

CQC Visits

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CQC PMS visits- Is it time to panic

- ▶ It is an opportunity to show case your practice
- ▶ It is opportunity to celebrate your achievements

Mythbusters-1

- ▶ **Defibrillators:** According to current external guidance and national standards, practices should be encouraged to have defibrillators.
- ▶ **Oxygen:** The National Resuscitation Council has the following view that: 'Current resuscitation guidelines emphasise the use of oxygen, and this should be available whenever possible.'
- ▶ **CPR:** This is mandatory. If a practice has not trained its staff, it would not have evidence that their staff could immediately respond to a person who requires resuscitation.
- ▶ Regulation 9 which states that: 'The planning and delivery of care and, where appropriate, treatment in such a way as to... ensure the welfare and safety of the service user.'

Mythbuster-2 Who should have a disclosure and barring service (DBS) check?

- ▶ Practices need to:
- ▶ have a process in place for undertaking criminal record checks at the appropriate level (only for staff who require a check).
- ▶ assess the different responsibilities and activities of staff to determine if they are eligible for a DBS check and to what level.

Significant Event Analysis (SEA)

- ▶ On an inspection, when an inspector will be looking at the seven steps involved in an SEA:
- ▶ All staff should be aware of and be able to prioritise a significant event.
- ▶ Information gathering. There should be evidence of information gathering, including factual information on the event such as personal testimonies, written records and other health care documentation. For more complex events, more in-depth analysis will be required.
- ▶ Facilitated team-based meeting should have occurred to discuss, investigate and analyse events. There should be evidence of the meeting regularly for the purpose of SEAs
- ▶ Analysis of the significant event including - What happened and why? How could things have been different? What can we learn from what happened? Is change required, if so, what needs to change?
- ▶ Agree, implement and monitor change. There are no fixed end-points; outcomes should be revisited and the implementation and success of any agreed changes monitored at pre-set intervals.
- ▶ Written records and all the processes of the SEAs should be written up to form a report. The SEA report is a written record of how effectively the significant event was analysed.
- ▶ Report, share, review. The SEA should be shared with all members involved in the significant event.

Clinical audits

- ▶ As long as the audit relates to the practice and has been discussed, evaluated and change instituted within the practice, then this can be used as supporting information within the effective domain for a CQC inspection. (effective)
- ▶ GMC- All healthcare professionals should take part in regular and systematic clinical audit, both quantitative audits of the care of groups of patients against defined criteria (with re-audit to demonstrate change)'

Carpets in GP practices

- ▶ Carpets should not be used in treatment and minor surgery rooms. The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. This also applies to all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances.
- ▶ Guidance on maintenance in built environment
- ▶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170705/HBN_00-09_infection_control.pdf

Guidance about curtains

- ▶ During a CQC inspection, we are looking for:
- ▶ curtains which appear visibly clean.
- ▶ a system in place to ensure that curtains are cleaned or changed at least once every 6 months.
- ▶ If disposable curtains are used, the date should be clearly entered and they should be replaced six monthly.
- ▶ If re-usable curtains used, they should be taken down and cleaned at 60 degrees at least six monthly and immediately when soiled.
- ▶ They should be vacuumed weekly as part of the general cleaning schedule.
- ▶ They should be well maintained, free of tears and clear of the floor.

Hand washing signs

- ▶ What we would look for in relation to hand hygiene during an inspection is that:
- ▶ there is adequate hand washing facilities available and easily accessible to all staff.
- ▶ practice staff should notify the practice manager of any lack of hand hygiene products (like hand gels, soap or hand towels) or obstruction to ensure that they remain available at all times (and are not obstructed by bins or other equipment).
- ▶ all clinical staff are trained in hand washing techniques.
- ▶ the practice has thought about risks of inadequate hand hygiene and processes are in place to prevent poor hand hygiene.

