INFECTION PREVENTION AND CONTROL AUDIT REPORT AND ACTION PLAN

Practice Name: Gower Street Practice

Practice Code: F83005

Introduction

The Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance (revised 2015) outlines the role of infection prevention (including cleanliness) and optimising antimicrobial use and reducing antimicrobial resistance. This applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers.

Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antibiotic stewardship as preventing infections helps to reduce the need for antimicrobials. Good management and organisational processes are also crucial to ensure that high standards of infection prevention and control (including cleanliness) are set up and maintained

Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 ensures that the care people receive meets essential standards of quality and safety and encourages ongoing improvements by those who provide or commission care.

Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare. Providers must also ensure that the premises and any equipment used is safe, fit for purpose and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

Infection Prevention and Control in Primary Care General Practice

In primary care general practice there are a variety of ways where cross infection may be a potential risk, some of them may include:

- Overcrowding.
- Staff health
- Poor hand hygiene.
- Inadequate equipment cleaning / decontamination.
- Sharps management and transmission of blood borne viruses.
- Specimen handling
- Clinical waste segregation and management.
- Environmental cleaning and blood / bodily fluid spillages management.

All of these modes of transmission of infection are either avoidable or the risks can be minimised to low levels if the appropriate standard infection control procedures are followed. These measures include Hand hygiene, equipment management and decontamination, maintaining Aseptic Non-Touch Technique (ANTT), medicine management including cold chain system, environmental cleanliness and spillage management, wastes and sharps management, adhering to the correct usage of Personal Protective Equipment (PPE), staff health and management of infectious diseases. Hand hygiene is the single most effective means of preventing health care associated infections and should be a priority for implementation.

The Audit Process

NHS England has placed increased emphasis on the use of audit to measure compliance to practice and the implementation of policies and procedures relating to infection control. The review of clinical practice through audit is a well-established means of monitoring and improving the quality of care and of supporting the implementation of change in practice.

As part of the process of ensuring that IPC standards are met, as well as ensuring that the quality of the infection control practice within primary care is of a high standard, NHS England implements a continuing programme of practice visits, supported by experienced NEL CSU Infection Prevention and control team. This entails a visit to all practice premises on a three yearly basis, or sooner, if circumstances dictate.

The Audit Tool used is a consistent resource developed by NHS England and is utilised during the visit. The audit tool consists of several standards of IPC and defines acceptable criteria which minimises the risk of infection to patients, staff and relatives. These standards reflect current legislation, national guidelines and good practice of infection prevention and control within a healthcare environment.

The audit report and its recommendations help to ensure that practices improve their compliance to infection prevention and control in line with the code of practice and other current national guidelines and should serve as a useful reference point. Therefore it is essential that this report and its recommendations is given due consideration and that the agreed action plan which outlines how the practice plan to address the issues highlighted is completed and returned appropriately as advised.

GP Contractor Details		
Practice Name	Gower Street Practice	
Practice Code	F83005	
Practice Address	20 Gower Street , LONDON	
Post Code	WC1E 6DP	
Telephone No	020 7467 6800	
PMName	Marcia Menichetti	
Contact Name	Dr R Murthi	
Principal GP	Dr R Murthi	
Practice Nurse	Nurse Irlene	
Audit Date	Wednesday 30 May 2018	
Audit carried out by	Margaret Munemo	
Minor Surgery	No	
IUCDFitting	No	
Practice Representative	Dr R Murthi	

Contact / Communication details

Organisation	Location	Names	email Addresses
NEL Primary Care IPC Team	NEL, Second Floor, Clifton House,75-77 Worship Street, London EC2A 2DU		nelcsu.ipcteam@nhs.net
		Margaret Munemo, IPC Nurse Tel:	margaret.munemo@nhs.net
		Melody Hussey, IPC Coordinator Tel:	melody.hussey@nhs.net

NEL Primary Care IPC Team	NEL, Second Floor, Clifton House,75-77 Worship Street, London EC2A 2DU	Sanjeev Bundhoo, Primary Care IPC Manager Tel:	s.bundhoo@nhs.net
		Toni Dos Santos, IPC Nurse Tel:	toni.dossantos@nhs.net
NHS ENGLAND Contracting	NHS England London		
		Team Head, Tel:0203 182 4994	England.Lon-ne-pcc@nhs.net; England.Lon-nw-pcc@nhs.net; England.swlprimarycare@nhs.net

