

Care Quality Commission

Inspection Evidence Table

Okehampton Medical Centre (1-547796480)

Inspection date: 9 April 2019

Date of data download: 9 April 2019

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Safety systems and processes

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

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who require medical indemnity insurance had it in place	Yes
Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: September 2018	Yes
There was a record of equipment calibration Date of last calibration: September 2018	Yes
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire procedure in place	Yes
Fire extinguisher checks	Yes
Fire drills and logs	Yes
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	Yes
Fire risk assessment Date of completion 12 July 2018	Yes
Actions were identified and completed. The fire risk assessment was in the process of being reviewed as part of the rolling schedule of reviews. A review of the risk assessment had taken place after a fire drill in January 2019 since the last inspection.	
Additional observations: A COSHH risk assessment was last reviewed in November 2018. Named staff monitored this process and documented when new hazardous chemicals were brought into use. No further actions had been required following the asbestos survey in August 2018, which was seen at the last inspection in November 2018.	
Health and safety Premises/security risk assessment? Date of last assessment: October 2018	Yes
Health and safety risk assessment and actions	Yes

Date of last assessment: October 2018	
<p>Additional comments:</p> <p>The practice used a health and safety specialist for advice. The health and safety risk assessment was reviewed in line with a schedule of other reviews taking place. No further actions had been identified since the last inspection.</p>	

Infection control	Y/N
<p>Risk assessment and policy in place</p> <p>Date of last infection control audit: September 2018</p> <p>The practice acted on any issues identified</p> <p>Detail:</p> <p>We reviewed three audits for December 2016, March 2018 and September 2018. There were no outstanding actions. Since the last inspection, the practice had liaised with the Care Quality Commission and other stakeholders about the employment terms and conditions requiring all staff, including receptionists to provide information about their immunisation status and offer of appropriate additional protection through vaccination. This demonstrated the practice was following national guidance to reduce the risks to patients and staff of infectious diseases wherever possible.</p>	Yes
<p>The arrangements for managing waste and clinical specimens kept people safe?</p>	Yes

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	Yes
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.	Yes
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
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.	Yes
<p>Explanation of any answers:</p> <p>The practice continued to review staffing resources to diversify and meet increased patient numbers and demands. Since the last inspection, two GP partners had retired as planned. The practice had successfully recruited new GPs, including a GP retainer (GP returning to practice after a period of parenting) to replace their sessions. Interviews were due to take place following this inspection for a full-time practice based pharmacist.</p> <p>We saw several examples of effective staffing management to meet patient demand: Recruitment for</p>	

GP maternity cover was underway for later in the year and the practice had chosen to recruit another GP covering six sessions per week creating additional capacity. Administrative staff were supported to diversify their skills and competencies providing a flexible workforce that was able to respond to needs, for example for unplanned absences.

GP partners continued to be mindful about the health and well-being of staff and reducing the potential risk of professional burnout. Staffing issues and resource planning was a standing agenda item at partners meetings. Lunchtime sessions to increase staff well-being continued and on the day of the inspection staff were able to attend a calligraphy session.

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.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Yes
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.	Yes
Explanation of any answers: Projects were underway to increase efficiency with workflow, in a safe and timely way. The practice had audits scheduled to monitor the safety of this process once implemented for example to review the monitoring and management of test results.	

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)	0.95	0.93	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)	9.1%	9.7%	8.7%	Comparable with 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.	Yes
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
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.	Yes
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 Controlled Drugs 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
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	NA
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
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.	Yes

Dispensing practices only	Y/N
There was a GP responsible for providing effective leadership for the dispensary.	Yes
Access to the dispensary was restricted to authorised staff only.	Yes
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	Yes
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on	Yes

medicines were supplied with the pack.	
Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	Yes
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	Yes
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	Yes

Explanation of any answers

The practice provided an action plan to the Care Quality Commission following the last inspection, which had been monitored.

A dispensary manager was appointed and changes implemented. The governance of medicines management at the practice had improved with several examples demonstrating this:

- The newly appointed dispensary manager was allocated an administrative day every week facilitating an opportunity to support staff and carry out quality improvements as part of the governance arrangements at the practice.
- Prescription stationary was now securely stored in a locked cupboard. Only authorised staff had access to the keys of this cupboard.
- A system for tracking blank prescription scripts had been implemented. The practice had assurance of security and tracking recorded in a log, which included the box identification number, the first and last prescription number and name of prescriber issued with new blank scripts.
- A system had been implemented which was clearly monitored and assured that fridge temperatures were recorded daily for the dispensary fridge. The dispensary manager verified there had only been two occasions where the temperature had fluctuated which was when the fridge was cleaned and not due to being faulty.
- The governance of controlled drugs had been strengthened since the last inspection. Records demonstrated stocks had been checked every week. The dispensary manager confirmed this was done on a rolling day of the week when the dispensary was closed for lunch to avoid any distraction.
- Risk assessments for dispensed medicines drop off points had been completed. Staff told us this had led to cold boxes being issued to the drop off point representatives to ensure integrity of medicines was maintained.
- The practice manager told us the process of ongoing risk assessment of the drop off points had enabled the practice to increase its engagement with the community thanking them for their support.
- The practice manager had worked alongside the medicines courier on their round since the last inspection. The importance of this service was reaffirmed and recognition of receiving updates from the employed courier about patients recognised as vital for their well-being. Staff shared an example of safeguarding a vulnerable patient who had not yet been supported through formal care arrangements being quickly reviewed and measures put in place to reduce potential risks for that person.

- A risk assessment and policy document was updated about emergency medicines held at the practice. Two emergency drugs (Atropine and naloxone) were now on the emergency trolley, which is recommended as the practice fitted contraceptive coils for women, performed minor surgery and held stocks of controlled drugs.
- Governance arrangements provided assurance that checks of the resuscitation trolley were completed every day.

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 The practice was part of a federation of GP practice, which had agreed to use funding for to set up a shared intranet. This was being used to manage information and improve governance. This had facilitated the practice using a standardised form for all significant events with mandatory fields that had to be completed. Prompts were sent automatically, with set timescales for completion of action. It was too early to report about the impact of this new system and this will be reviewed at the next inspection.	Yes
Staff understood how to report incidents both internally and externally	Yes
There was evidence of learning and dissemination of information	Yes
Number of events recorded in last 12 months.	52
Number of events that required action	43

Example of significant event recorded and action by the practice;

Event	Specific action taken
An audit identified an error of controlled drugs being dispensed twice to a patient, which the patient denied having received.	The practice had followed procedures raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. Learning for the practice was identified and changes made to the way roles were allocated in the dispensary. This had introduced protected time for staff who were dispensing medicines to reduce the risk of being distracted and further errors being made. Since these changes the practice reported no further errors had occurred.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes
Comments on systems in place: Safety alerts continued as seen at the last inspection to be sent to the assistant practice manager. These were disseminated to named staff within each team to action. We looked at safety alerts received from Medical Devices Regulatory Agency (MHRA). The practice held a register of safety	

alerts received, named staff responsible and action/s taken.

An example seen at this inspection, which had been actioned on 25 March 2019 was a batch of Losartan Potassium had been recalled by the manufacturer. Two boxes were identified in the dispensary and had been returned to the supplier.

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" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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

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

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](#)).