Gillick competency and Fraser guidelines

- ▶ In UK law, a person's 18 birthday draws the line between childhood and adulthood (Children Act 1989 s105) - so in health care matters, an 18 year old enjoys as much autonomy as any other adult.
- ▶ To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

Emergency drugs for GP practices

- ▶ This is **not** intended to be either exhaustive or mandatory and that final decision needs to be taken contextually so that choices/omissions can be professionally justifiable.
- ▶ Adrenaline for injection Anaphylaxis or acute angio-oedema
- ▶ Atropine for practices that fit coils or minor surgery is performed Bradycardia
- ▶ Benzylpenicillin for injection Suspected bacterial meningitis
- ▶ Chlorphenamine for injection Anaphylaxis or acute angio-oedema
- ▶ Glucagon (needs refrigeration) or Glucagel Hypoglycaemia
- ▶ Hydrocortisone for injection Acute severe asthma, Severe or recurrent anaphylaxis
- ▶ Salbutamol either nebulised or inhaler with volumatic Asthma

Emergency drugs for GP practices

- ▶ Antiemetic – Cyclizine or Metoclopramide Nausea and vomiting
- ▶ Opiates – Diamorphine or Morphine or Pethidine Severe pain
- ▶ Naloxone (dependent on if opiates are kept at the practice) Opioid overdose
- ▶ Diclofenac (intramuscular injection) Analgesia
- ▶ GTN Spray or unopened in date GTN SL tabs Chest pain of possible cardiac origin
- ▶ Aspirin soluble Suspected myocardial infraction
- ▶ Rectal diazepam and/or IV diazepam Epileptic fit

Emergency drugs for GP practices

- ▶ We would want to see evidence that an appropriate risk assessment has been carried out to identify a list of medicines that are **not** suitable for a practice to stock, and how this is kept under review. There should be a process and system in place to check that drugs are in date and equipment is well maintained.

GPs and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- ▶ The Mental Capacity Act (2005) is a crucial safeguard for the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care and treatment.
- ▶ GPs and their staff (and all providers of health and social care) should have a good understanding of the MCA 2005.

Prescriptions in dispensing practices

- ▶ Repeat prescriptions
- ▶ These should be signed before medicines or appliances are supplied to the patient – and ideally before the dispensing takes place. There needs to be a robust process around this. There may be occasions where this is not possible, but the procedure to follow for these occasions should be covered by the practice protocol. On these occasions there would also need to be a clear audit trail.
- ▶ The prescriber takes responsibility for the medicine being provided to the patient. This function is provided in the consultation by the prescriber (as opposed to a dispenser) pressing the 'issue' button, much as letters can now be electronically 'signed'. All IT systems have an audit trail that records exactly when this took place. So in many ways this is more robust than a paper signature.

Accessing medical records during inspections of GP practices

- ▶ CQC has powers under the Health and Social Care Act 2008 (the 2008 Act) to access medical records for the purposes of exercising our functions (which includes checking that registered providers are meeting the requirements of registration).
- ▶ We assess the quality of care and corroborate this through the evidence we see in medical records.

Who can diagnose death?

- ▶ While we do not have a specific CQC policy on this, we can look to national guidance and English Law. The BMA guidance is clear and summarises the issue very well.
- ▶ To comply with statutory requirements

English law:

- ▶ does not require a doctor to confirm death has occurred or that "life is extinct".
- ▶ does not require a doctor to view the body of a deceased person.
- ▶ does not require a doctor to report the fact that death has occurred.
- ▶ does require the doctor who attended the deceased during the last illness to issue a certificate detailing the cause of death.

Who can diagnose death?

For an expected death

- ▶ "If the death occurs in the patient's own home, it is wise to visit as soon as the urgent needs of living patients permit.
- ▶ "If the death occurs in a residential or nursing home and the GP who attended the patient during the last illness is available, it is sensible for him or her to attend when practicable and issue a death certificate.

For an unexpected death

- ▶ "If death occurs in the patient's home, or in a residential or nursing home, we recommend a visit by the GP with whom the patient was registered, to examine the body and confirm death, although this is not a statutory requirement.

Chaperones

- ▶ The GMC has published guidance on intimate examinations and chaperones.
- ▶ Every GP practice should have a chaperone policy in place for the benefit of both patients and staff. The chaperone policy should be clearly advertised through patient information leaflets, websites (where available) and on notice boards.
- ▶ A formal chaperone is usually a clinical health professional, such as a nurse, or can be a specifically trained non-clinical staff member, such as a receptionist. This person will have a specific role to play during the consultation and this role should be made clear to both the patient and the person undertaking the chaperone role.