Practice details		
Practice Building	Other	Rented
Num Consult Rooms	7	
Num Treatment Rooms	1	
Dedicated MSRoom	No	
Clean Utility Room	No	
Dirty Utility Room	No	
Cleaners Room	Yes	Adequate space
Noof Vaccine Fridge	1	

Comments

The environment was visibly clean. Infection prevention and control is managed effectively in this practice. Staff are aware of the importance of hand hygiene and bare below the elbows is followed. The practice is compliant with most standards of infection prevention and control. The practice has a robust system in place as part of antimicrobial stewardship. However there are areas of non-compliance as detailed in the attached action plan.

Executive Summary

This is the report of infection prevention and control (IPC) audit carried out at Gower Street Practice, on 30th May 2018.The audit was completed with the assistance of the practice manager. The practice had 7 consulting rooms and 1 treatment rooms. Findings: There were a few areas of non-compliance on standards of IPC. Three standard out of 14 were identified as non-compliant Recommendation: An action plan in this report addresses all areas of non-compliance with agreed timeframe for actions to be completed. Risk assessment: There are no immediate risks to patient safety. Next face-to-face audit: "Next routine audit

	No of Non Compliant Indicators	Percentage of Non Compliant Inds
Standard 1	0	0.00%
Standard 2	0	0.00%
Standard 3	2	25.00%
Standard 4	1	6.67%
Standard 5	0	0.00%
Standard 6	0	0.00%
Standard 7	0	0.00%
Standard 8	0	0.00%
Standard 9	0	0.00%
Standard 10	0	0.00%
Standard 11	0	0.00%
Standard 12	1	6.67%
Standard 13	0	0.00%

Standard 14	0	0.00%

Acknowledgement of the audit by the GP Contractor Principal / Practice Representative

I confirm that I have read and understood the audit findings and suggestions of how to implement the recommendations and time frame for actions to be completed.

I confirm that I have the authority to sign on behalf of the Principal GP Contractor	Dr R Murthi
Signature of GP Contractor Principal / Practice Representative:	
Name of GP Contractor Principal / Practice Representative:	Marcia Menichetti
Date	30/05/2018
Signature of Infection Prevention/Health Protection Adviser:	
Name of Infection Prevention/Health Protection Adviser:	Margaret Munemo
Date	30/05/2018

INFECTION PREVENTION AND CONTROL AUDIT ACTION PLAN

Section and Question Number	EQR or BP	Issues Identified	Remedial Action / Recommendations	Action Agreed or Not Agreed by Practice	Time Frame for Action to be completed	Person Responsible
S3Q4	EQR	Not all walls in all areas were in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces, some walls had tiled splash back.	To ensure that all walls in all areas are in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces.	Agreed	12-18 Months	Marcia Menichetti
S3Q5	EQR	Flooring in some areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms & treatment rooms and other clinical areas had carpets.	To ensure that all flooring in all areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms & treatment rooms and other clinical areas) in a good state of repair, impervious to fluids and easy-to-clean.	Agreed	12-18 Months	Marcia Menichetti
S4Q9	EQR	Some hand washing sinks had overflows.	To ensure that all hand washing sinks are free of overflow.	Agreed	12-18 Months	Marcia Menichetti
S12Q12	EQR	There was no evidence that the vaccine fridge is serviced annually.	To ensure that the vaccine fridge is serviced and evidence that the vaccine fridge is serviced annually is kept for 2 years.	Agreed	8 Weeks	Marcia Menichetti
Please return completed action plan (with dates) within three months after receipt of report to the infection control team addressed to nelcsu.ipcteam@nhs.net						

KEY for Audit Tool:

* EQR = Essential Quality Requirements are the minimum requirements for compliance as detailed in the Health and Social Care Act 2008 (Hygiene Code).
** BP = Best Practice are standards that exceed the Essential Quality Requirements and if not already compliant at the time of audit, the Practice should develop detailed plans showing how the practice intends to work towards achieving Best Practice requirement.
E = Educational and useful good practice questions.

