

The Ivy Medical Group

Quality Report

Lambley Lane Surgery

6 Lambley Lane

Burton Joyce

Nottingham

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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

Requires improvement



Are services safe?

Inadequate



Summary of findings

Contents

Summary of this inspection

Overall summary	Page 2
The five questions we ask and what we found	3

Detailed findings from this inspection

Our inspection team	4
Background to The Ivy Medical Group	4
Why we carried out this inspection	4
How we carried out this inspection	4
Detailed findings	6

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of The Ivy Medical Group on 18 July 2016. The practice was rated as requires improvement overall.

We then carried out an unannounced focused inspection of The Ivy Medical Group on 30 August 2016. This inspection was undertaken to follow up a Warning Notice we issued as a result of our inspection of 18 July 2016, as the practice had failed to comply with the regulations in respect of providing safe care and treatment for patients. This inspection cannot change the ratings. There will be a full re-inspection within six months of the publication date of the initial report.

Our finding across the areas we inspected was as follows:

- Detailed records were kept to evidence the receipt of and actions taken in respect of nationally available patient safety information including Medicines Health and Regulatory Authority (MHRA) alerts to ensure medicines were prescribed safely.
- The practice had reviewed the activities undertaken within the dispensary, consulted staff and produced updated standard operating procedures (SOPs are written instructions about how to safely dispense medicines) which reflected current practice.

- The arrangements for managing medicines in the practice kept patients safe and risks to patients were well managed. Specifically: effective systems were in place for shared care arrangements with secondary care to ensure adequate monitoring and follow up of patients on high risk medicines; repeat prescriptions dispensed at Lowdham medical centre were signed before the medicines were given to patients; and medicines were securely kept within the dispensary.
- Regular clinical meetings and staff bulletin updates were facilitated to promote learning from patient safety alerts and medicines related issues.
- The practice had purchased defibrillators for both sites (Lambley lane surgery, in Burton Joyce and Medical centre, in Lowdham) and staff had received relevant training for dealing with medical emergencies.

We found that the practice had complied with the Warning Notice.

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?

We found the provider had made significant improvements to ensure patients received a safe service following our comprehensive inspection of the practice in July 2016. For example:

- The practice had an effective approach to receiving, reviewing and acting upon information received from the Medicines and Healthcare Regulatory Agency (MHRA), NHS England and NHS Improvement. Patient safety alerts were also discussed in regular clinical meetings and disseminated in staff bulletin updates to promote learning and patient safety.
- A clear audit trail was maintained to demonstrate how the practice had responded to alerts by reviewing patients' medicines and taking action to ensure they were safe.
- The provider had strengthened the arrangements and procedures in place to ensure the safe management of medicines. This included the processes of prescription handling and the recording, safe keeping and dispensing of medicines.
- Suitable arrangements were also in place to ensure the security of the medicines kept in the dispensary.
- The practice had recently purchased an automated external defibrillator for both locations (Lambley Lane surgery and Lowdham Medical Centre) to ensure medical equipment was available for use during a medical emergency.

Inadequate



The Ivy Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a member of the CQC medicines team.

Background to The Ivy Medical Group

The Ivy Medical Group provides medical services to approximately 3,800 patients through a primary medical services contract (PMS). The catchment area for registered patients includes Burton Joyce, Lowdham and surrounding villages.

The practice has two GP surgeries with Lambley lane surgery, in Burton Joyce as the main surgery and Medical centre, in Lowdham as the branch site. We visited both locations as part of our inspection. A dispensary service is offered from the Medical centre, Lowdham and about a third of the practice population access this service.

The level of deprivation within the practice population is significantly below the national average, with most of the practice population living in affluent villages / semi-rural areas.

The current clinical team comprises one full-time GP (male), a salaried GP (female), a practice nurse (female) and a part-time health care assistant (female). The clinicians are supported by an administration team comprising a full time practice manager, a lead receptionist, six part-time receptionists, two medical secretaries and a practice administrator. The dispensary staff includes a dispensing manager and a dispensing assistant.

The Ivy Medical Group is a GP training practice offering placements for students from the University of Nottingham medical school.

The practice opens from 8.15am to 1pm and 2pm to 6.30pm Monday to Friday with the exception of Thursday when the practice closes at 12.30pm.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Nottingham Emergency Medical Service (NEMS).

Why we carried out this inspection

We undertook a focused inspection of The Ivy Medical Group on 30 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out to check that improvements had been made to meet a legal requirement (Regulation 12: Safe care and treatment) following our comprehensive inspection on 18 July 2016.

On 25 July 2016, we issued the provider a Warning Notice requiring improvements to be made and compliance with the legal requirement by 19 August 2016.

How we carried out this inspection

We inspected the practice against one of the five questions we ask about services:

- Is the service safe?

This is because the service was not meeting Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment.

Detailed findings

Before visiting, we reviewed information received from the practice following our July 2016 inspection. During our visit we:

- Spoke with a range of staff including the GP, practice manager, dispensing member of staff and non-clinical staff.
- Reviewed a range of records held by the practice and a sample of the treatment records of patients to corroborate our evidence.

