

Care Quality Commission

Inspection Evidence Table

Avisford Medical Group (1-562962584)

Inspection date: 7 July 2021

Date of data download: 07 July 2021

Overall rating: Good

Well-led

Rating: Requires improvement

The practice was previously rated as requires improvement for providing well led services. This was because whilst there was evidence of systems and processes for learning, continuous improvement and innovation, learning from significant events and complaints was not always used or shared effectively to make improvements

At this inspection, we found that the practice had made some improvements to the way it shared learning from significant events. However, we found that the practice had not fully implemented its action plan and still required improvement because:

- The practice held a central summary of significant events but they had not fully implemented the new significant event reporting form, referred to in a previous action plan.
- The practice had a significant event policy but did not adhere to this. There were no minutes of team meetings that detailed a significant event being discussed nor what learning had been considered.
- Complaints were not always responded to within the timescales set out in the practice complaints policy and response times were not monitored.
- The practice had not implemented a system for assuring that all safety alerts received were disseminated appropriately and acted on. The information provided for this issue was incomplete and missing details in relation to how the information was shared and when this was discussed at a meeting.

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
Explanation of any answers and additional evidence: <p>We saw that the practice had a clear complaints policy which set out how to complain, what to expect in terms of a response and how to escalate the complaint if still not satisfied with the outcome. We found that in the complaints we looked at the outcome was explained to the individual.</p> <p>Complaints were not always responded to within the practice policies timescales and the complaints spreadsheet did not capture why this had happened. For example, a complaint received on 31 October 2020 was not responded to until 12 November 2020 with no explanation as to what had caused the delayed response whilst the spreadsheet inaccurately detailed the complaint was received and acknowledged on the same day. The practice did not maintain a clear record of complaints management and no minutes were available of meetings where these were discussed for three of the four complaints reviewed.</p> <p>It was not always clear from the practice records how or when lessons from complaints were shared. Four complaints were reviewed with one receiving an apology. The other three did not identify whether there was any better way of managing and/or resolving the issue.</p> <p>The practice did not maintain a clear audit trail of complaints management and records were difficult to find. Four complaints were reviewed during the desktop review. Three did not have any minutes available detailing that they had been discussed at a meeting even though all four had dates recorded as being discussed. One complaint had a final response before the complaint had been documented as being discussed at a meeting.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
Explanation of any answers and additional evidence: <p>Whilst the practice had a policy in place for identifying and managing significant events, this was not adhered to.</p> <p>We saw that whilst staff had filled in significant event forms using the new form identified in the practice's action plan, this was not being used consistently. There was no evidence from any of the significant event records, and no meeting notes were available, to demonstrate that actions were followed up and closed to ensure they were complete. The practice policy stated that each significant event report form completed would initially be reviewed and then "RAG" rated. However, the policy did not identify what would constitute either a red, amber or green rating to the significant event.</p> <p>Whilst the practice maintained a significant events spreadsheet we could not find a chronological, accurate log, or summary of significant events, that allowed progress against action agreed to be monitored and reviewed and for trends to be identified. The practice used an electronic system for recording significant events and the outcomes of these could be viewed by staff. However, there were differences in how many times different significant events had been viewed by staff and whether it had identified staff that needed to see the information but had not. This meant there was limited oversight and management of issues and risks.</p> <p>Some significant event report forms indicated a discussion had been held at a meeting but no evidence was available to support this. Other significant event forms indicated that these had not been discussed at a meeting. There was limited evidence to show whether enough information gathering or investigations into the root cause of a significant event had taken place. This meant appropriate action and lessons learned might not always be identified.</p> <p>Four significant events were reviewed during the desktop review. Where actions were documented as needing to be taken, no significant event form had any follow up meeting date documented as per their policy to ensure any actions were embedded.</p> <p>We found at this inspection that the practice had implemented a system for acting upon safety alerts received within the practice. However, the information supplied by the practice detailed a process that had not yet become fully embedded within their systems. For example, in April 2021 an alert was received in relation to food thickening agents but the supplied spreadsheet did not document who, or how, this information was shared with, the date that this information was shared or at what meeting the information was discussed.</p> <p>There were also some alerts missing from the safety alert spreadsheet that had been sent to practices. One of these, from August 2020, involved identifying any patient on long term steroid therapy and the need for these patients to be issued a steroid alert card for any emergencies they encountered. This alert might have been acted upon but it was not recorded as having done so.</p>	

