

# Care Quality Commission

## Inspection Evidence Table

### Avisford Medical Group (1-562962584)

Inspection date: 29 March 2022

**Overall rating: Good**

## Well-led

**Rating: Good**

At our last review on 7 July 2021 the practice was rated as requires improvement for providing well-led services. This was because the practice had not fully implemented its action plan and still required improvement. At this review we found that the practice had made sufficient improvements and is now rated as good for providing well-led services.

### Culture

**The practice culture effectively supported high quality sustainable care.**

	Y/N/Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
Explanation of any answers and additional evidence: At the last review in 2021 we found that complaints were not always responded to within the timescales set out in the practice complaints policy, and response times were not monitored. At this review we saw that the practice had a clear complaints policy which set out how to complain, what to expect in terms of a response and how the patient could escalate the complaint if still not satisfied with the outcome. We saw that the practice now had a system for recording and monitoring response times to complaints to provide internal assurance that its policy was being adhered to. The practice now maintained a clear record of the details of complaints, the outcome, learning points and action taken. We saw minutes of meetings which showed that complaints were regularly discussed. The practice maintained a clear audit trail to demonstrate that any learning points had been shared and understood by staff. We looked at two complaints and saw that they were thoroughly investigated. For one of the complaints there was clear evidence that investigations had appropriately included third parties. In the responses to both complaints, we saw that patients were given an apology and were informed of action that had been taken as a result.	

## Managing risks, issues and performance

### The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Explanation of any answers and additional evidence: <p>At our last review in 2021 we found that whilst the practice had a policy in place for identifying and managing significant events, this was not adhered to. We found staff had filled in significant event forms using the new form identified in the practice's action plan, but this was not being used consistently. There was no evidence from any of the significant event records, and no meeting notes were available, to demonstrate that actions were followed up and closed to ensure they were complete.</p> <p>Whilst the practice maintained a significant events spreadsheet, we could not find a chronological, accurate log, or summary of significant events, that allowed progress against action agreed to be monitored and reviewed and for trends to be identified. Some significant event report forms indicated a discussion had been held at a meeting, but no evidence was available to support this. Other significant event forms indicated that these had not been discussed at a meeting. There was limited evidence to show whether enough information gathering or investigations into the root cause of a significant event had taken place. This meant appropriate action and lessons learned might not always be identified.</p> <p>At this review, we looked at three significant events. We found that the form for reporting significant events had been completed consistently and was detailed enough to show that sufficient investigation and analysis into root causes had taken place. We saw evidence that any action required had been identified, implemented and followed up. We also saw that the significant events had been discussed in meetings with staff and the learning points shared. In addition, the practice maintained a clear audit trail to demonstrate that any learning points had been shared and understood by relevant staff. The practice showed us that they now maintained a significant events spreadsheet which was complete, accurate and up to date. The spreadsheet clearly identified the actions required and whether they were complete. This enabled progress to be monitored and reviewed.</p> <p>At our last review we found that the practice had implemented a system for receiving and acting upon safety alerts. However, the information supplied by the practice detailed a process that had not yet become fully embedded within their systems.</p> <p>At this review we found that the system was now being managed by the practice-based pharmacist. There was a clear, embedded policy and procedure in place whereby the pharmacist received all alerts. For relevant alerts the pharmacist ran searches to identify affected patients for discussion with the GPs. Action was taken and the patients were contacted where appropriate. The practice maintained a clear audit trail of the end to end process which included brief details of the alert, the actions taken, where, when, how and with whom the alert was shared. Records of the search details and patients identified were also maintained. We saw that safety alerts were a standard agenda item for practice meetings and that the pharmacist provided quarterly and half yearly summaries of all alerts that had been relevant and acted on.</p>	