

Care Quality Commission

Inspection Evidence Table

Dronfield Medical Practice (1-584963261)

Inspection date: 18 October 2019

Overall rating: Good

Safe

Rating: Good

- At our previous inspection in October 2018, we rated the practice as 'requires improvement' for providing safe services as the systems for checking temperatures in vaccine refrigerators was seen to be incomplete. Therefore, there was insufficient evidence that vaccines were being stored within the recommended temperature ranges to ensure their viability. In addition, there was no evidence that oxygen cylinder checks were regularly undertaken to ensure they contained a sufficient quantity of oxygen, or that they worked effectively.
- At the inspection in October 2019, we saw that the practice had undertaken effective action and operated a safe and reliable procedure to monitor vaccine refrigerator temperatures, and this was supported by documentation.
- Staff knew what action to take if temperature recordings were noted to be outside of recommended ranges. Staff with a responsibility to monitor the temperatures were trained appropriately, and the nurse practitioner provided leadership of the process.
- Oxygen cylinders were checked weekly to ensure the flow of oxygen was working and that there was a sufficient remaining oxygen supply available within the cylinder.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Following our findings at the previous inspection, the practice had taken immediate action to check their stock of vaccines were safe in liaison with Public Health England. They also informed and worked with their CGG to ensure improvements were made. The practice provided CQC with an action plan outlining the steps they had taken to address the areas of identified concern.• The practice had purchased an independent thermometer for each of their five vaccine refrigerators to ensure that temperatures could be monitored in the event of a power failure.	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • Vaccine refrigerator temperatures were recorded twice daily, and a data logger inside the fridge was downloaded once a week (or more frequently if manual recordings showed a temperature outside of the recommended ranges). • We saw evidence that the system worked effectively and if a temperature was outside of range, an explanation was provided on the temperature log sheets. We saw that data loggers had been downloaded when this happened to ensure that temperature ranges had not been breached. • The practice displayed clear information on what to do and who to contact in the event of a known concern with readings outside of the recommended temperature ranges. • Staff were able to describe how vaccines were transported safely. • The nurse practitioner provided clear leadership to the process, and staff who had been appropriately trained. • There was a practice cold-chain policy available which supported the procedure to monitor vaccine refrigerator temperatures and this was due to be reviewed in October 2019. • There was a clear system for checking oxygen cylinders which was documented. 	