Care Quality Commission

Inspection Evidence Table

Spring Street Surgery (1-548937393)

Inspection date: 28 July 2020
Date of data download: 22 July 2020

Overall rating: Good

Safe Rating: Good

The practice had previously been rated as requires improvement for the safe domain because locum recruitment files did not contain all the information required, significant events and safety alerts recording process needed to be improved and fridge temperatures were not always recorded. At this inspection we found all these previous concerns had been rectified.

Safety systems and processes

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Explanation of any answers and additional evidence: At our previous inspection, staff recruitment files we reviewed held the appropriate information with the exception of one locum GP file. At this inspection the practice was able to send us a recruitment check list that was used for locums. This included, amongst other things, recording of dates of training, DBS checks and references. We saw evidence that this information had been collected for three locums that had previously been used by the practice. The practice was not currently using locums.	

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
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence: At our previous inspection we found the fridge temperatures had not been consistently recorded. At this inspection we found that the practice was consistently recording fridge temperatures and staff were aware of the action required if temperatures went out of the required range. The practice had raised a significant event in April 2019 where a fridge had become unplugged and the fridge temperatures had been out of range. We saw there had been an action plan to ensure that this could not happen again. We noted that all actions had been completed. This included, purchasing plug covers, data recorders being bought for each fridge, additional staff trained to monitor temperatures,	

Medicines management	Y/N/Partial
an audit of fridge temperatures, updating of the cold chain policy, a rota for checking temperatures and nurses being given allocated time to check fridge temperatures.The practice was able to send the latest fridge temperature recordings to review. Fridge temperatures were recorded each day for the five fridges within the practice. At the time of our inspection these were recorded in paper format. However, the practice told us they were planning to start recording them onto Teamnet (a web based platform for sharing, exchanging and collaborating in Primary Care).	

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 a system for recording and acting on significant events.	Yes

Explanation of any answers and additional evidence:

At our last inspection we found significant events were being appropriately recorded and actions taken but outcomes were not centrally recorded or dated.

At this inspection we found that significant events were centrally recorded as well as the outcomes which included dates for completion. The practice reviewed significant events at practice meetings, which we were able to see the minutes for. The practice also held an annual review of all significant events to ensure that actions were adequate, and no follow up action was required. We noted that a review of significant events from 2018 – 2019 cycle had been completed and discussed in February 2020 at a practice team meeting. For significant events in 2020 – 2021 cycle the practice was recording these on Teamnet. Actions and review dates were recorded and shared with the practice. Any reviews or actions required for individual staff members were flagged via Teamnet until the actions had been confirmed as being completed. All staff had access to review significant events within Teamnet.

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

Explanation of any answers and additional evidence:

At our last inspection we found that patient safety alerts were not always recorded as being actioned appropriately.

At this inspection we found, all patient safety alerts were recorded centrally and actions taken recorded. Alerts were recorded, reviewed and actioned by the practice manager or the clinical pharmacist. If an alert was applicable to general practice they were shared with the clinical team by email. The practice was able to track who had read and acknowledged the alert and was able to monitor accordingly.

If action was required, this was completed and recorded against the alert. If any actions, such as searches were required, these were performed, and any identified patients passed to their registered GP. A note of whether any action was required was recorded on the spreadsheet.

A monthly prescribing bulletin produced by the clinical commissioning group medicines management team included safety alerts which the provider also reviewed.

The practice was using a new system called TeamNet which was also being used to record safety alerts. This system was linked directly to receive safety alerts to the database.

We saw examples of actions taken on recent alerts for example, regarding sodium valproate.