

# Care Quality Commission

## Inspection Evidence Table

### Denton Village Surgery (1-5007453379)

Inspection date: 05 October 2020

Date of data download: 05 October 2020

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

## Safe

## Rating: Good

A desk-based review was completed on 05 October 2020 to determine whether the practice had made the improvements which were identified in our previous inspection on 05 February 2019. We found that the provider was in breach of the following regulations:

Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

- The provider did not have effective arrangements in place for ensuring medicines were safely stored.
- The provider did not have effective arrangements in place to ensure safety alerts into the practice and dispensary were actioned to ensure the safe care and treatment of patients.

The provider had made improvements in all areas identified to ensure they were compliant with the regulations in accordance with the fundamental standards of care. The provider is now rated as **good** for providing safe services.

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
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
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
During the last inspection we found a stock of medicines were stored in a room where the temperature could fluctuate. There were no arrangements in place to monitor the temperature of this room to ensure the medicines were being safely stored. The practice took steps to address this: <ul style="list-style-type: none"><li>• A risk assessment was carried out immediately following the inspection.</li></ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The room temperature was logged, monitored and managed daily by the dispensary team.</li> <li>There was an air conditioning unit in the storage room which ensured the temperature remained constant. This was to be serviced and maintained annually.</li> </ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

At our last inspection we found there was a lack of systems to ensure that all safety alerts received by the practice were recorded, shared and actioned. We found instances where some alerts had not been acted upon as required to ensure patient safety. For example, we found one medicines alert which should have resulted in the patients on that medicine receiving a review. This had not happened and applied to four patients at the practice. The practice took immediate steps to fully review the safety alerts which had been received. Further action included:

- The lead GP, practice manager, dispensary manager and deputy dispensary manager were all signed up to receive safety alerts.
- All safety alerts were delivered automatically to the practice intranet (GPTeamNet).
- A written protocol for handling all safety alerts has been implemented and recently updated.
- The protocol was to be reviewed annually or when there was a change identified.
- The dispensary manager and deputy manager completed the first review of all alerts, which were then acted upon, according to their degree of urgency and relevance.
- There was a clear audit trail of action taken which was recorded via the practice intranet.
- All staff had access to all alerts on the practice intranet.
- Medicines and Healthcare products Regulatory Agency (MHRA) alerts which were relevant for prescribers (as opposed to those solely for action by dispensary e.g. batch recalls) were circulated using a designated MHRA task template within the system. This alerted prescribers to the MHRA and included the link for them to read/action.
- The data administrator was informed of any alerts which required a clinical search. Patients identified by the searches were reviewed by clinicians.
- Significant MHRA alerts were reviewed at the practice monthly multi-disciplinary meetings.

**Additional evidence provided to demonstrate improvements made since last inspection in relation to the population group for patients with poor mental health**

Mental Health Indicators.	Practice	CCG average	England average	England comparison
( to ) <sup>(QOF)</sup>		-		-
Exception rate (number of exceptions).	()	-		N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <sup>(QOF)</sup>	93.5%	-	81.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	()	-		N/A

### Any additional evidence or comments

This was an area where the practice needed to improve. The practice needed to review the care plans for mental health and dementia to ensure patients had these in place where needed. Improvements had been made and included:

- All care plans were documented as part of QOF and showed that there had been an increase in the number of care plans reviewed in the past 12 months.
- The practice had invested in specific templates to ensure that clinicians had access to the most up to date clinical templates when conducting their reviews.
- The practice participated in PCN led frailty reviews where information and support was discussed for patients who required additional input. These reviews allowed the opportunity to link up with a social worker, the collaborative care team and organisations such as Money Advice Service and Age UK. Most often patients selected had complex mental health needs or suffered from dementia.
- Clinicians referred many patients onto their social prescriber for signposting and 1-1 support
- The learning disability lead nurse had great involvement with a nearby residential home and was in the process of setting up regular, virtual ward rounds.
- Carers were actively reviewed by the social prescriber who may also identify additional mental health and support needs, signposting patients to relevant groups for this support.