

Care Quality Commission

Inspection Evidence Table

School House Surgery (1-558258019)

Inspection date: 4 May and 5 May 2021

Date of data download: 4 May 2021

Overall rating: Inadequate

At our last inspection in November 2020, the practice had remained rated inadequate overall.

This inspection carried out in May 2021 was a focused inspection, to confirm whether the provider was compliant with the two warning notices issued against Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance). This inspection was not rated and therefore the previous ratings remain unchanged. This report only covers out findings in relation to the warning notices.

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

Safe

Rating: Inspected but not rated

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: At our last inspection in November 2020 we found there was no specific policy to follow up on children who were not brought to appointment or following referral to secondary care. We also found the safeguarding policy did not provide the process for reporting concerns, the details for safeguarding contacts or the Prevent lead (PREVENT is about recognising when vulnerable individuals are at risk of being exploited for extremist or terrorist-related activities).	

Safeguarding	Y/N/Partial
<p>At this inspection we found systems and processes to safeguard children and adults from abuse had been improved. We saw the practice had updated their safeguarding policy to include the process for reporting concerns. There were contact details for the local safeguarding teams and out-of-hours safeguarding contacts. The designated Prevent lead was the safeguarding lead.</p> <p>The practice had processes in place to follow up when children were not brought to their appointment or following a referral to secondary care. We saw evidence of this, including a spreadsheet to monitor failed attendances and to ensure those patients were followed up. They were considering extending their review to include larger groups. For example, they were also following up on adult patients who missed eye screening appointments, as they had noticed an increase in failed attendances.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization.

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2020 we found that blank prescriptions were not always tracked once distributed to rooms throughout the practice.</p> <p>At this inspection in May 2021 we found the practice had improved their processes and recorded the details of each prescription that was distributed. They also limited the number of prescriptions that were placed in each room, to minimise the risk.</p> <p>At our last inspection in November 2020 we found the practice did not always ensure the proper and safe storage of medicines. This included emergency medicines and medicines requiring refrigeration, including vaccines.</p> <p>At this inspection in May 2021 we saw the practice had moved the emergency medicines to an appropriate location and had included guidance to staff with information about storage requirements. We were told about new processes to ensure that vaccines requiring refrigeration were monitored. This included that all reception staff had been trained to complete these tasks, including that a log of temperature checks was recorded. The logs were checked by the practice manager. We saw evidence of this.</p>	

Medicines management	Y/N/Partial
<p>At our last inspection in November 2020, we reviewed a sample of individual patient records. We found patients' health was not always monitored in relation to the use of some medicines, and the clinical records did not always evidence appropriate monitoring and clinical review prior to prescribing.</p> <p>At this inspection in May 2021 we found the practice had created an action plan to ensure they addressed the areas of concern and to ensure patients were followed up appropriately. They told us that they recognised the need for improvement and had acted quickly following our inspection. The provider explained they had a new pharmacist who worked within their network of local practices. The pharmacist had worked with the practice to improve systems and processes, as well as providing clinical assistance.</p> <p>We saw the practice had reviewed and improved procedures and processes relating to medicines management, particularly high-risk medication monitoring. We reviewed a sample of individual patient records for all of the areas that were of concern at our last inspection. We saw evidence that patients' health was being monitored appropriately. The records we saw had documented information we would expect to see. We saw evidence of new or improved systems in place to enable the practice to have oversight of all identified patients on high risk medicines in future.</p> <p>At our last inspection we found medication reviews were unstructured and incomplete as they did not include a review of the patients' entire medication list. At this inspection we viewed the records of six consultations for medication reviews. We saw evidence of detailed reviews that encompassed all medicines prescribed for the patient. However, during our review, we identified one medication review that evidenced incorrect advice being given to a patient about monitoring requirements for a certain type of medicine. We saw that no medications had been changed or amended as this was not part of the staff members role. This meant the patient would still be followed up as part of the practice's monitoring processes for patients prescribed long term medication. We discussed our findings with the provider who demonstrated they took our concerns seriously. They told us the member of staff will be provided with further training, support and ongoing supervision. They also told us they would review all medication reviews undertaken by this member of staff.</p> <p>We also noted that the way the practice used their clinical system could be improved further. Where medication was re-authorised by a clinician, the system automatically coded that a medicines review had been completed. This could result in a delay for the patients' actual medication review.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Explanation of any answers and additional evidence:	

