

# Care Quality Commission

## Inspection Evidence Table

### Budleigh Salterton Medical Practice (1-566738131)

Inspection date: 26 March 2019

Date of data download: 14 January 2019

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

## Safe

### Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y

Disclosure and Barring Service checks were undertaken where required	Y
<p>Additional comments:</p> <p>During our previous inspection we found areas where the provider must make improvements. These were to ensure systems and process arrangements for child safeguarding were established and maintained, and ensure the process for checking expiry dates of emergency equipment was in place.</p> <p>On this inspection, on 26 March 2019, we found that the provider had made the required improvements. Specifically, the safeguarding policy had been reviewed in January 2019. The practice lead GP for safeguarding was working with other East Devon practices to ensure consistency across the locality.</p> <p>We saw minutes of safeguarding meetings which GPs had attended. For example, during the January 2019 meeting discussions had included the NSPCC website, counter terrorism, county lines organised crime, and preventing the sexual exploitation of children and vulnerable adults.</p> <p>There were written flowcharts in place which provided clear guidance for staff to follow a safeguarding process. We found there was an up to date list of currently safeguarded children. Meeting minutes showed that cases had been regularly discussed at quarterly multi-disciplinary meetings and weekly practice meetings.</p>	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person.	Y Aug 2018
There was a record of equipment calibration	Y Jan 2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y October 2018
Fire alarm checks	Y Nov 2018 Quarterly
Fire training for staff	Y Annually
Fire marshals	Y
Fire risk assessment	Y
Actions were identified and completed.	Y A heater was identified as being unsafe, and was removed.
Additional observations:	Emergency lighting was in place and checked quarterly.
Health and safety Premises/security risk assessment? Date of last assessment:	Y May 2018
Health and safety risk assessment and actions Date of last assessment: May 2018	A daily walk around took place to check health and safety.  Weekly in-depth review. Actions identified included boxes found left on stairway. These were removed to a safe storage location enabling safe egress in the event of a fire.

**Additional comments:**

Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals. There was an Annual review of COSHH (Control of Substances Hazardous to Health Regulations 2002) folder by practice nurse and ongoing risk assessments.

Infection control	Y/N
<p>Risk assessment and policy in place</p> <p>Date of last infection control audit:</p> <p>The practice acted on any issues identified</p> <p>Detail:</p> <p>Carpet in waiting room area and corridors in patient facing areas was identified as needing replacement. The practice took action. Funds were raised by a charity supporting the practice. The carpet was replaced throughout with tough vinyl non-slip flooring in September 2018.</p>	<p>Y</p> <p>Sept 2018</p>
The arrangements for managing waste and clinical specimens kept people safe?	Y

## Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
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.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
<p>Explanation of any answers:</p> <p>The practice had a daily duty GP whose responsibility was to assess and treat patients in the absence of their own GP.</p> <p>All GPs carried intravenous antibiotics in their bag that could be delivered at the bedside.</p> <p>The practice used a computerised template within the clinical system to help assess patients in line with the latest guidance.</p>	

## Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols	Y
<p>Explanation of any answers:</p> <p>Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation. Pre-approved templated within the clinical system and also computerised risk assessment templates were used which demonstrated latest guidance.</p> <p>The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. We found evidence of pre-populated referral templates, core group meetings every other week, General Data Protection Regulation (GDPR) guidance was followed.</p>	

## 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).(01/07/2016 to 30/06/2017)(NHS Business Service Authority - NHSBSA)	1.01	0.96	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.(01/07/2016 to 30/06/2017) (NHSBSA)	8.0%	10.6%	8.9%	Comparable to other practices

