Castle Gardens Surgery

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Inspection report

Castle Hill Gardens
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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The practice rating for the safe key line of enquiry has been reviewed as part of this desktop review and is rated as good for providing safe services

Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement. Systems for ensuring the changes to practice were embedded and sustained have now been put in place. Risks to patients who used services were assessed and systems and processes to address these were in place. Risks with regard to the security medicines have now been addressed and improvements made. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

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Detailed findings

Background to this inspection

Why we carried out this inspection

We carried out an inspection on 13 October 2014 and published a report setting out our judgements. 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 have followed up to make sure the necessary changes have 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.

We have not revisited Castle Gardens Surgery as part of this review because the practice was able to demonstrate compliance without the need for an inspection.

How we carried out this inspection

We reviewed information given to us by the practice. We have not revisited Castle Gardens Surgery as part of this review.

Good

Is the service safe?

Our findings

Following the comprehensive inspection in October 2014, the practice sent us an action plan and provided evidence showing the improvements made in relation to management of medicines. The improvements related to monitoring the temperature of the dispensary, storing dispensed controlled drugs securely until collection and calibration of equipment used to monitor temperatures and risks associated with the storage of vaccinations.

At the last inspection, we found that the practice dispensed medicines for approximately half of the registered patients. There was a refrigerator in the dispensary for any items requiring cold-storage and we saw that there was monitoring of temperatures to ensure these medicines were stored correctly. We were told that there were no regular checks made of expiry dates of stock held in the dispensary, but that these were checked at the time of dispensing. The practice did not monitor the temperature of the dispensary to ensure that all medicines kept were suitable and safe to be used. Evidence reviewed for this desktop review demonstrated that the practice now monitors the temperature of the dispensary and records are kept of this.

Controlled drugs were stored securely and were recorded in a register when received, given out or destroyed at the last inspection. The practice had detailed standard operating procedures for dispensary tasks which provided guidance for staff. However, controlled drugs dispensed for patients were not stored in the safe whilst they were waiting to be collected, which was not in line with these procedures. Evidence sent to us for this desktop review demonstrated that the practice had reviewed the standard operating procedures so that controlled drugs dispensed for patients are now stored securely until the patient collects them.

Vaccines were stored appropriately at the last inspection. There were auditing systems in place to ensure that the cold chain was maintained so that these products would be safe and effective to use with patients. At the last inspection, we found that the thermometer used to carry out these checks was not calibrated regularly providing assurance of the temperatures being monitored. The refrigerator used to store vaccines was not hard wired, which would reduce the potential risk of it being accidently switched off. Evidence sent to us for this desktop review demonstrated that the practice had assessed the risk and had the refrigerator used to store vaccines hard wired. A system to regularly calibrate the thermometer had been set up. Other medicines kept at the practice for use by GPs and practice nurses were stored safely and systems were in place to monitor expiry dates. Emergency medicines and equipment were available at the practice.

Systems in place ensured that all dispensed medicines had been prescribed and signed by the doctor before they were prepared or given out to patients. There were arrangements in place for the destruction of controlled drugs.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff at the last inspection. There were systems to record any errors or incidents occurring, so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. We found that there had been no incidents reported in the dispensary over the last two years.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. There were systems in place to ensure that all prescriptions were authorised by the prescriber, and that patient medicines were regularly reviewed. The computer system allowed for highlighting high risk medicines and those that required more detailed monitoring, and for checking for allergies and interactions.

Patient records were updated following a patient's hospital discharge or a home visit. Systems were in place to make sure that any changes or updates to patient medicines were always made and authorised by the doctor.

Systems were in place to make sure these were checked regularly. Medicines that were kept in any doctors bags were the responsibility of each GP to maintain supplies and ensure expiry dates were checked. We checked two doctor's bags and found supplies were in date.

Blank prescription forms for printing were stored securely, and serial numbers were recorded on receipt, and when issued to doctors rooms or printers. However, we saw that some blank prescription forms, pre-printed with the surgery details, were kept in an unlocked drawer in the dispensary. We were also told by dispensary staff that it was not recorded if these were taken by doctors for their bags or surgery rooms. This was not in line with current

Good

Is the service safe?

guidance from NHS Protect on the security of prescription forms. Following the inspection, we received further information from the practice demonstrating that the protocols had been discussed at a practice meeting and reviewed to improve security and included an audit process.

Records of practice meetings noted the actions taken in response to reviews of prescribing data, for example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. In April 2014, the practice had looked at prescribing patterns of medicines used to reduce gastric reflux for patients. This showed the GPs were working within the latest guidelines so patient safety was maintained and with the local area optimisation team to prescribe in a cost effective way.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. Staff told us the administration team held a list of tasks each nurse and healthcare assistant had received training for and were able to undertake. For example, only nurses who were trained to do so carried out baby immunisations.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice had recently carried out a prescribing review of pain relieving medication for patients with complex needs. This showed the team of GPs had worked with patients to reduce the dose they had been prescribed and doses were within safe limit guidelines.

Training records showed that staff working in the dispensary had received appropriate training and regular checks of their competence were completed. The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. An audit was carried out in April 2014 by an external assessor from the local area team, which concluded the dispensary was well run.