Audit tool

Section 1: The Management of Infection Prevention and Control (General Management)

Standard: Infection prevention and control is managed effectively and complies with the Health and Social Care Act 2008: Code of practice on the prevention and control of infection and related guidance (July 2015).

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S1Q1	Is there a named clinical lead person in the practice for infection prevention and control?	EQR	Yes					1
S1Q2	Does the practice have infection prevention and control policies?	EQR	Yes					2
S1Q3	Is infection prevention and control included in all staff induction programmes?	EQR	Yes					3
S1Q4	Does the practice have evidence to show that all clinical and non-clinical staff (including cleaning staff) are up to date with infection prevention and control training specific to their roles?	EQR	Yes					4
S1Q5	Is there a process for internally recording/reporting untoward incidents in relation to infection prevention and control (e.g. sharps and body fluid splashes)?	EQR	Yes					5
S1Q6	Does the practice have documentary evidence of infection prevention and control audits undertaken, evaluated and with actions taken to improve practice standards?	EQR	Yes					2

S1Q7	Has the Practice carried out a risk assessment for Legionella under the Health & Safety Commissions “Legionella’ disease – the control of Legionella bacteria in water systems: Approved code of practice & Guidance” (also known as L8)	EQR	Yes					7,8,9,10
S1Q8	Does the practice have written scheme for prevention of Legionella contamination in water pipes and other water lines	EQR	Yes					11
S1QE1	Does the practice have a recorded process in place that includes access to:	EQR						2
S1QE1.1	Local IPC advice and support as needed.	EQR	Yes					
S1QE1.2	Local Hospital Consultant Microbiologists?	EQR	Yes					
S1QE1.3	Public Health England Health Protection teams?	EQR	Yes					
S1QE1.4	Local anti-microbial Pharmacy Lead	EQR	Yes					
Additional Comments / Notes								

Section 2: The Management of Infection Prevention and Control (Staff Health)

Standard: Infection prevention and control is managed effectively and complies with the Health and Social Care Act 2008: Code of practice on the prevention and control of infection and related guidance (July 2015)

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S2Q1	Have all staff at risk been immunised against hepatitis B and have they had their response to vaccination confirmed by serology for anti HBs antibodies. It is recommended that practices keep a copy (At risk staff are those who may have direct contact with with patient's blood or blood stained body fluids (including cleaning staff)}	EQR	Yes					12,13
S2Q2	Has the issue of immunity to Measles, Rubella and Varicella in clinical staff been considered in the practice and a risk assessment undertaken?	EQR	Yes					14
S2QE1	Are all staff routinely advised regarding immunisation against seasonal influenza?	BP	Yes					3,14,15
S2QE2	Does the practice have access to Occupational Health service or access to appropriate occupational health advice? (This may include pre-employment checks to ensure appropriate immunisations have been given.)	BP	Yes					16

Additional Comments / Notes

Section 3: Environment

Standard: The environment is designed and managed to minimise reservoirs for microorganisms and reduce the risk of cross-infection to patients, staff and visitors.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S3Q1	Are all areas including clinical areas and equipment visibly clean and free from extraneous items?	EQR	Yes					17,18
S3Q2	Are there comprehensive written specifications for cleaning the environment and equipment in the practice?	EQR	Yes					18
S3Q3	Are there up to date cleaning schedules which includes regular cleaning of clinical, admin and sanitary areas (e.g. toilets, fans, air conditioners, high areas, curtains, blinds, toys, computer keyboards, telephones and desks)?	EQR	Yes					18
S3Q4	Are walls in all areas in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces?	EQR	No	Not all walls in all areas were in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces, some walls had tiled splash back.	To ensure that all walls in all areas are in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces.	Agreed	Low risk.	19
S3Q5	Is flooring in all areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms & treatment rooms and other clinical areas) in a good state of repair, impervious to fluids and easy-to-clean? (Carpets are not recommended)	EQR	No	Flooring in some areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms & treatment rooms and other clinical areas had carpets.	To ensure that all flooring in all areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms & treatment rooms and other clinical areas) in a good state of repair, impervious to fluids and easy-to-clean.	Agreed	Low risk.	19
S3Q6	Are furniture (e.g. chairs, couches, pillows etc) in clinical areas and other areas accessible to patients impermeable / washable / suitable for its use?	EQR	Yes					18,19

