Mid Devon Medical Practice

Quality Report

Witheridge Medical Centre
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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	Good
Are services safe?	Good

Summary of this inspection

Detailed findings from this inspection

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 as good for safe having made improvements to the way medicines are managed.

The practice rating for the safe key line of enquiry has been reviewed as part of this desktop review. We followed up the areas we were concerned about. Risks with regard to the safety security medicines highlighted at the last inspection have now been addressed and improvements made.

Our findings at the last inspection were that 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 were in place. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

Mid Devon Medical Practice

Detailed findings

Why we carried out this inspection

We carried out an inspection on 27 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 Mid Devon Practice 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 sent to us by the practice. We have not revisited Mid Devon Medical Practice as part of this review.

Good

Are services safe?

Our findings

Medicines Management

Since the comprehensive inspection in October 2014, the practice sent us an action plan and provided evidence showing the improvements made. The improvements related to ensuring that repeat prescriptions were signed by a GP before the medicines were given patients and reviewing the standard operating procedures for managing controlled medicines and ensuring they were followed.

At the last inspection, we found that the practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. We checked the arrangements for looking after medicines in the main practice at Witheridge and the two branch practices at Morchard Bishop and Cheriton Fitzpane. Each of the practices had a dispensary. All the dispensaries used the same procedures to maintain consistent standards. Dispensary staff told us they usually worked at one practice but would work in any of the practices as the need arose.

In October 2014, there were safe systems were in place for the generation of repeat prescriptions. Patients had a number of ways to request their repeat prescriptions. Staff had arranged with some patients for their repeat prescriptions to be generated automatically. Repeat prescriptions had an annual review date after which staff could not generate a repeat prescription unless the GP had reviewed the prescription. Prescription pads were kept secure when not in use. Safeguards were in place to make sure that high risk medicines were identified and regularly monitored.

Appropriate systems were in place for the safe dispensing of medicines. However, patients were given their repeat medicines before the prescriptions had been checked and signed by the GP. The prescriptions were kept with the dispensed medicines. Staff said that prescriptions were always signed by the GP on the day they had been given to the patient. The systems have been improved since the inspection. We reviewed and the amended standard operating procedures, which showed that systems had been put in place as required. The practice had implemented a system whereby GPs sign scripts before medicines are dispensed and given to patients. The practice manager verified that a designated area for signed and scripts waiting to be signed had been created at all three GP surgeries in the practice. Minutes of staff meetings held in November 2014 and July 2015 showed that changes had been made and that staff reported that the systems were working well.

In October 2014, medicines were stored securely at each of the practices and were only accessible to authorised staff. Medicines were stored at the required temperatures. Staff monitored the temperatures of medicines refrigerators to make sure these medicines were safe to use. Each practice had a supply of emergency medicines. These were checked regularly to make sure they were in date and safe to use.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. We checked the arrangements in place at each practice. There were arrangements in place for the recording of controlled drugs. There were several slightly different controlled drugs registers in place. This increased the risk of staff making mistakes as they completed them. We saw examples where records had not been completed correctly. The practice manager arranged for one form of register to be available and staff to have training to make sure records were completed accurately.

In October 2014, at one practice we found the controlled drugs were not stored according to the practice procedure. We brought this to the attention of the dispensary staff and the practice manager. Immediately after the inspection, the practice manager sent us information showing they had taken action to address this issue by ordering a new secure cabinet to store these medicines. For this review, we saw invoices demonstrating that a secure cabinet had been purchased and fitted at the surgery concerned.

Arrangements were in place for the destruction of out of date controlled drugs and of those returned by patients. However, in October 2014 there were a number of out of date controlled drugs in one practice, due to delays in a suitably qualified person being available to go and destroy the stock. A further request was made to the local area medicines team to make sure these out of date medicines would be disposed of safely. For this desktop review, we saw documentation between the practice and medicines team at the clinical commissioning group showing that the out of date controlled medicines had been destroyed within days of the inspection as per agreed protocols.

Good

Are services safe?

We have not looked at any other areas in relation to medicines management as these were satisfactory when we inspected and included –

Directions in line with legal requirements and national guidance were in place for nurses administering vaccines. There were up to date copies of these directions, which staff demonstrated they followed. There was a hard wired refrigerator in the treatment room for any items requiring cold-storage and temperatures were monitored to ensure these medicines were stored correctly. Nurses responsible for carrying out this task showed us the stock control system in place and vaccines used for patients were within date. Three patients attended appointments for flu vaccination during the inspection. Patients said that the nurse had first checked whether they had any allergies before giving the vaccination. All of the patients said the nurse had answered their questions and given them information about the vaccine before leaving. This promoted patient health and safety.