 16 July 2015 and published a report setting out our findings. We asked the provider to send us a report of the changes they would make to comply with the regulation they were not meeting. We inspected the practice to ensure the actions stated had been completed.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We reviewed information sent to us by the practice. We carried out an announced focussed inspection at short notice. We looked at management and governance arrangements and a sample of patient records and spoke with eight staff members and eight patients who used the service.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available. We reviewed the significant event records within the practice, only one had an action plan that identified learning from the incident.

Overview of safety systems and processes

The practice had a dispensary offering pharmaceutical services to those patients on its practice list who live more than one mile (1.6km) from their nearest pharmacy premises. The practice was signed up to the Dispensing Services Quality Scheme, to maintain a high quality service to patients using the dispensary.

At our inspection in July 2015 we found :

The practice did not have systems in place to check medicines were within their expiry date and suitable for use. We had checked the GP visiting bag and found medicines out of date. The provider sent us an action plan stating that a monthly review of the GP visiting bag with log book of the audit was in place and there was also a log book with medicines stored in treatment room to ensure they remained in date.

At this inspection on 13 December we found the arrangements for managing medicines, including controlled drugs, emergency medicines and vaccines, did not always keep patients safe. Medicines in the dispensary were stored securely and the date checking process ensured medicines supplied to patients on prescription were within their expiry dates. However, we saw many medicines stored in the nurse's treatment room were out of date. For example Glucose had an expiry date of November 2016, an inhaler to assist with breathing had an expiry date of October 2013 and an optic eye patch expired in July 1988. Out of date medicines were found in the doctor's room, including injectable medicines that were over ten years out of date. These were stored along with other in date, injectable medicines which increased the risk that they may be used.

Although medicines returned to the dispensary for destruction were disposed of safely according to waste regulations, we found several patient returned medicines in the doctor's room which were not stored or disposed of safely and securely. One such box of medicines, which had passed its expiry date, had a note attached asking the doctor if it could be re-used. (Unwanted medicines returned from patients cannot be re-used, as it cannot be guaranteed that they have been stored according to the manufacturer's recommendations to maintain their effectiveness). This indicated a lack of clarity about the safe use of medicines.

In July 2015 we found that controlled drugs were stored correctly with only relevant staff having access. We looked at the controlled drugs (CD) book and saw that there were no running balances of CD medicines completed although spot checks were carried out and the balances were correct.

At this inspection we found the practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). Staff recorded the receipt and use of controlled drugs appropriately in the dispensary. Stock checks were carried out to make sure these medicines were looked after safely. Although staff recorded, denatured and disposed of controlled drugs returned to the dispensary safely and securely, we found one ampoule of a controlled drug stored insecurely in the consulting room. This ampoule had been prescribed and dispensed for a home visit to a patient, but was not needed. The controlled drug should have been returned to the dispensary for safe custody prior to destruction. When this was highlighted the practice made a referral to the General Medical Council which was followed up the inspection team.

In July 2015 we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely however access to the keys was not restricted. We found the practice was not recording the room temperature of the dispensary and the refrigerator used to store medicines did not have a thermometer that could record minimum and maximum temperatures so only actual temperatures were being recorded. The refrigerator was also in need of defrosting.

At this inspection we found staff monitored and recorded the temperature of the dispensary to ensure that medicines were stored at the recommended room temperature. There were systems in place to monitor the temperature of the fridges and staff took appropriate action when they recorded temperatures outside of normal

Are services safe?

ranges in the dispensary fridge. However, vaccines were not stored securely elsewhere in the practice; the vaccine fridge was found in an unlocked storage room with the key in the lock. There were systems in place to monitor the temperature of all the fridges but these had been recorded infrequently so could not ensure vaccines and medicines had been stored safely. Consequently the vaccines may be less effective in preventing illnesses. We found a further refrigerator storing medicines outside the manufacturers recommended temperature range of 2 to 8 degrees centigrade. The fridge in the treatment room had a visual display that indicated that the fridge required defrosting and a temperature of .08 degrees. We asked a staff member what they would do if the fridge temperatures were out of the normal range and they were unable to tell us. We also asked for the practice vaccine safety and cold chain storage guidance but the practice were unable to provide us with a copy.

In July 2015 we found there was a lack of systems in place to ensure appropriate prescription monitoring was in place. Repeat prescriptions were issued and printed in the dispensary and then dispensed and given to the patient without the prescription being signed by a GP; this included high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which required regular monitoring in regard of national guidance, and controlled drugs regulations.

At this inspection we found processes were in place for handling requests for repeat prescriptions, which included reviews of high risk medicines. Dispensary staff identified when a medicine's review was due and told us they would alert the prescriber to ensure appropriate tests were carried out. The prescriber had to re-authorise the medicine before dispensary staff could issue a prescription. This process ensured patients only received medicines that remained necessary. All prescriptions were signed by a prescriber before being issued to patients.

At our inspection in July 2015 we found the practice employed a qualified registered pharmacist and an assistant who had not received any accredited training or was currently on any training courses.

At this inspection we found all members of staff involved in dispensing medicines had received or were undertaking appropriate training. However, there was no process to check that staff were competent to undertake the tasks asked of them. Staff used a bar code scanner to double check dispensed items matched what was prescribed to reduce the chance of errors. Medicines incidents or 'near misses' were recorded, investigated and relevant learning shared to reduce the chance of reoccurrence. For example, an audit tool had been developed for reception staff who handed out medicines to patients to reduce the risk of them being given someone else's medicines. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).