Chaperones

- ▶ These include an understanding of the following points:
- ▶ What is meant by the term chaperone.
- ▶ What is an 'intimate examination'.
- ▶ Why chaperones need to be present.
- ▶ The rights of the patient.
- ▶ Their role and responsibility. It is important that chaperones should place themselves inside the screened-off area as opposed to outside of the curtains/screen (as they are then not technically chaperoning).
- ▶ Policy and mechanism for raising concerns.

Chaperones

- ▶ All members of staff who undertake a chaperone role should have had a Disclosure and Barring Service (DBS) check

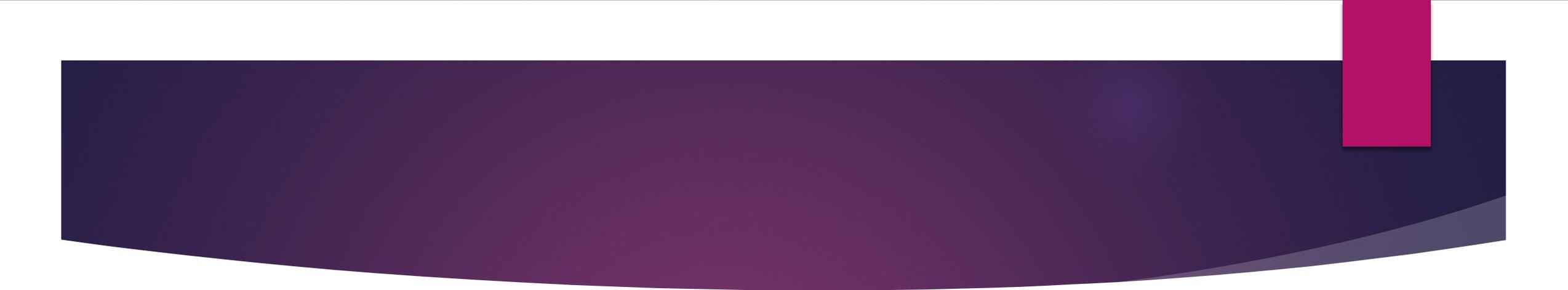
Vaccine storage and fridges in GP practices

Temperature monitoring

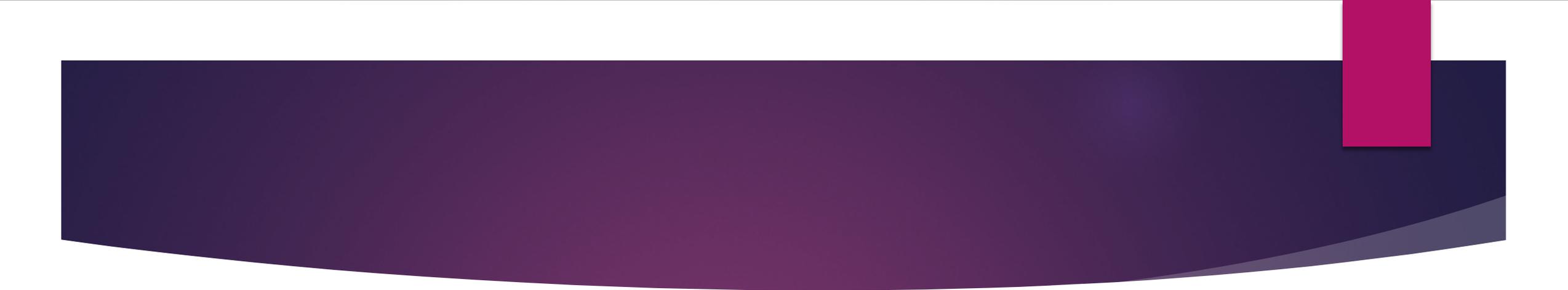
- ▶ Observe the four
Rs: **Read; Record; Reset; React**

Vaccine storage and fridges in GP practices

- ▶ Named, trained, people need to be responsible for ordering, receipt and care of vaccines (preferably one from the nursing team and one from management). All members of the primary care team should be aware of the importance of good vaccine management.
- ▶ all those administering vaccines should have had training on the importance of maintaining the cold chain
- ▶ validated cool boxes from a recognised medical supplier should be used to transport vaccines
- ▶ all those involved in administering vaccines as well as the practice manager should understand what to do in the event of a failure in the cold chain.



Any Questions



Thank you