Care Quality Commission

Inspection Evidence Table

Mitcheldean Surgery (1-568423037)

Inspection date: 09 October 2018

Date of data download: 24 September 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member(s) of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required	Y

Further Information:
The practice had an information leaflet on "keeping Children and young people safe". This contained information for patients on what they should do if they were worried about a child including useful numbers they could call. Monthly Safeguarding meetings were held with other professionals such as health visitors and community staff.

- Security of blank prescriptions.
- The processing of test results.

We also told the practice that they should:
- Review systems and processes across all aspects of care so that governance is consistently effective.
- Assess risks in relation to lone working in the dispensary.
- Review systems in place to ensure medicines were managed correctly and were in date.
- Invite carers for a health check.

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y
Explanation of any answers: Chaperone training was provided on 18/07/2018 by an external organisation and additional in-house training was delivered by the practice nurses on the 31/07/2018. All non-clnical staff attended those training. Lone working risks assessment had been undertaken for contract cleaners.	

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: 20/09/2016	Y
There was a record of equipment calibration Date of last calibration: 09/05/18 & 22/08/18	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks (monthly check carried out by a member of staff and an annual check was completed by an external contractor on 14/08/2018.	Y
Fire drills and logs (June and Sept 2018)	Y
Fire alarm checks	Y
Fire training for staff (undertaken on the 22/03/18)	Y
Fire marshals 22/03/18 due March 2019	Y
Fire risk assessment Date of completion 06/02/18 by Ellis Whittam	Y
Actions were identified and completed. For example, combustible around the room where the boiler is located needed to be removed, and additional signage needed to be fitted with "keep shut signs". These have been completed.	Y
Additional observations: The practice had an Electrical Condition Inspection carried out on the 4 October 2018 and was currently awaiting the full report.	
Health and safety Premises/security risk assessment? Date of last assessment: 06/02/18 by Ellis Whittam	Y
Health and safety risk assessment and actions Date of last assessment: 06/02/18 by Ellis Whittam	Y
Additional comments: The practice engaged with an external contractor to manage risk assessments for fire, health and safety and suitability of the premises. They worked with the contractor to implement and complete actions and used templates provided to record these.	

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: Sept 2018 The practice acted on any issues identified Detail: • Quotation had been obtained and there were plans for the flooring in two consulting rooms to be changed in Oct/Nov 2018. • IPC – Additional training had been put on for the Locality including for practice nurses from other practices. • Cleaning contract had been changed in August 2018 and the new contractor were training cleaning staff to achieve the standards required by the practice. • It was identified there was no Anti-bacterial wipes by the baby changer. These had now been put in place. • There were plans for old hand wash basins to be replaced through ongoing maintenance of the building.	Y
The arrangements for managing waste and clinical specimens kept people safe?	Y
Explanation of any answers: clinical wastes were labelled and managed safely.	

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
Explanation of any answers: Staffing was considered when work was being planned, for example during flu campaign and there was a risk assessment in place for staff cover. The practice had held training led by a GP by simulating emergency scenarios aimed at helping all staff identify what should be done in a 'real' situation. The last training was undertaken in June 2018. Equipment and assessment tool were in place to assist with the identification of patients with suspected sepsis.	

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers: There was a "buddy system" implemented where each GP were allocated to cover for their colleagues during absences. Additionally, there was a system whereby results were automatically allocated to the GP's buddy for checking and processing.	

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	1.23	0.91	0.95	Comparable with other practices
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA)	10.4%	9.3%	8.7%	Comparable with other practices

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Y
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y

Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y

Explanation of any answers:

- One of the GPs was leading on work to undertake reviews patients on long-term opiates together with the Clinical Pharmacist and prescribing was audited.
- The liquid nitrogen container was stored securely. Cold insulating gloves and eye protection was available and a padlock had been fitted to the cylinder so that this could not be tampered with.
- Locks had been fitted to each consulting and treatment rooms. A system had been introduced where prescriptions were removed from all rooms at the end of the day and stored securely.

Dispensing practices only	Y/N
There was a GP responsible for providing effective leadership for the dispensary.	Y
Access to the dispensary was restricted to authorised staff only.	Y
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	Y
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	Y
Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack.	Y
Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	Y
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	Y
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	Y

Explanation of any answers

All surgery staff authorised to access dispensary (staff need to use an adjoining room) but door locked to general public. There is not a designated area to confidentially speak face-to-face with patients, however, if required, any available clinical room would be used.

The practice held three monthly meetings with dispensers and the practice manager. We were told by the practice that incidents occurring in the dispensary were discussed.

Any other comments on dispensary services:
- The practice carried out three monthly stock checks where expiry dates were also checked. These were also recorded. Medicines at higher risks were checked twice a day.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	3
Number of events that required action	3

Example(s) of significant events recorded and actions by the practice;

Event	Specific action taken
Care of a patient following a total hip replacement.	Clinical staff were made aware of late post-operative wound infections. Where appropriate, staff were encouraged to discuss similar events with secondary care where appropriate.
Patient became unwell when they were given a difficult news about their spouse.	Although the practice identified that this emergency situation was well managed, they had arranged for a training session to practise emergency scenarios with all staff
A patient did not attend the practice to receive their periodical injectable treatment and this had not been picked up by the practice.	The practice identified that there were no systems in place to identify patients on similar treatment who had not attended the practice. An audit of those patients were carried out and a recall system established to ensure they were picked up if they did not attend for treatment.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
Comments on systems in place:	
All alerts were sent to one member of staff for circulation on the staff intranet system. Staff must acknowledge once they had read the alerts.	

Any additional evidence
Complaints and incidents were anonymised and shared with members of the patient forum. The purpose of this was to ensure that there was a quality monitoring process that these were being handled appropriately and in a timely manner. The practice also encouraged this to promote openness and transparency.
Forty-two patients were registered as carers. Out of those 19 had received a health check. The practice had reviewed the number of patients who were still carers and identified out of 200 patients, 42 were currently carers. Information were available in the waiting area so patient could identify as carers. There was a dedicated reception staff who would actively asked patient if they were carers.

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.(See NHS Choices for more details).