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y



For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
<p>Explanation of any answers:</p> <p>With regard to checking expiry dates of emergency equipment, we found that the practice now had a safe system in place, with regular checking recorded on a spreadsheet system. A new practice nurse who had started in January 2019 had previous experience of working in a hospital emergency department. This member of staff had taken over the responsibility of the practice's emergency crash trolley and emergency bag.</p> <p>We inspected emergency equipment and found it to be in order, with no expired items. Items which were due for replacement in the next three months had been highlighted on the new checking system and replacements already ordered. Checks on the oxygen cylinder had been documented appropriately.</p> <p>Prescriptions (pads and computer prescription paper) were kept securely and monitored. There was an audit trail of all prescription paper and pads; additional named pads and blue scripts were held securely.</p> <p>The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. Emergency medicines were in GP bags as the practice was in a rural area. Controlled drugs were only kept at the practice within a lockable safe, discussed as required at partner meetings and documented in minutes. In-house audits had been completed on controlled drugs and medicine optimisation demonstrating appropriate medicines management. The practice also ran regular audits to monitor any unusual activity. There was a named GP responsible for oversight of controlled drugs who completed a weekly check using current standard operation procedures.</p> <p>The oxygen was checked on a daily basis and there was written evidence to confirm this.</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 Events were discussed at a regular significant event meeting, forms were completed to include learning and actions, minutes were distributed to all staff via email with a list of learning and actions, each event was reviewed at the following meeting to ensure actions had been completed. Events were shared at the practice managers WEB (Woodbury, Exmouth, Budleigh Practices) meeting for learning purposes. Also shared with National Reporting and Learning System (NRLS) with NHS England.	Y
Number of events recorded in last 12 months. There were quarterly staff significant event meetings and ad hoc meetings for anything more urgent. Between 01/09/2017 and 31/08/2018 there were 32 recorded significant events. These include all complaints as the practice felt it was important to include these in meetings in order to discuss them as a team any learning to be gained.	32
Number of events that required action The practice looked at each event and identified any possible learning or changes to practice. Even when there was no direct action it was considered useful to discuss best practice and share learning.	32

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

Event	Specific action taken
1. Data Breach	<p>Name, address, date of birth and NHS number of patient A was seen by patient B when given an incorrect prescription. This was because patient B used their middle name rather than their given name and the computer identified them as patient A. Patient A was sent a letter to advise what had happened along with an apology and was followed up with a telephone call from the practice manager.</p> <p>The ICO (Information Commissioner's Office) was notified within 72 hours as per GDPR (General Data Protection Regulation) which came into force in May 2018.</p> <p>A follow up letter was sent to patient B who had identified the breach to apologise, explain how the error occurred and to advise the ICO was aware of the data breach.</p> <p>All staff were verbally advised and emailed regarding the need to ask every patient to confirm their address as well as their name to ensure the correct patient was selected.</p>

2. Slow Ambulance Response	<p>Patient attended for regular COPD (chronic pulmonary disorder) review. As consultation progressed nurse became increasingly concerned about patient's state of health and called the duty doctor. Patient was in extreme distress with an exacerbation of COPD. It was felt patient was not improving and emergency services were called. There was an hour's wait for an ambulance to arrive.</p> <p>Learning points at this stage: The GP practice was deemed to be low priority despite explaining the patient was in extreme difficulties breathing. An investigation found no atrovent was held to give via a nebuliser at the practice (medicine used to assist breathing), for emergency use and none was available at the nearby pharmacy at the time of the incident.</p> <p>Actions had been taken to prevent reoccurrence. The practice emergency trolley now had atrovent and salbutamol medicine to administer via a nebuliser. The practice manager was escalating reports of delays to other stakeholders.</p>
3. Medication Error	<p>A patient attended the practice with a blister pack of medicine. The patient had been advised in August 2017 that they no longer needed a certain medicine by their GP. This message was written on their repeat prescription form. A memo was sent to the pharmacy stopping this medicine. However, the patient still obtained the medicine from the pharmacy. The medicine had contra indications to their condition.</p> <p>An apology was given and the patient's medications were reviewed.</p> <p>On investigation it was noted the GP had requested the medicine to be stopped. The administrator had put a reason for stopping on the repeat and alerted the pharmacy. However, despite these measures the repeat was not stopped and had still been dispensed from the pharmacy. This had been discussed with all staff and the pharmacy to prevent reoccurrence.</p>

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
<p>Comments on systems in place:</p> <p>This was managed by the practice manager who reviewed any alerts being received. All alerts were saved and we saw documented action taken. The practice manager managed the alerts and cascaded them to the appropriate members of the team. A shared folder was in place which staff had access to.</p>	

**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>

**Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ( [See NHS Choices for more details](#) ).