# Care Quality Commission

## Inspection Evidence Table

## Pond Tail Surgery (1-545206429)

**Inspection date: 6 August 2019**

**Date of data download: 26 June 2019**

# Overall rating: Good

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

# Safe Rating: Good

At our last inspection in June 2018 the practice was rated as requires improvement for providing safe services. This was because:

- The systems for the appropriate and safe handling of medicines were not always reliable or operating effectively, such as for the regular and appropriate health monitoring and clinical review for patients, including those prescribed with high risk medicines, and the oversight of uncollected prescriptions.
- The practice did not always have systems to monitor and follow up on concerns for patients at risk, including children who were not brought to their appointments. The practice did not have a risk register of vulnerable patients
- The actions taken by the practice in response to safety alerts were not always clearly recorded.

At this inspection, we found improvements had been made and the practice is now rated as good for providing safe services.

**Safety systems and processes**

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

| Safeguarding | Y/N/Partial |
|---|---|
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| 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. | Yes |

| Safeguarding | Y/N/Partial |
|---|---|
| Explanation of any answers and additional evidence:<br><br>The practice demonstrated they had developed a risk register of specific patients. The practice performed a search of their clinical system every month to locate patients with a code that identified a safeguarding concern. This list was then reconciled with the risk register and patients were removed or added as required. We saw evidence of this. We saw they monitored and recorded concerns and any actions; for example, the date the concern was discussed at a meeting and letters sent to external agencies. Although the practice safeguarding lead was on long-term leave, there were alternative cover arrangements. This included the practice manager, duty GP or GP partner who would then seek advice from the CCG lead for safeguarding if necessary. Staff we spoke with were aware of this.<br><br>Children who were not brought to their appointment were identified by receptionists who informed the practice manager for monitoring on the risk register. The practice told us they shared information internally and externally with other health and social care professionals on an ad hoc basis. | |

**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. | Yes |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Yes |
| 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. | Yes |

Explanation of any answers and additional evidence:

At our last inspection in June 2018 we found that the care coordinator role was not always covered during staff absences.

We also found that not all staff were aware of where to find additional information on sepsis if they needed it.

At this inspection we found the practice had revised the cover arrangements for the care coordinator role. They had a member of staff who managed the rotas.

We also found the practice had printed guidance posters of ‘red flag’ symptoms and displayed these in consultation rooms and reception. All staff had access to an online training module for sepsis and serious infection. Staff we spoke with demonstrated an understanding of the actions to take if they suspected sepsis.

**Appropriate and safe use of medicines**

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

| Medicines management | Y/N/Partial |
|---|---|
| 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. | Yes |

Explanation of any answers and additional evidence:

We found the practice had improved their process for monitoring patients' health in relation to the use of medicines, including high risk medicines. They now performed monthly searches of the clinical system for patients prescribed high risk medicines, to check appropriate tests had been recorded. GPs checked last review dates before prescribing and added notes to the patient record or pharmacy note to remind patents when their next review was due.

We looked at a sample of records for patients prescribed such medicines and saw their health was being monitored appropriately, prior to prescribing.

We reviewed ten out of 93 clinical records for patients prescribed a blood thinning medicine. We reviewed eight out of 37 patients being prescribed a medicine used for several conditions, including cancer. We reviewed four out of nine patients being prescribed a medicine used to treat severe mental health disorders. In all cases, we found patients were being monitored in line with national guidelines and appropriate test results were recorded.

The practice ensured that uncollected prescriptions were recorded in patient notes and the GP's were informed.

**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 |
|---|---|
| There was evidence of learning and dissemination of information. | Yes |

Explanation of any answers and additional evidence:

At our last inspection in June 2018 we found a lack of evidence to demonstrate learning and shared lessons, identified themes and action taken to improve safety as a result of significant events.

At this inspection we saw significant events were thoroughly recorded, investigated and acted upon. The practice used a template to record information about the event and subsequent learning. The practice had also developed a log which contained information such as the incident date, summary of what happened, the outcome, details of completed actions and a summary of the GP review. Significant events were discussed at six monthly meetings, which were minuted. The practice invited their long-term locums to attend these meetings.

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

| Event | Specific action taken |
|---|---|
| Referral sent for the wrong patient | The practice fully investigated and found this was human error. They apologised to both patients and sent the referral for the correct patient. The practice also sent duty of candour letters for both patients. We found these to be open and honest about what had happened and the practice action, including that there would be a delay for the referral. The practice had also ensured patients records were corrected. The practice advised all administrators to double check patient details and to only have one record open at a time when actioning referrals. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |

Explanation of any answers and additional evidence:

We found the practice had improved their systems for recording and acting on safety alerts. Not all alerts had clinical oversight, however the practice ensured clinical input if deemed necessary. The practice had developed a log that contained information such as the date received, summary of the alert and details of completed actions. We saw the practice had a system to ensure all clinical staff had received and read new alerts. We looked at the practice records relating to four recent alerts. We saw detailed information had been documented, including actions taken by the practice such as searches performed on the practice clinical system for affected patients and subsequent action. For example, we looked at an alert received on 1 August 2019 relating to stock issues for an adrenaline auto-injector, used for severe allergic reactions. We saw the practice had searched their systems for affected patients and contacted them by letter. We saw evidence this was completed on 2 August 2019. The practice had updated their safety alert log with this information.

## Any additional evidence or comments

At our last inspection in 2018 we saw evidence that complaints were fully investigated, with transparency and openness. We found some evidence that the practice conducted an analysis of trends, but this was not always completed routinely or formally recorded.
At this inspection we saw evidence that complaints were fully investigated, with transparency and openness. The practice had developed a log to record relevant information including the date received, date acknowledged, the action taken and the date it was discussed at a meeting. All complaints were now reviewed during an annual meeting, to identify any trends and appropriate action. We saw evidence of minutes from the most recent meeting on 6 February 2019.

At our last inspection we also found high exception reporting on Quality Outcomes Framework for patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The exception reporting rate was 24%, which was above the CCG average of 12% and the England average of 13% (01/04/2016 to

31/03/2017). The practice were unable to provide an explanation for this high rate of exception reporting.

At this inspection we found the exception reporting rate had increased to 33%, which was above the CCG average of 16% and the England average of 13% (01/04/2017 to 31/03/2018). The practice told us they had a system to invite patients by letter and by phone call, if there was no response from the third attempt the patient would be excepted. They told us they would discuss the high exception reporting. They explained that they monitor their performance on a monthly basis and their second partner would be focussing on performance monitoring on their return.

At our last inspection we also found a lack of evidence to demonstrate a programme of clinical audit and quality improvement activity.
At this inspection we were not provided with evidence of clinical audits. The practice explained they planned to re-start this activity once their staffing challenges had reduced and they had regained stability at the practice.

At our last inspection we also found that not all staff were aware of any future plans or changes at the practice, other than what they had heard word-of-mouth.
At this inspection we found the practice had improved their communication methods to staff. Any changes or notices were sent to staff within a memo, which all staff were asked to sign once read. We saw the practice had a system to ensure this was completed. For example, we saw a memo from April 2019 informing staff that basic life support training would take place 16 May 2019.
We were told that the lead partner was retiring in December 2019. We found the practice had used a variety of ways to communicate this to both patients and staff. This included that staff were told individually or in small groups, along with a memo. They displayed notices in the waiting room for patients and added this information to their practice website and within the local parish magazine. Staff we spoke with were happy with how this had been communicated, although there was some concern and uncertainty about the future of the practice. The second partner was returning in September 2019. The practice hoped to recruit either a new partner or salaried GP.