‘Preparing for CQC’ - Forum for Practice Managers & GP CQC leads Workshop 4

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About this session: The content of this session is intended to provide general guidance based on our current understanding of CQC expectations. It should not be relied upon as definitive or exhaustive advice. As CQC approaches and areas of focus may change, practices remain responsible for their own compliance and governance arrangements.

Session 4: Learning Culture & Patient Focus

- What do CQC mean by a learning culture? How is this different to taking actions from incidents?
- Significant Events management, themes & trends & LFPSE (Learning From Patient Safety Events – national reporting system)
- Complaints management, themes & trends
- Duty of Candour

- Carers
- Reasonable adjustments – flags
- DNACPR – Respect forms
- End of Life – care planning

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What do CQC mean by a Learning Culture?

CQC are big on 'learning culture' and how you learn from Significant events and complaints.

What is a learning culture and how is this different to actions you taker from significant events and complaints?

Example: You receive a complaint from a patient that '*they did not have their normal nurse for a smear test – the one they had made her feel uncomfortable and did not seem to know what she was doing.*'

- What are the actions the practice should document and take from this complaint?
- What is the learning the practice should document and identify from this complaint?

Actions could be: Check if it was a regular or agency nurse, check cervical sample taker register number is correct for Sussex, check if nurse requires an update, has competency check been documented as part of induction on her cervical screening?

Learning: on looking at the actions - wider issues might be uncovered such as: policy was out of date, some of the other nurses had not been updated, there were some queries from nurses about accessing the new cervical screening system, admin didn't know they need to check cervical screening register for agency nurses – therefore your learning would be to address all of these.

GP mythbuster 104: Cervical screening - Care Quality Commission

Actions and Learning – what's the difference?

So

Actions – are what you do as part of the investigation to address the issue

Learning – what other or wider things have you uncovered as a result of your investigations that may apply which could improve things further?

If you are a learning practice that means there is less of a chance that the incident might happen again as you identified extra learning from complaints and incidents.

In this case, the learning led to overall improvements your cervical screening competency / update checks of all your nurses
So - less chance you get another complaint about your nurses and cervical screening....for example!

Sometimes its difficult to identify learning every time, particularly with some complaints about things outside your control. But you can always review a policy or talk to the staff if there are wider issues and think about extra training.....which you might do in-house – in a meeting, maybe? Or could you do more on giving clarity to what patients can expect?

Complaints - What do CQC expect?

- That you have an up-to-date policy
- That you have information available online via website and in the waiting room regarding patient feedback which should include how to make a complaint

- CQC will look if you adhere to your own policy on complaint response timeframes, and if there are exceptions - have you kept the patient informed?

- CQC may want to look at a complaint letter – have a fairly recent, good one handy!

- That you and all the staff understand Duty of Candour – 'being open and honest when things go wrong' GP mythbuster 32: Duty of Candour and General Practice (regulation 20) - Care Quality Commission

- At least yearly, review all your complaints for themes and trends and you document this review and discuss in a practice meeting – why do CQC want to see this?

GP mythbuster 103: Complaints management - Care Quality Commission

Complaints – what does CQC say?

GP mythbuster 103: Complaints management - Care Quality Commission – make sure your policy follows this

All providers must handle complaints efficiently and investigate them properly. This involves:

- treating complainants with respect and courtesy
- providing appropriate assistance or information to understand the complaints procedure
- responding promptly, fully and honestly
- apologising when appropriate.

You must:

- Manage any immediate issues appropriately and promptly to ensure the person's safety
- clearly identify every issue that needs a comment or response
- Investigate the complaint properly
- Identify who will answer each issue raised.

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 state that complaints can be either verbal or in writing. However, providers cannot insist complainants 'put their complaints in writing'.
If you are not sure whether the information received is a complaint, a concern, or simply feedback, you should ask the patient or enquirer.

