

Care Quality Commission

Inspection Evidence Table

Priory Medical Centre (1-521142701)

Inspection date: 16 October 2018

Date of data download: 29 October 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Infection control	Y/N
Risk assessment and policy in place	Y
Date of last infection control audit:	Dated Spring 2018
The practice acted on any issues identified	Y
Detail: There was a system to manage infection prevention and control; there was an action plan to ensure that identified issues were followed up within an agreed timescale. For example; we saw that the practice had replaced 50% of the lever taps identified from the infection control audit and the pedal bins. We were told that issues and progress of the action plan were discussed at the weekly management meeting and we saw evidence of minutes of meetings where these issues were discussed.	

Appropriate and safe use of medicines

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) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	1.00	0.88	0.95	Comparable with other practices
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). (01/07/2017 to 30/06/2018) (NHSBSA)	3.4%	4.2%	8.7%	Variation (positive)

Medicines Management	Y/N
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
Both were checked regularly and this was recorded.	Y
<p>Explanation of any answers:</p> <p>Systems for prescription safety were in place. All surgery teams (clinical and reception staff) had been reminded to follow the practice policy on prescription security. We were told that the practice had modified their process to reduce the number of prescriptions in circulation at any given time to reduce the risk of prescriptions going missing.</p> <p>There were systems in place for the safe handling of medicines and equipment. The systems for managing and storing medicines, including emergency medicines and equipment, were effective and kept patients safe. We were told that there was a designated person who checked and recorded that emergency medicines were in date and equipment was working. There was a deputy who covered in their absence. We saw examples of this recording and that it was updated on the shared computer system. We found that there was a robust system in place on the computer system which highlighted any medicines that were due to expire. The practice had arrangements to ensure that facilities and equipment were safe and in good working order and we saw evidence that checks had been completed. There was also a weekly system in place for a designated member of staff to oversee that the equipment had been checked.</p>	

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y

Any additional evidence
<p>The practice had reviewed their internal legionella risk assessment policy and updated it to reflect the national guidance provided by the Health and Safety Executive (HSE). Where a risk had been identified, regular periodic monitoring had been implemented and added to routine surgery checklists.</p> <p>There were systems for reviewing and investigating when things went wrong. The practice displayed evidence of learning and implementation of improvements when things went wrong. Staff understood their duty to raise concerns and report incidents and near misses. The significant event policy had been updated and was available on the shared computer for all staff to access. There was a form on the shared computer system for staff to document significant events and advice to do this within a certain timescale. Leaders and managers supported them when they did so. The recording of significant events had increased to on average four per month.</p> <p>The practice had set up regular significant event meetings with clearly documented learning points. These were monthly meetings at Priory Medical Centre where significant events were shared and discussed. We saw evidence of minutes of meetings where learning from the events was shared. Staff not present at the meetings were sent a reminder with a read receipt to ensure they had accessed the information. All staff had access to the shared computer system to read minutes of meetings.</p>