Are services safe?

Our findings

At our last inspection on 18 July 2016, we found the provider was not adequately assessing, monitoring and mitigating the risks to patient safety; and effective systems were not in place to ensure the proper and safe management of medicines. Specifically:

- We found practice staff were not receiving all of the nationally available patient safety alerts
- We found there were no robust systems in place to ensure patients prescribed high risk medicines were receiving essential blood monitoring in line with recommended guidance.
- We saw that repeat prescriptions being dispensed at Medical Centre, Lowdham were not signed before the medicines were given to patients.
- There were issues with the security procedures in place in the dispensary. This included storage of the controlled drugs cabinet keys and the security of medicines kept in the dispensary.
- There was no functional automated external defibrillator on the premises.

As a result, we issued a Warning Notice on 25 July 2016 requiring the provider to become compliant with Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment by 19 August 2016.

At this inspection we found the provider had made significant improvements and had complied with the Regulation relating to safe care and treatment.

Safe track record and learning

An effective system was now in place to address safety alerts and significant events related to medicines management on an ongoing basis. This was underpinned by an updated policy titled “Dissemination of Drug Alerts, Patient Safety Notices, Guidance and Formularies Protocol” which was accessible to all staff for guidance.

We found the practice was now receiving a range of patient safety alerts via email including alerts from the Medicines Health and Regulatory Authority (MHRA), NHS Improvement and NHS England. The GP lead had completed an audit of 32 drug safety alerts issued over the

past 12 months as part of the practice’s clinical governance review. Searches were then undertaken on the clinical system to identify any affected patients and a review of their medicines was arranged.

In addition, a one off message was added to the repeat prescription forms for patients taking the specific medicines to inform them of the alert.

The lead GP had produced a bulletin for clinical staff and a separate one for dispensary staff to ensure historical alerts were highlighted and the actions taken to mitigate risks to patient safety. Systems were in place to ensure discussions taking place in clinical meetings included patient safety information. A traffic light rating system (red, amber and green) was also used to track the progress in following up affected patients and ensuring that all relevant staff were aware of action taken.

Medicines Management

The arrangements for managing medicines at both surgeries (Lambley lane surgery, in Burton Joyce and Medical centre, in Lowdham) had been strengthened in order to keep patients safe. We were assured by the processes we saw in place that patients were followed up and appropriately monitored. For example,

- The practice had completed a review of the activities carried out within the dispensary and updated and / or implemented new standard operating procedures (SOPs are written instructions about how to safely dispense medicines). This included SOPs related to dispensing a prescription, assembly and labelling, accuracy checking and counting/sorting prescriptions daily.
- Relevant staff to which the SOP would apply had been consulted and informed of the changes. The records we reviewed showed most of the staff had signed to confirm they understood the relevant procedures; and some staff were due to review the policies on return from their annual leave.
- We reviewed the SOP for disease-modifying anti-rheumatic drugs (DMARD) monitoring and shared care arrangements. We found these procedures reflected current practice within the surgeries. For example, our review of the clinical system with practice staff demonstrated effective procedures were in place for coding and recalling patients taking DMARDs to ensure appropriate monitoring and follow-up took place for affected patients.

Are services safe?

- The practice had undertaken a review of patients receiving high risk medicines, to establish if monitoring was within schedule in accordance with shared care arrangements. For example, seven out of eight patients receiving methotrexate were being monitored appropriately and the surgery was aware of the one patient who was due a blood test and follow-up action was taken to ensure they attended.
- We saw that patients who took medicines that required close monitoring for side effects had their care and treatment shared between the practice and hospital. The system for ensuring patients had received the necessary monitoring and tests before prescribing of the medicine was effective.
- The security of the dispensary at medical centre, Lowdham had been risk assessed and improved on to ensure the secure storage of medicines. For example, the controlled drug cabinet keys was now kept in a 'key safe' and blinds at the window were closed and this obscured the dispensary from being seen from the car park area. Security bars for the windows were scheduled to be installed within two weeks of our inspection and external advice had been sought to ensure the bars would not have an impact on fire safety.
- Staff were fully aware of the need for repeat prescriptions to be signed by a GP before they were

dispensed and given to patients. Our review of the 'medicines to be collected' boxes in the dispensary showed all but two prescriptions had been signed. This was brought to the attention of the dispensing member of staff and practice manager who told us that this was to be addressed as a significant event to ensure patient safety and learning from errors.

- Staff we spoke to had an awareness of the importance of dispensing near-miss errors being routinely reported and analysed to minimise the risk of recurrence.
- The management of blank prescriptions and uncollected prescriptions had been reviewed to ensure they were handled in accordance with national guidance.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. For example:

The practice had purchased two automated external defibrillators for both of its locations and these had been delivered on 11 August 2016. The practice nurse was the lead person responsible for undertaking regular checks going forward and staff we spoke with were all aware of the location of the equipment.