Clift Surgery Partners

Quality Report

Minchens Lane
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RG26 5BH
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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 findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Clift Surgery Partners on 24 August 2016 to monitor whether the practice had made improvements related to medicines management, identified at our inspection in February 2015.

At our last inspection in February 2015, areas which did not meet the regulations were:

- Prescriptions were not reviewed to ensure they were signed by a GP before they were given to a patient.
- Fridge temperatures were recorded but we were unable to see historical records.
- Keys for controlled drugs and prescription forms were accessible by all staff entering the dispensary.
- Prescription serial numbers were not recorded when they were given to GPs to use.
- Standard operating procedures (SOP) for dealing with medicines were in place but some of the SOPs, especially for controlled drugs (CDs) were not complete as they needed to reflect the procedures at the practice.

At this inspection in August 2016, we found that the provider had taken action to meet the requirement. Key findings were as follows:

- The practice had a suitable system in place for reviewing prescriptions prior to being given to patients.
- Complete records of fridge temperatures were available for inspection.
- Keys for controlled drugs and prescription forms were kept securely and only accessible to authorised members of staff.
- Records were maintained of prescription serial numbers when they were given to GPs.
- Standard operating procedures had been reviewed and reflected procedures at the practice.

The Care Quality Commission is satisfied that the regulations are now met. However, there are two areas where the practice should consider making further improvements:

- The practice should make sure that maximum and minimum temperatures are recorded for all medicine fridges and that actions are noted when the temperature is outside of the recommended range.

Summary of findings

- The practice's stock management system for blank prescription stationery should include what has been received, along with serial number data.

The full report published on 9 July 2015 should be read in conjunction with this report. The rating for the safe domain is now good and the overall rating remains good.

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 rated as good for providing safe services:

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process.
- Dispensary staff showed us standard operations procedures (SOP) which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). The SOPs were being followed by staff in the practice.

Clift Surgery Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was carried out by a CQC pharmacy inspector.

Background to Clift Surgery Partners

The Clift Surgery, Minchens Lane, Bramley, Basingstoke RG26 5BH is located in a rural area. The practice covers three moderate sized villages having both a rural and commuter population.

The Clift Surgery has a general medical services (GMS) contract to provide services to approximately 6,500 patients living in the surrounding area. The practice provides an in house dispensary serving 90% of patients registered at the practice and can provide acute and repeat prescriptions.

The practice reception is open Monday to Friday 8.30am to 6pm although telephone calls are taken until 6.30pm. The dispensary is open Monday to Friday 8.30am to 1.00pm and 2pm to 6pm. Routine surgeries are held Monday to Friday from 9am to 12pm, 2pm to 4pm and 3.30pm

to 5.30pm. The practice also offer extended hours, for pre-booked appointments only, as follows: On the first Saturday of the month from 9am to 12pm and every Tuesday from 7am to 8am. Alternate Wednesdays 7am to 8am alternate Thursdays 6.30pm to 8pm. The practice has opted out of providing out-of-hours services to their own patients and refers them to Hantsdoc who are the out-of-hours provider. Patients can access Hantsdoc via the NHS 111 service.

The practice has three GP partners and a salaried GP who together provide an equivalent of three and a half full time staff. In total there are one male and two female partner GPs. The practice also employs one salaried female GP. The GPs are supported by two nursing staff and two health care assistants. The practice also has an administration team which consists of receptionists, administrators, secretary, reception manager, IT manager and the practice manager.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This follow up inspection was carried out to ensure compliance with the breaches in medicine management that were found at our inspection in February 2015.

We carried out a focussed inspection of this service 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service.

How we carried out this inspection

We carried out an announced visit to the practice on 24 August 2016 and looked specifically at the shortfalls identified with medicines management at our inspection in February 2015.

We did not look at population groups or speak with patients who used the service.

Detailed findings

We spoke with the practice manager and four dispensary staff.