Complaints continued

- When investigating, you can ask the complainant for more information if necessary.
- Anyone making a complaint about an NHS service is entitled to support from an NHS Complaints Advocate.
- Complaints and investigations are not routinely stored as part of clinical records. This is to avoid future prejudice and may also be necessary as part of clinician confidentiality.
- Complaint records should be retained for 10 years.
- If you receive a verbal complaint (that is not resolved in 24 hours) you need to make a written record of it. You need to share this with the complainant so they can agree the content.

- Your practice must have a well-publicised complaints process. It should set out arrangements for handling and considering complaints. This may include:
- information about the policy on the practice website
- a leaflet and poster showing a simple version of the policy
- a full working policy for practice staff that reflects the regulations and local organisation.
- Each practice must have clear responsibilities and arrangements for managing complaints. This is to avoid delays in responding.
- The Local Authority Complaints Regulations require each practice to designate a responsible person to:
  - manage the complaint
  - ensure compliance with the arrangements, including sign off of the complaint.

Significant Events: What do CQC expect?

CQC expect that you complete a full investigation and identify actions and learning from each event and you discuss this with staff in a meeting – evidenced by the minutes.

CQC expect all staff know what a significant event is, may want an example - and how does that member of staff report it?
Are staff confident something will be done if they report a significant event?

CQC expect to see this described in an up-to-date significant events policy
May look at an example of a significant event to see if you have followed your policy

Know if you have to report it to CQC or not: GP mythbuster 21: Statutory notifications to CQC - Care Quality Commission – legal obligation to report certain things to CQC.

At least yearly review all your significant events & complaints for themes and trends, document this review and discuss at a practice meeting (discussion captured in minutes) – why will CQC look for this?

CQC: *We want to see evidence of learning from incidents and improving quality. On inspection we look for the impact and learning that has resulted from the Significant Event.*
We expect 'good' practices to ensure that the learning from significant event analysis, involves the whole team and becomes embedded in everyday practice.

Managing Significant Events – what does CQC say?

GP mythbuster 3: Significant event analysis (SEA) - Care Quality Commission

Examples of significant events can be very wide-ranging and can reflect **good** as well as **poor** practice.

Examples could include:

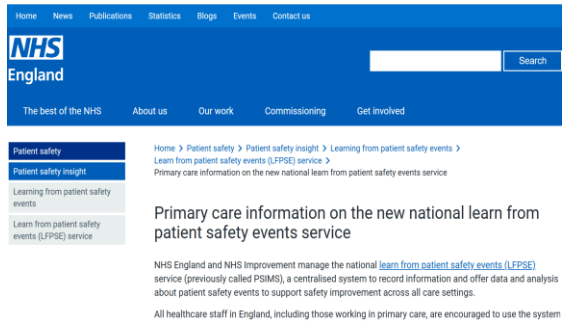
- new cancer diagnoses.
- coping with a staffing crisis.
- complaints or compliments received by the practice.
- breaches of confidentiality.
- a sudden unexpected death or hospitalisation.
- an unsent referral letter.
- prescribing error.

Written records and all the processes of the SEAs should be written up to form a **report**. This should record how effectively the event was analysed

The aims of undertaking Significant Event Analysis are to:

- identify events in individual cases that have been critical (beneficial or detrimental to the outcome) and to improve the quality of patient care from the lessons learnt.
- instigate a culture of openness and reflective learning, not individual blame or self-criticism
- enable team-building and support following stressful episodes
- enable identification of good as well as suboptimal practice
- be a useful tool for team and individual continuing professional development, identifying group and individual learning needs
- share learning between teams within the NHS where adverse events occur at the 'overlap' or in shared domains of clinical responsibility (such as out-of-hours, discharge problems).

LFPSE: Learning From Patient Safety Events – the national reporting system



Where else may you have to report significant events?

The LFPSE service has replaced the National Reporting and Learning System (NRLS).