S3Q7	Are cleaning equipment and materials for cleaning colour coded, suitable for use and stored appropriately?	EQR	Yes					17
S3Q8	Is the area for storing cleaning equipment well ventilated, clean and tidy (no clutter) and is it of an adequate size?	EQR	Yes					17
Additional Comments / Notes								

Section 4: Hand Hygiene

Standard: The practice has a clear mechanism to ensure effective implementation of hand hygiene procedures are in place and hand hygiene is practiced at all times to reduce the potential for cross infection between staff, patients, the environment and equipment.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S4Q1	Does the practice have a Hand Hygiene Policy?	EQR	Yes					2
S4Q2	Is the hand hygiene technique displayed as a laminated poster adjacent to the hand washbasin or is it featured on the soap dispenser?	BP	Yes					20
S4Q3	Does your practice policy demonstrate an awareness of the DH uniform policy? (E.g. bare below the elbows)	EQR	Yes					2,21
S4Q4	Are there wash basins dedicated to hand hygiene in each clinical and consulting room which can be easily accessed?	EQR	Yes					22
S4Q5	Do all hand wash basins for use in connection with clinical procedures have elbow or wrist operated mixer taps?	EQR	Yes					18,22
S4Q6	Is the hot water thermostatically controlled?	EQR	Yes					23
S4Q7	Are taps at all clinical hand wash basins free from swan neck type taps?	EQR	Yes					19

S4Q8	All hand washing sinks are free from plugs?	EQR	Yes					22
S4Q9	Are all hand washing sinks free of an overflow?	EQR	No	Some hand washing sinks had overflows.	To ensure that all hand washing sinks are free of overflow.	Agreed	Low risk.	22
S4Q10	Are hand hygiene facilities clean and free from clutter (check wash basins, taps, splash-backs, soap and paper-towel dispensers)?	EQR	Yes					18
S4Q11	Are hand hygiene facilities free from damage?	EQR	Yes					19
S4Q12	Is the tap off-set from the waste outlet?	EQR	Yes					22
S4Q13	Is liquid soap dispensed from single use cartridges or bottles? (I.e. no bar soap).	EQR	Yes					24
S4Q14	Is alcohol-based hand rub available for use when required, including use during domiciliary visit?	BP	Yes					20
S4Q15	Are paper towels available? (I.e. no cloth towels in use).	EQR	Yes					20
S4Q16	Are hand wash basins free from nail brushes?	EQR	Yes					25
S4Q17	Are there separate arrangements to dispose of waste materials (e.g. urine) other than using the hand washbasin?	EQR	Yes					26
Additional Comments / Notes								

Section 5: Personal Protective Equipment (PPE)

Standard: Protective clothing is available/worn for all aspects of care which may involve contact with blood/body fluids or where asepsis is required

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S5Q1	Does the practice have a policy on the appropriate use of PPE?	EQR	Yes					2
S5Q2	Are the following PPE available for staff?	EQR						27,28,29,30

S5Q2.1	Gloves (sterile/non-sterile) are appropriate for use, i.e, latex & latex free nitrile? Vinyl gloves are not recommended for clinical activities were blood/body fluid may be anticipated.	EQR	Yes					27,28,29,30
S5Q2.2	Disposable aprons available?	EQR	Yes					31
S5Q2.3	Disposable face and eye protection (to be worn by staff if splashing of blood, body fluids or chemicals is anticipated)?	EQR	Yes					31
S5Q3	Are staff aware of the principles of wearing and disposing of personal protection equipment (PPE) i.e. disposable gloves, aprons and additional availability of masks and goggles) – for example:	EQR	Yes					31
S5Q4	Are PPE items worn as single use items?	EQR	Yes					31,32
S5Q5	Where required are aprons and gloves changed between different episodes of care on the same patient?	EQR	Yes					
S5Q6	Are gloves removed and hand hygiene performed after every clinical activity?	EQR	Yes					
S5Q7	Are staff aware on the decontamination process required for re-usable goggles (if available)?	EQR	Yes					
Additional Comments / Notes								