At our last inspection in November 2020 found some of the systems and processes were still being embedded at the practice. For example, we found one incident which had not been raised or recorded as significant events.

At this inspection in May 2021 we saw an effective system for reporting and recording significant events. We were shown examples of events that had been thoroughly recorded, investigated, discussed and lessons learnt.

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

Event	Specific action taken
Delay sending non-urgent referral	We saw evidence that a significant event form had been completed and documented the actions taken. Following identification, the referral was immediately actioned. A GP partner was alerted and agreed there was no risk to the patient. An investigation was completed and as a result, all staff were provided with information regarding this particular type of referral. We saw minutes of a discussion about the significant event in a meeting. The minutes described the staff working through examples of these referrals for shared learning/training.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2020, during our review of patient records, we did not always find evidence that actions resulting from medicines alerts had been completed.</p> <p>At this inspection in May 2021 we saw evidence that patients affected by safety alerts had been followed up and advised appropriately. We reviewed a sample of patient records for the medicines that were of concern at our last inspection. These documented that the risks associated with certain types of medicines had been discussed with the patients. We were shown examples of the information leaflets issued to patients.</p>	

Effective

Rating: Inspected but not rated

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Explanation of any answers and additional evidence: At our last inspection in November 2020 we found that annual health reviews had not always been completed, to ensure patient health and medicines needs were being met. This included patients with a learning disability and those experiencing poor mental health. At this inspection in May 2021 we saw evidence that the completion of health assessments had improved. During our review we noted that the recording of learning disability reviews could be improved further, within the clinical system, related to the templates in use. We saw that learning disability health assessments were being undertaken using a document form/template that was not necessarily resulting in information being coded to a patient's clinical record, such that it would be visible and searchable in future. We also noted that the forms were not always fully completed. We discussed our concerns with the practice. They explained they already had plans in place to improve health reviews by using a new method of recording the information. They planned to use a form that would be used by all practices within their network to improve consistency.	

Well-led

Rating: Inspected but not rated

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Explanation of any answers and additional evidence:	
<p>At our last inspection in November 2020 we found there were some systems and processes that were not implemented effectively or were not yet well embedded. This included safeguarding procedures and significant events. We found significant concerns around clinical governance relating to medicines management, which meant we could not be assured there were comprehensive systems to identify, manage and mitigate risks to patient safety.</p> <p>Following our visit, the practice demonstrated they took our concerns seriously and took immediate action. The provider sent us their action plan to address all of the concerns we had highlighted at our last inspection. Each action had been given a realistic timescale for completion.</p> <p>At this inspection in May 2021 we saw and were told about the significant work that had been undertaken to improve systems and processes at the practice following our inspections.</p> <p>We found the provider was open and transparent about their progress against their action plan. We saw that most of the actions had been completed and some were ongoing due to the nature of the specific improvement. This included actions relating to the ongoing monitoring of patients prescribed high risk medicine.</p> <p>We found that the provider did not always have effective processes to identify, understand, monitor and address current and future risks, including risks to patient safety. The provider was continuing to improve on the areas of concern that we found at our last inspection, including the recording of learning disability reviews. However, we found that the provider was not aware of some other risks that we identified through our inspection. This included the oversight and supervision of staff undertaking clinical work, and the automated coding of medication reviews.</p> <p>We feedback our concerns to the provider. During our visit and following our inspection, the provider demonstrated they took these concerns seriously. They told us about the immediate actions completed and explained the ongoing improvements that would take place.</p>	