At our inspection in July 2016 we found a modesty curtain in a consultation room had not been changed at the correct frequency of six monthly. At this inspection we observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. However, systems and processes had not been improved; the modesty curtain in the treatment room remained dated 15/1/14 and in the consultation room the last date of 15/1/16 had been crossed out and replaced with the date 15/1/14 making it difficult to identify if the curtain had been replaced correctly. We also found unlabelled and undated sharp bins, sharps bins should be labelled with surgery name and date of first use, stored in a place not accessible to children, locked ready for collection when contents reach the black line or after three months even if not full.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The visions and values had been included on the new website, found as a link in the Hatherleigh Medical Centre Website. The vision and guided values of the practice on the website were listed as:

- Care close to the patient.

- Provide holistic care for the patients minimizing the traveling to the hospitals.

- Improve the access of the patients to the health services.

- Respect the family and cultural environment of the patient.

- Cooperation with other health services and teams.

- Development of skills mix in the working team.

The patients we spoke with stated they were receiving care and treatment in line with the practices vision and were highly satisfied with the services received.

Governance arrangements

At our last inspection in May 2015 there were several aspects of practice and performance governance which required improvement. Whilst improvements had been made in some areas, such as managing the dispensary, other areas had not been improved or had deteriorated. We found the delivery of high-quality care was not assured by the leadership and governance in place. The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care.

Areas which required improvement were;

- Governance of infection control was not effectively in place including; updating and monitoring of adherence to policies and maintaining equipment standards such as replacing dignity curtains and correctly assembling and managing sharps waste bins.
- Governance arrangements to ensure staff awareness of medicines protocols in regard of vaccine storage were not effectively communicated or monitored.
- Governance arrangements to review practice specific policies and information for patients were not always current, accurate or kept under review; for example, the complaints management process policy was out of date.
- Systems and processes were not in place to ensure an effective oversight of significant events, particularly in regard of action planning and learning from these occurrences.
- Systems for safe medicines management were not managed effectively. There was no system for the safe governance of prescription paper to ensure all prescription forms were accounted for. Security processes for ensuring printers could not be accessed when rooms were not in use had not been considered making the practice vulnerable to the risk of theft.
- Systems and process were not in place to ensure safe management of medicines, including fridge temperature monitoring and management of emergency equipment and medicines.
- Systems and process were not in place to ensure all medicines used within the practice were in date or disposed of correctly.
- Systems and process were not in place to ensure blood and urine samples were sent for testing in a timely way. We found two such samples in a refrigerator which had been there for three days and had not been sent off. This could result in ineffective test being carried out and delays in providing appropriate treatment to patients.

The provider and practice manager gave us a folder of practice policies; these had all been updated on the 20 September 2016. The policies and procedures were a mixture of Beech House, Shebbear Surgery and the Hatherleigh Medical Centre and contained out of date information, for example, naming previous staff members as the Caldicott guardians.

Leadership and culture

Since the last inspection in July 2015 the leadership team had taken over, in October 2015, the Hatherleigh Medical practice, approximately 10 miles from the Beech House practice. Both practices provide a combined service to approximately 3540 patients. 2150 of these used the services at Hatherleigh medical centre and 1300 at Shebbear surgery. The partners workedas a GP and nurse

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

at the Hatherleigh practice and also worked at and managed this GP practice. It was not clearly identified through discussions with the management team how the management of the two GP locations, considering the geography of the locations coupled with the clinical commitments of the partners, worked.

There were a number of issues outstanding from the inspection in July 2015 that had not been actioned to a satisfactory standard and other issues were apparent at the latest inspection and this demonstrated that the clinical and other leadership at the practice required further improvements.

We noted the lead GP worked at both locations and the nurse partner acted as practice manager at one location and nurse at the other. Evidence from the patient appointment system, the unclear practice opening times and comments from staff indicated the provider lacked capacity to lead the practice effectively despite the improvements seen. Similarly, evidence from the incomplete governance arrangements, the practice manager's inability to locate information when requested and errors of judgement in regard of medicines management indicated the capability of the provider was compromised through lack of capacity to maintain a full oversight of the practice. Discussions with practice staff, NHS England and the Clinical Commissioning Group indicated the providers resources had been invested in the Hatherleigh practice, to the detriment of the Shebbear practice.

Seeking and acting on feedback from patients, the public and staff

There was minimal formal engagement with patients to obtain feedback. The practice had a patient participation group (PPG). The PPG representative told us they had a meeting three weeks ago, the first in a long while, and they were able to raise that patients are unhappy with the change of name, they told us of a couple of incidents were older patients had been taken to hospital and were told they were from Hatherleigh practice. This has caused a lot of confusion as they identified themselves as being from Shebbear Surgery and had not been consulted about recent changes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the Regulation was not being met: There was no evidence to demonstrate competence of how the management of the two locations, considering the geography of the locations coupled with the clinical commitments of the partners, provide safe, effective, caring, responsive and well led services. Regulation 19(1) & 19(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** How the regulation was not being met: All medicines in the practice were not in date and stored securely. Patient returned medicines were not stored securely and safely disposed of according to The Hazardous Waste (England and Wales) Regulations 2005. Controlled drugs were not prescribed, dispensed, stored, recorded and disposed of according to The Misuse of Drugs Regulations 2001 and The Misuse of Drugs (Safe Custody) Regulations 1973. Blank prescription forms for use in printers, were not handled in regard of national guidance as these were not tracked through the practice and kept securely at all times.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes in regard of governance arrangements were not effectively established or operated to ensure an effective oversight of the practice was maintained and services for patients were improved. Systems or processes in regard of risks to patients were not were not assessed or monitored to help improve the quality and safety of the services provided, Areas of

This section is primarily information for the provider

Enforcement actions

concern included; a poor oversight of infection prevention, sharing and learning from significant events, and an overview of policies and procedures relating to the practice.

Regulation 17 (1)