Ashlea Medical Practice

Quality Report

Gilbert House,
39 Woodfield Lane,
Ashtead,
Surrey,
KT21 2BQ
Tel: 01372 276385
Website: www.ashlea.nhs.uk

Date of inspection visit: 14 July 2015
Date of publication: 17/09/2015

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 of this practice on 5 November 2014. Breaches of legal requirements were found during that inspection within the safe domain. After the comprehensive inspection, the practice sent to us an action plan detailing what they would do to meet the legal requirements in relation to the following:

- Improve the security for the storage of blank prescription forms and recording the serial numbers of prescription forms in line with national guidance
- Record all significant events and ensure that regular review meetings are documented to demonstrate that the practice had learned from these and that findings are shared with relevant staff

Our previous report also highlighted areas where the practice should improve:-

- Record notes from reception staff meetings
- Ensure all staff complete safeguarding for Vulnerable Adults

We undertook this focused inspection on 14 July 2015 to check that the provider had followed their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link on our website at www.cqc.org.uk

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

- Significant events were a standing agenda item in the practice meeting held every three weeks.
- Minutes were kept of the significant events meeting discussions and reflective learning was recorded.
- Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.
- Records were kept of the serial numbers of blank prescriptions pads issued to the GPs and these were counter signed by the GP and the reception manager.
- Prescription pads were stored in a lockable draw in an area where non authorised staff did not have access.
- Most staff had completed training on safeguarding vulnerable adults and dates were in place for those that were yet to take place.
- We saw that minutes were being kept of reception staff meetings.

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 is now rated Good for delivering Safe services

Previously we found the practice had not ensured the secure storage of all blank prescriptions pads and that the serial numbers of prescriptions were not routinely recorded. At this inspection we found that blank prescriptions were now being handled in accordance with national guidance. We saw that they were tracked through the practice and kept securely at all times. Records were kept of the serial numbers of prescriptions pads issued to the GP and these were counter signed by the GP and the reception manager. Prescription pads were stored in a lockable draw in an area where non authorised staff did not have access.

At our last inspection we found that significant events were not being centrally recorded and although they were discussed at daily meetings, the meetings were not minuted. There was no evidence that significant events were used by staff for continuous learning. At this inspection we found that significant events were a standing agenda item for discussion at the practice meeting held every three weeks. Minutes were kept of the meeting discussions and reflective learning was recorded. A partner GP and the practice manager reviewed all significant events to ensure that no trends were emerging and that any relevant information was passed to staff for continuous learning. All significant events were recorded centrally and were sent to the local clinical commissioning group each year.

Ashlea Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 5 November 2015 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

Breaches of legal requirements were found. As a result we undertook a focused inspection on 14 July 2015 to follow up on whether action had been taken to deal with the breaches.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At our previous inspection we reviewed the annual summary of significant events which had had recorded two significant events which had taken place over the last 12 months. However, after talking with the GPs it was recognised that significant events were taking place but were not being recorded in the annual summary. GPs we spoke with told us of other significant events which had been discussed at the GPs daily meetings and were used in their re-validation. GPs we spoke with told us discussion ensured that appropriate learning took place. However, the daily meetings were not recorded so we were unable to see evidence that findings were communicated to all relevant staff to allow for learning to be shared.

At this inspection we found that significant events were being centrally recorded and discussed at the three weekly practice meeting. We saw these meetings were minuted and that reflective learning was captured in the significant event record. The practice manager and one of the partner GPs told us that following our last inspection a meeting was held with the GPs to discuss significant events and re-enforce how these needed to be centrally recorded and discussed. Significant events were now a standing item on the agenda for the practice meetings and we reviewed past minutes of meetings which confirmed this. We also saw evidence that GPs were ensuring that appropriate learning was also recorded and where appropriate disseminated to relevant staff. The GP partner we spoke with informed us that they and the practice manager reviewed all significant events as they arose to ensure that there were no trends emerging. The practice manager informed us that a meeting was planned in October 2015 to review all significant events from the last year.

Medicines management

At our previous inspection we found that blank prescription forms were not always handled in accordance with national guidance. Blank prescriptions had not been tracked through the practice or kept securely at all times. We saw that blank prescriptions pads were stored in unlocked drawers that could have been accessed by patients. Prescription serial numbers had not been recorded, including where, when and to whom the prescriptions had been issued.

At this inspection we found that blank prescriptions were handled in accordance with national guidance as these were now tracked through the practice and kept securely at all times. We saw evidence of a new system in place where the reception manager counter signed all prescription pads being signed out by GP's. Records we reviewed evidenced this procedure. This information was stored in a folder with the name of the GP, a record of the serial numbers for the prescription pad and the date. The prescription pads themselves were stored in a lockable draw with the key stored in a separate locked location; therefore no unauthorised staff or members of the public were able to access the pads. We spoke with a partner GP who told us that the practice was using electronic prescribing which meant the need to use hand written prescriptions had reduced. GPs, after attending home visits, could now issue prescriptions from the practice via electronic prescribing which meant that the prescription could be sent to the patients' choice of pharmacy ready for collection.