Care Quality Commission

Inspection Evidence Table

Cowplain Family Practice (1-544009443)

Inspection date: 18 June 2019

Date of data download: 6 June 2019

Overall rating: add overall rating here

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N (a)
Policies and procedures were monitored, reviewed and updated.	Y
Policies were 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 (b)
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
(a) We saw evidence that the safeguarding adult and children policies had been regularly reviewed and updated. However, policies we reviewed did not contain reference to patients' use of online services such as e-Consult which is used by the practice. (b) At the previous inspection in March 2018 not all staff had received training to a level suitable for their role in safeguarding adults and children. Since this inspection the practice had improved their recording process for monitoring training and produced a matrix of staff training records. All staff had received training relevant to their role. The matrix was colour coded to easily identify when staff were in need of an update.	

Recruitment systems	Y/N/Partial
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
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: Staff induction checklists were detailed and embedded into practice. We saw completed induction checklists in the recruitment files of all three staff files we reviewed.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 2 March 2019	Y (c)
There was a record of equipment calibration. Date of last calibration: 16 April 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 17 October 2018	Y
There was a log of fire drills. Date of last drill: 5 December 2018	Y
There was a record of fire alarm checks. Date of last check: 25 May 2019	Y
There was a record of fire training for staff. Date of last training: 14 May 2019	Y (d)
There were fire marshals.	Partial (e)
A fire risk assessment had been completed. Date of completion: 5 December 2018	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

(c) The portable appliance testing was in place and we saw evidence that testing had been undertaken on the listed objects.

(d) All staff had a record of having completed fire safety training and all but two staff had been recorded as completing this within the past year. The other two staff had completed training on 7 March 2018 and 4 April 2018The practice had a process in place for monitoring when training was overdue and had clearly marked these staff as overdue.

(e) The practice did not have designated members of staff to act as fire marshals. We spoke to the practice manager who told us there were informal fire marshals as everyone was responsible for fire safety. We spoke to staff who verified this stating that they were all responsible for evacuation processes and would check the doors and rooms to see if they were empty as they walked through the building. All staff were aware of the fire evacuation process and had completed their fire safety training. There was no way to identify on the matrix whether staff had undergone additional fire safety training that would normally be given to staff who have been identified as designated fire marshals (for example how to fight small fires safely and appropriate evacuation procedures).

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Partial (f)

Date of last assessment: 7 November 2018	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various – see (e)	Partial(f)
Explanation of any answers and additional evidence: (f) The premises and security risk assessment that was presented to us on the day of inspection was one that was for the whole building and had been undertaken by the landlord. Cowplain Family Practice are not the only tenants on the premises. The environmental risk assessment presented to us on the day of the inspection only contained information relating to shared communal areas of the building such as the entrance hallway, stairs and lifts used by everyone and not areas specific to the practice such as the meeting rooms and treatment rooms at Cowplain Family Practice. The practice did not have any further risk assessments in place to cover environmental risk for the areas not covered. The practice had a variety of ad hoc risk assessments in place for health and safety processes and there was a health and safety policy in place. The practice had a Legionella risk assessment undertaken in 2014. We saw evidence of water temperature recordings being completed in June 2019 with ranges varying between 36 and 55 degrees for hot water. There was no documented evidence of annual water sample testing. We discussed this with the practice manager who told us that they had been told there was no risk of Legionella due to it being a closed system.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 6 December 2018	Y (g)
The practice had acted on any issues identified in infection prevention and control audits.	Y (g)
The arrangements for managing waste and clinical specimens kept people safe.	Y (g)

Explanation of any answers and additional evidence:

(g) Hand Hygiene audit June 2019

Since the previous inspection the practice had changed their infection and prevention control (IP&C) lead to oversee systems and processes. Since taking on the role at the end of 2018, the lead had overhauled policies and procedures undertaking a full review of each. We saw evidence through the practice's IP&C folder that there were dates for when the next annual reviews were due and that audits had been undertaken. Actions from audits had been completed and any additional items identified documented at further audits, for example cleaning of skirting boards.

We were told that the practice had access to support from Southern Health NHS Trust infection control team for training and guidance.

