

Care Quality Commission

Inspection Evidence Table

Dr Paramjit Wasu (1-526774472)

Inspection date: 3 May 2018

Date of data download: 23 April 2018

Safe

Safety systems and processes

Safeguarding people from the risk of abuse	
Partners and staff were trained to appropriate safeguarding levels for their role (for example level three for GPs, including locum GPs)	Yes

Safety Records	
Fire training for staff	Yes
Infection control training	Yes

Safe and appropriate use of medicines

Medicine Management	
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	No
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team CD Accountable Officer.	Yes
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.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	No

The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases	No
There was medical oxygen on site	Yes
The practice had a defibrillator	Yes
Both were checked regularly and this was recorded.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	No
Explanation of any 'No' answers: - The practice did not maintain a comprehensive list of the medicines it held on the premises or their locations. We found medicines which were not logged (for example, two bottles of Oromorph 100mls) and medicines where the quantity held did not tally with the practice's recorded stock level. For example, we saw five ampoules of Buscopan in the emergency bag but 10 were listed as in stock. The practice could not identify what had happened to the other five ampoules. - Most medicines were now stored in lockable rooms and cupboards. But some medicines were also stored in the safe behind reception. This contained 15 ampoules of hydroxocobalamin (Vitamin B₁₂). The receptionists said this was needed by the principal GP. However, the principal GP told us he was unaware that any practice medicines were located there. These medicines were not logged. - The doctor's bag was kept in a car. This contained adrenaline (1:1000) which was in date but which was not logged anywhere. This bag also contained a blood pressure monitor which had not been calibrated since August 2016. - The controlled drugs cupboard also included a number of other medicines including: atropine, prednisolone solutions and Neo-Cytamen (Vit B₁₂) that were not logged. This latter medicine is not prescribable under the NHS primary care formulary in this form and the staff told us they did not know why it was being stocked. - The emergency medicines were not well organised. The emergency medicines had been organised into labelled bags. For example, there were separate bags for anaphylaxis and cardiac emergencies. One of the medicines (adrenaline ampoules) placed in the cardiac bag was the wrong dose (1:1000 instead of 1:10000) and inappropriate for use in this situation. - Diazepam ampoules for injection were found in the epileptic bag, but this is not part of the current guidance for treating epilepsy as an emergency. This medicine was not logged. - We found that one of the emergency medicines (amoxicillin syrup) was out of date and had been stored incorrectly. - There was an epileptic guidance sheet stating that after administering the buccal midazolam an ambulance should be called if no response after 10 minutes; the current guidance is five minutes. - Other supplies were not being stored or monitored safely. The oxygen cylinder was full and in date but the mask and tubing were open to elements and not sterile. The Ambu Bag and bag valve mask was stored in an open plastic bag with no details of manufacturing date. We found cotton wool and blood sample tubes that were out of date but had not been removed. - Hydrocortisone ampoules were stored in the doctor's medicine cupboard (another consultation room) and not the emergency medicines cupboard; there was no log for them. - The anaphylaxis bag included three Epipens suitable for use in babies from the age of one month to five years; one JEXT pen suitable for a child or adult over 30kg. There was no adrenaline or	

hydrocortisone in the anaphylaxis bag although the practice did have chlorphenamine ampoules in the cupboard. There was no printed anaphylaxis pathway or guidance.

- Most but not all medicines were kept securely, for example in locked cupboards. However, the practice had a nebuliser as part of its emergency equipment. The medicines (nebules) for this were located alongside the equipment and were unsecured and not logged.
- The practice had a policy and procedure to maintain medicines such as vaccines that needed to be refrigerated at the correct temperature. The practice kept a log of the fridge temperatures in line with national guidance. However, we found a two-week gap in April 2018 when no temperatures had been recorded for either of the fridges. The practice staff were unable to explain why this had occurred.
- The practice was keeping several medicines originally dispensed to individual patients and returned in its stock such as amoxicillin syrup, Piriton syrup and white spirits. The practice had not removed the original dispensing labels which posed a risk to patient confidentiality.
- Security of prescription materials remained a concern. The practice had introduced protocols to log prescription stationery but this was not applied consistently to all prescription materials. For example, the staff noted prescription serial numbers when stationery was issued but did not keep a record of the numbers when these were returned. We were not assured that the staff would be able to detect breaches in prescription security.

Safety Alerts

There was a system for recording and acting on safety alerts	No
Staff understand how to deal with alerts	No

- The practice manager saved all alerts on a computer drive and forwarded any relevant alerts to the clinical team. They had also added the practice's generic email list to the alert circulation list so that these would be still be picked up by staff when the practice manager was away.
- However, there was no documentation showing which alerts had been assessed as relevant and the action that had been taken. The principal GP was able to recall and discuss action taken in response to a recent alert relating to the prescribing of sodium valproate to women of childbearing age. Two patients had been identified – in one case the prescription had already been discontinued. In the other the doctor had discussed with patient and there was an alert on her notes.
- We asked how the practice had responded to another recent alert about a specific emergency medicine (buccal midazolam). The principal GP told us they could not recall this alert and there was no record on file to show the alert had been reviewed for relevance.

Well-led

Leadership capacity and capability

Examples of actions to improve quality in past 2 years

Area	Impact
The practice had responded to some but not all concerns raised at our previous inspection in December 2017.	• The practice had reviewed its mandatory training and ensured that all staff were up to date with required training. • The principal GP had completed the first cycle of a clinical audit reviewing 'two-week wait' referrals. As a result, the practice could show that all referrals had been actioned appropriately.

Continuous improvement and innovation

Examples of innovation and improvements	Impact on patients
The practice had invested in an electronic document management system and was in the process of centralising its records including its training and recruitment records.	Direct impact not possible to assess at this stage.
The practice had recently recruited an assistant manager to support the practice manager in running the practice safely and effectively	Direct impact not possible to assess at this stage.

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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

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

The following language is used for banding variation:

Significant variation (positive)

- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

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

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

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>