We looked at policies and procedures and inspected records related to the running of the service. These included minutes of staff meetings, significant events and action plans produced by the practice to address concerns and complaints.

Good

Are services safe?

Our findings

At our inspection in February 2015 we made a requirement related to medicines management. Shortfalls were found in reviewing prescriptions and ensuring they were signed by a GP before they were given to a patient to ensure safety. Fridge temperatures were recorded but we were unable to see historical records. Fridges used for the storage of medicines did not have records of their temperature being monitored on a regular basis readily available. Keys for controlled drugs and prescription forms cupboards were accessible by all staff entering the dispensary. Prescription security, serial numbers were not recorded. Standard operating procedures (SOP) for dealing with medicines were in place but some of the SOPs, especially for controlled drugs (CDs) did not reflect the procedures at the practice.

At this inspection, in August 2016, we found:

The practice adopted a system of checking repeat prescriptions that involved dispensary staff and the prescribing GP.

- Repeat prescriptions were printed in the dispensary.
- The dispenser labelled the medicines and put the medicines in a basket with the unsigned prescription.
- The GP checked the dispensed medicines and signed the prescription.
- A dispensing assistant checked the medicines against the prescription before bagging the medicines ready for collection by the patient or their representative.

This was a safe system involving three checks. The involvement of the GP ensured that there was a clinical check of the prescription before the patient received their medicine.

Acute prescriptions were printed in the dispensary and the medicine was supplied to the patient before the prescription was signed. The GPs signed prescriptions at the soonest opportunity, usually the same day. This is in line with dispensing GP guidance. The process was detailed in the dispensary standard operating procedures.

We examined 12 months of temperature records for the four medicine fridges. The records for the two dispensary fridges did not show the maximum and minimum temperature recordings. The staff did not consistently record actions when temperature readings were outside the recommended temperature range of 2-8 °C.

The keys to the controlled drug cupboard and the cupboard that stored blank prescription forms were kept in a key safe. Only the dispensary staff knew the code for the safe.

The printer prescription paper (FP10s) was stored in the dispensary and issued by dispensary staff. The prescriptions were issued in bundles of 100 forms; the prescriptions were separated in to bundles when a new box was opened. When bundles were issued, records included; start and finish serial numbers, date of issue, who issued to. Out of hours, staff locked printer trays in cupboards so that unauthorised staff could not access the prescriptions.

FP10 prescriptions for handwritten prescriptions were kept in a locked filing cabinet that was only accessed by two members of staff. The administrator or practice manager issued the prescriptions to doctors as single sheets. The serial number of each form issued was recorded.

The practice did not record what prescriptions were received and did not keep the delivery notes; this was against best practice guidance. The NHS Protect: security of prescription forms guidance August 2013; states organisations' stock management should record 'what has been received, along with serial number data'.

The practice reviewed the dispensary standard operating procedures following the last inspection and the SOPs were rewritten in August 2015. The procedures were reviewed on 22 June 2016. All dispensary staff signed a log in July 2016 stating they had read and understood the SOPs. We reviewed four SOPs (including the controlled drug SOP) and they accurately reflected the processes in the dispensary.

At our inspection in August 2016, we also reviewed areas where we considered the provider should make improvements. These related to learning form significant events; management of medicine alerts; and which emergency medicines were carried by GPs in their doctors' bags.

The practice had reviewed their near miss and incident reporting process. Any incidents were collated on a

Good

Are services safe?

spreadsheet and discussed at monthly meetings. In the dispensary there was a white board where staff wrote information on common errors. There was an open culture with a willingness to learn from errors.

Medicine and patient safety alerts were received by the practice manager. The practice manager forwarded alerts via email to the clinical staff. The dispensary staff reviewed the alerts in hardcopy and signed a log. Staff annotated the hard copy with the action taken.

The practice had risk assessed the contents of the doctor's bags and decided not to carry medicines.