A clinical waste audit had been undertaken on 23 May 2019. At the previous inspection, not all sharps boxes were being disposed of in line with national guidance but since the new IP&C lead had started there were frequent checks of the sharps boxes which were all documented. Visual checks on the day of the inspection showed all sharps boxes conformed to national guidance.

The IP&C lead had identified issues with the cleaning company they were using and brought this to the attention of the partners and practice manager. Subsequently a new cleaning company has been appointed and the IP&C lead worked closely with the company to identify what cleaning was required and for the cleaning company to document when cleaning had occurred.

Since the previous inspection the practice had improved their process for accessing personal protective equipment. They had purchased new wall mounted holders for aprons at the main site and made aprons accessible at the branch site. We saw evidence at the main site of the wall mounted aprons. Nitrile gloves had also been purchased and made readily available.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y

Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y (h)
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was 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 and additional evidence:

(h)Since the previous inspection, the practice had increased the hours of the scanning team to address the backlog to scanning of patient records. We spoke with staff at this inspection who told us that this had been increased further with the practice allocating new job roles and upskilling existing staff that wanted to take on extra hours. On the day of the inspection there were no two-week wait documents waiting to be scanned and they were up to date with all other scanning. There was now more than one person trained for each role so that in the event of absences or busy periods someone was always able to cover and support.

The staff within the scanning and workflow team had identified a lack of an effective protocol relating to monitoring workflow and had written a new workflow optimisation protocol to replace the existing one. This document had been awaiting final review and sign off from the GP lead and had been done so whilst we were on site. Prior to this sign off the old protocol was in operation.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.83	0.85	0.88	No statistical variation
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). (01/04/2018 to 31/03/2019) (NHSBSA)	7.1%	9.1%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	5.23	5.47	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.64	2.63	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial (i)
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y (j)
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use 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, investigation of 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 appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	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:

(i) The practice had a process for recording prescription stationery when it was received in the building. There was no process in place to demonstrate that serial numbers were recorded when stationery was allocated to each printer. This was not in line with NHS Counter Fraud guidance. The practice told us that they had deemed the risk to be minimal but there was no documentation to address this or to verify their decision not to record the serial number allocation.

(j) The practice had a folder containing all the practice's patient group directives (PGDs). PGDs are a set of written instructions to help clinicians supply or administer medicines to patients. We reviewed these and found that all of them had been signed by staff and an authorising clinician. However, we noted there had been a delay of up to four months for several of the PGDs to be signed by the authorising clinician.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y (k)
Number of events recorded in last 12 months:	56 (k)
Number of events that required action:	unknown

Explanation of any answers and additional evidence:

(k) We saw that significant events meetings were undertaken quarterly and viewed the meeting minutes from the 12th December 2018.

For 2018/19 the practice had recorded 56 significant events. Two of these remained open on the day of the inspection. One was awaiting a response in regards to a meeting with NHS England and the other was waiting upon evidence to confirm that all of the nursing team were aware of the error that caused the significant event to be raised.

For 2019/20 there had been 12 recorded significant events up until the date of inspection. Eight of these were open awaiting feedback and evidence to document that learning had been covered and that staff were aware.

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

Event	Specific action taken
Patients dose of prescribed medication documented incorrectly.	Identified that patients dose was correct but prescription was detailed incorrectly. Prescribers reminded to check that old doses are removed from repeat medication list.
Controlled drug prescription issued twice as original was unable to be found until later as it had been misfiled under another patients prescription.	Original was destroyed and records updated. Prescribing team to implement a new controlled drugs protocol and an alert issued to all pharmacies in Hampshire and West Sussex. The reception and admin team were reminded to visually check all prescriptions issued to ensure they related to the correct patient.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y (l)

Staff understood how to deal with alerts.	Y (l)

Explanation of any answers and additional evidence:

(l) Since the previous inspection the practice had made improvements to the process for recording and acting upon safety alerts. Every staff member we spoke to on inspection was able to describe the process for them to receive the alerts and how they acted upon them.

The practice had revised their safety alerts protocol to make it more comprehensive and had embedded this into practice. They had also created a log for when safety alerts were received and any action that was to be required as a result of the update.

Notes: CQC GP Insight

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 no statistical variation, 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 no statistical variation 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 Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG 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: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **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.