

# Care Quality Commission

## Inspection Evidence Table

### Guildowns Group Practice (1-544213010)

Inspection date: 20 August 2020

Date of data download: 21 August 2020

## Safe

### Risks to patients

**There were gaps in systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective induction system for temporary staff tailored to their role.	No
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No
<p>Explanation of any answers and additional evidence:</p> <p>We asked the practice to demonstrate how they had provided a role specific induction to a member of staff seconded to a new role. The practice told us they did not have a role specific induction and had not recorded any role specific training. The practice also told us that they did not provide supervision or monitor the work carried out by this member of staff.</p> <p>There had been a reduction in the amount of medical secretarial time within the practice and the practice had two members of staff who were new in post. The practice did not have a documented risk assessment or action plan in place to monitor this change and its impact on patient safety.</p>	

### Information to deliver safe care and treatment

**Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	No
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
<p>Explanation of any answers and additional evidence:</p>	

We reviewed the individual care records of 16 patients who had received a new diagnosis of cancer since 1 December 2019 and found no concerns.

We reviewed the individual care records of 20 patients who had been referred through the two week wait pathway since 1 December 2019 and found no concerns. (The two week wait pathway is an urgent referral when a patient has symptoms that might indicate they have cancer).

Referrals to specialist services were documented. However, the tracker system used to monitor referrals did not contain appropriate information and was not always completed. There was no clinical or management oversight of the system used to monitor referrals.

### Track record on safety and lessons learned and improvements made

**The practice did not always learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	Partial
There was evidence of learning and dissemination of information.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a system for recording and acting on significant events and we saw an increase in the number of significant events recorded since our last inspection in December 2019. We found that the significant event recording system was not always being used to identify and monitor trends. We noted in some cases records were duplicated or not fully completed. Eight events referred to delays in referrals. However, the practice had failed to recognize this as a trend and put together an action plan to check if other patients had been affected and to how this would be addressed to prevent the same events happening again.</p> <p>We reviewed eight significant events recorded since February 2019 relating to delays in referrals. Of these one appeared to be an error by the referring GP not recording the referral in the clinical system and one, which was an urgent referral, was related to difficulties with the practice dictation system. The remaining six significant events were related to delays due to referral processing within the secretarial team, two of these events were related to two week wait referrals. The longest delayed referral was requested in June 2019 and not completed until December 2019.</p> <p>In addition to the eight significant events the practice told us that during a training session provided by the supplier of the practice clinical system it was discovered that a further four, two week wait referrals, had not been processed in a timely manner, leading to delays of approximately one month. We asked the practice how they had investigated this. They told us, they had reviewed the records of the four patients concerned, that they had processed the referrals, and contacted the patients to explain the delay. The practice told us they had not considered retrospectively checking their systems to ensure other referrals had been processed in a timely manner.</p>	

# Effective

## Effective staffing

**The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
The learning and development needs of staff were assessed.	No
Staff had protected time for learning and development.	No
There was an induction programme for new staff.	No
Explanation of any answers and additional evidence:	
<p>We asked the practice to provide evidence of role specific induction and training for two staff members, one who was seconded to a new role and one who was a new employee. The practice told us they had completed the general staff induction but they did not have a role specific induction or training plan.</p>	
<p>We asked the practice how the performance of staff in a new role was monitored to ensure that their work was being completed satisfactorily. The practice told us that there was no formal monitoring of these two staff members and they were responsible for checking their own work.</p>	
<p>The practice told us that the new member of staff was behind on their mandatory training due to workload in their department. We reviewed the training the new member of staff had completed and found that they had not received any safeguarding training, had only completed basic GDPR awareness and had only received online hand hygiene training. There was no evidence that they had completed any other infection prevention and control or COVID-19 specific training.</p>	