Section 6: Prevention and management of spillages of blood & high risk body fluids

Standard: Equipment appropriate for cleaning blood or other body fluid is available specifically for dealing with such incidents safely.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S6Q1	Does the practice have a policy for managing spillages in healthcare premises?	EQR	Yes					4,33
S6Q2	Are all staff aware of the procedure for dealing with spillages of blood or other body fluids?	EQR	Yes					2,31
S6Q3	Are spillage kits available for dealing with spillages of blood/body fluids, i.e, separate kits for dealing with blood spillages and a separate kit for dealing with urine/vomit spillages?	EQR	Yes					34
S6Q4	Are disposable cloths or mop heads available for cleaning blood or other body fluid spillages?	EQR	Yes					34

Additional Comments / Notes

Section 7: Safe handling and disposal of sharps

Standard: Sharps are managed safely to reduce the risk of inoculation injury.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S7Q1	Does the practice have a policy on safe handling & disposal of sharps?	EQR	Yes					2,35

S7Q2	Are sharps containers that conform to BS 7320 and UN3291 available in every clinical/consulting area and are they positioned safely; out of reach of vulnerable people?	EQR	Yes					36
S7Q3	Are sharps containers discarded when two thirds full and stored in a secure facility away from public access until collected for disposal?	EQR	Yes					35
S7Q4	Is blood sampling undertaken by using a ‘Sharp Safe’ single-use vacuum blood collection system?	EQR	Yes					37,38,39,40,41,44
S7Q5	Is Aseptic Non-Touch Technique (ANTT) used when performing venepuncture?	EQR	Yes					42,43
S7Q6	Are sharps used for taking blood from patients at home/care home, disposed of in to an appropriate sharps container which is returned to the surgery for safe disposal?	EQR	Yes					35
S7Q7	Is there evidence that the practice has undertaken a review of sharps management within the practice and employed ‘safer sharps’ techniques where applicable.	EQR	Yes					44
S7Q8	Are the sharps containers assembled according to manufacturer's instructions and labelled in accordance with legal requirements?	EQR	Yes					45
S7Q10	Are Staff aware of the correct procedure to follow after a needle stick injury, other sharps or blood splash exposure?	EQR	Yes					46
S7Q11	Are posters available which show staff the emergency algorithm to follow in case of a sharp injury and is it up to date?	EQR	Yes					46

S7QE1	Are practice staff encouraged to wear gloves when undertaking venepuncture?	BP	Yes					37,41

Additional Comments / Notes

Section 8: Waste Management Policy and Procedures

Standard: Waste is always managed safely and in accordance with legislation to minimise the risk of infection or injury to patients, staff and the public.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S8Q1	Does the practice have a policy on waste management?	EQR	Yes					1,2,3,4,5,6,18,35
S8Q2	Is there documentary evidence to show that all clinical waste (including sharps containers) is disposed of by a registered waste collection company?	EQR	Yes					47
S8Q3	Are records of waste transfer and disposal arrangements kept and stored in accordance with the EPA 1990?	EQR	Yes					47
S8Q4	Are there easily accessible and compliant foot-operated clinical waste bins, with the appropriate colour coded bag (yellow or orange) available, in each clinical area? (E.g. is the foot operation in working order).	EQR	Yes					35
S8Q5	Is clinical waste and domestic waste correctly segregated (clinical waste in yellow or orange bags, according to waste regulations and domestic waste in black bags)?	EQR	Yes					35
S8Q6	Are clinical waste bags marked with the practice code when securing for disposal?	EQR	Yes					35

S8Q7	Are waste bags less than 2/3 full and securely tied?	EQR	Yes					47
S8Q8	Where clinical waste is not collected directly from clinical areas, is it stored in a separate, secure area for waste which is kept clean and tidy and secure from vermin and/or other inappropriate/extraneous items?	EQR	Yes					47
S8Q9	Are staff encouraged to report all incidents (including near misses) to the designated infection control lead at the practice?	EQR	Yes					47
Additional Comments / Notes								