Primary care staff are encouraged to use the system to record any events where:

- a patient was harmed or could have been harmed. For example, an unsafe discharge.
- there has been a poor outcome, but it is not yet clear whether an incident contributed or not.
- risks to patient safety in the future have been identified.
- safe and effective care has been delivered that could be learned from to improve patient safety

Have an awareness of this – do you have a log in?: NHS England » Primary care information on the new national learn from patient safety events service

GP mythbuster 24: Recording patient safety events with the Learn from patient safety events (LFPSE) service - Care Quality Commission

Many GP pharmacists use this system for reporting drug errors that others can learn from. Check if yours has a log in for LFPSE

Carers – what do CQC expect?

Keep an up-to-date register of carers and include children that care for adults

Offer advice and support for all carers

GP mythbuster 44: Caring for carers - Care Quality Commission

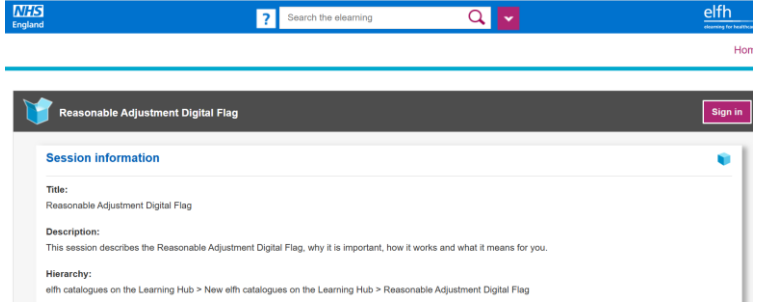
Good to have an admin Carers lead and consider how the practice can support carers – do you do a carers survey, for example - or maybe ask the Patient Participation group if there are more considerations on how the practice can support carers?

New CQC draft framework: *Unpaid carers and advocates are supported to be active partners in people's care.*

Across Sussex, carers can access support through:
Care for the Carers (East Sussex)
Carers Support West Sussex
The Carers Centre for Brighton & Hove

Maybe ask the PPG to contact them to see what is on offer?

Reasonable adjustments



What do CQC want to see?
That all relevant patients have their individual reasonable adjustments flagged and staff know to action on them e.g. hearing, sight, language, learning disability access issues etc etc consider this training:
NHSE elfh Hub

GP mythbuster 67: Reasonable adjustments for disabled people - Care Quality Commission

What is meant by 'reasonable'?
Adjustments can be:

- Physical changes to a building – e.g. wheelchair access
- Providing extra services, or e.g. providing longer appointments in afternoons for patients with learning disabilities (if that's what they want!)
- Changing a policy or procedure. E.g. having translation support available and promoted, or policy adjustments for visual or sight impaired, particularly in accessing appointments.

New draft CQC framework: *Staff treat people as individuals, considering any relevant protected equality characteristics. They make sure they understand and meet people's personal, cultural, social and religious needs.*

- Meeting the Accessible Information Standard - Care Quality Commission

End of Life and DNACPR / RESPECT forms

GP mythbuster 38: Care in advanced serious illness and end of life - Care Quality Commission

Will probably ask:
How do you review your end of life patients, particularly with others e.g. hospices – meeting minutes

DNACPR: (Do Not Attempt Cardiopulmonary Resuscitation) or also known as ReSPECT form:(Recommended Summary Plan for Emergency Care and Treatment)

- Ardens CQC search – make sure a GP has reviewed all of the DNACPR / RESPECT forms minimum yearly.

- Have you got a copy of the RESPECT form in patient's record? Have you coded them correctly?
- Estimate that all of your care home residents will have one – check with care home manager

- Do NOT need to re-do every year! Review if they are clinically appropriate & document in pts records – if not clinically appropriate then need to redo the form with patient / family.
- GP mythbuster 105: Do not attempt cardiopulmonary resuscitation (DNACPR) - Care Quality Commission

- Taken from new draft framework: *There are systems in place to ensure that decisions around advance care planning, including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR), are informed, documented and regularly reviewed.*

Reflection on today

What will you take away and implement or change in your GP Practice?

Please write in the chat