Section 9: Management of Specimens

Standard: All specimens will be collected packaged and transported safely in approved containers in line with recognised standards – Packaging Instruction 650 and 621 and requirements of UN3373 or UN3291 to minimise the risk of cross infection.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S9Q1	Does the practice have a policy or procedure for specimen handling?	EQR	Yes					6
S9Q2	Where applicable are specimens stored in a dedicated refrigerator (not with food, vaccines or medicines)?	EQR	Yes					48
S9Q3	Are arrangements for specimen testing appropriate in consulting rooms?	EQR	Yes					48
S9QE1	Are staff aware of the appropriate way to handle and transport specimens?	EQR	Yes					49,50
S9QE1	Are staff aware of the appropriate way to handle and transport specimens?	EQR	Yes					49,50
Additional Comments / Notes								

Section 10: Decontamination of medical devices

Standard: All medical devices are decontaminated in a safe and appropriate manner to minimise the risk of infection and cross-infection. Note: Medical devices include not only surgical instruments but a wide variety of other equipment such as dressing trolleys, BP cuffs and baby scales. A risk assessment needs to be carried out on each medical device to ensure that the appropriate level of decontamination is carried out. For those in the high or medium risk categories cleaning and sterilisation must be carried out (e.g. autoclaving). For those in the lowest risk category cleaning or cleaning plus disinfection are needed depending on circumstances

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S10Q1	Does the practice have a policy which outlines the decontamination processes the GP Practices use for all medical devices?	EQR	Yes					2,51,52
S10Q2	Does the practice use single use surgical instruments?	EQR	N/A					53
S10Q3	Does the practice use an accredited external sterile supply service for re-usable surgical instruments and devices that need to be sterile at the point of use?	EQR	N/A					53
S10Q4	Are medical devices stored appropriately and above floor level to avoid being contaminated?	EQR	Yes					54
S10Q5	Are items of sterile equipment within their use-by date?	EQR	Yes					53

S10Q6	Are all items of equipment that come into contact with patients cleaned or decontaminated according to guidelines or are disposed of after each use? (E.g. all tubing and the mask of the nebuliser should be treated as single use and disposed of as clinical waste after use. The Nebuliser machine must be cleaned. Spirometer/peakflow meter mouthpieces must be single use.and the spiriometer cleaned after each use. Ear syringing tips and otoscope tips must be single use. Ear syringe noot tanks must be disposed of after each patient and the ear syringing machine cleaned as per guidelines.. All other equipment must be cleaned as per manufacturer's instructions.)	EQR	Yes					26
S10Q7	Is there a cleaning schedule/check list maintained for all items requiring cleaning?	EQR	Yes					26

Additional Comments / Notes

Section 11: Clinical Rooms

Standard: The environment is designed and managed to minimise reservoirs for micro-organisms and reduce the risk of cross infection to patients, staff and visitors.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S11Q1	Are all clinical rooms and all work surfaces clean and free from clutter?	EQR	Yes					17,19
S11Q2	Is the flooring impervious to liquids, non-slip, intact and clean?	EQR	Yes					17,19

S11Q3	Does the flooring form a coved skirting (i.e. uplifted at the edges on to the walls) OR is the gap between the floor and the skirting sealed and is the seal maintained?	EQR	Yes					55
S11Q4	Are walls and ceilings clean, dry and free from visible defects (no cracks, peeling paintwork) and have smooth easy to clean surfaces?	EQR	Yes					55
S11Q5	Is there an examination couch with an intact, impervious cover and single use roller paper available for use?	EQR	Yes					17,56,57
S11Q6	Is the examination couch fitted with a paper roll holder?	EQR	Yes					17
S11Q7	Are there sufficient work surfaces and dressing trolleys of smooth, impervious and cleanable material?	BP	Yes					56,57
S11Q8	Are all treatment surfaces in the room cleaned every working day with hot water and detergent or detergent wipes, in accordance with written practice cleaning schedules?	EQR	Yes					56,57

Additional Comments / Notes

Section 12: Vaccine Storage and Cold Chain

Standard: Vaccines are stored and transported safely.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S12Q1	Does the practice have an up to date cold chain policy (reviewed within the last two years) as per the standards of the Green Book and is this accessible to all staff?	EQR	Yes					58,59

S12Q2	Is there a designated person/s (at least two recommended) in the practice responsible for the ordering, delivery and storage of vaccines?	EQR	Yes					58,59
S12Q3	Are vaccines monitored for their expiry dates and the close to expiry stocks clearly labelled?	EQR	Yes					58,59
S12Q4	Is the refrigerator specialised for the storage of vaccines (eg. the refrigerator has wire shelves/baskets or shelves capable of allowing air ventilation, there are no vaccines stored in enclosed plastic trays at bottom of refrigerator, domestic type refrigerators are not recommended)?.	EQR	Yes					58,59,62
S12Q5	Are vaccines correctly stored to allow good air flow within the vaccine refrigerator. (eg. vaccines are not stored against the back plates, touching the side of the fridge, at bottom of fridge or in vegetable bins and not stored in containers that are not webbed baskets)?	EQR	Yes					58,59
S12Q6	Are there measures in place to prevent the fridge from being turned off (switch-less socket or warning label on plug)?	EQR	Yes					58,59,60
S12Q7	Is/Are the vaccine fridge/s located in a well-ventilated area. (eg. not located near any heat source, ie radiator, or direct sunlight)?	EQR	Yes					58
S12Q8	Is the temperature of the vaccine fridge continually monitored with a min/max thermometer and the temperatures are recorded each working day to ensure vaccines are maintained at 2-8OC? (Min, max and actual fridge temperatures are recorded)? (It is best practice to record the temperatures twice daily)	EQR	Yes					58,61

S12Q 9	Is the min/max fridge thermometer calibrated annually and are all records retained?	EQR	Yes					58,59
S12Q 10	Is a second min/max thermometer or Data Logger temperature recording device, independent of mains electricity supply available and used?	EQR	Yes					58,59
S12Q 11	Is the fridge either self-defrosting or is it defrosted monthly or sooner if needed and is a validated cool box then used to maintain the cold chain?	EQR	Yes					60
S12Q 12	Is there evidence that the vaccine fridge is serviced annually?	EQR	No	There was no evidence that the vaccine fridge is serviced annually.	To ensure that the vaccine fridge is serviced and evidence that the vaccine fridge is serviced annually is kept for 2 years.	Agreed	Low risk.	58,59,62
S12Q 13	Is there a process in place for safe disposal of expired, damaged or surplus vaccines?	EQR	Yes					58
S12Q 14	Does the practice have records of vaccines received, batch numbers, expiry dates, fridge temperatures, servicing and defrosting of the fridge?	EQR	Yes					58,59,62
S12Q 15	Is there accessible written guidance on what staff should do in the event of a power cut or a temperature reading outside the required range?	EQR	Yes					58,59,62

Additional Comments / Notes

Section 13: Notification of infectious diseases and contamination

Standard: All notifiable diseases are reported on suspicion, within the time frames set out in the Health Protection (Notification) Regulations 2010

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S13Q 1	Does the practice have a policy on managing patients with communicable diseases?	EQR	Yes					63

S13Q 2	Does the practice notify all reportable infectious disease on suspicion to the proper officer at the local authority?	EQR	Yes					63
S13Q 3	Does the practice have access to notification forms?	EQR	Yes					63
S13Q 4	Does the practice notifying gastro intestinal disease (food poisoning) on suspicion?	EQR	Yes					63,64
S13Q 5	Does the practice notify Gastro intestinal disease (food poisoning) when stool specimen results are received from the microbiology laboratory?	EQR	Yes					64
S13Q 6	Is the practice aware of the new requirements to notify cases of contamination and other diseases which may have public health significance that are not listed in the regulations?	EQR	Yes					63
S13Q 6	Is the practice aware of the new requirements to notify cases of contamination and other diseases which may have public health significance that are not listed in the regulations?	EQR	Yes					63
Additional Comments / Notes								

Section 14: Antimicrobial Stewardship (AMS)

Standard: Prescribers are aware of the relevant guidelines and regularly audit their own, and discuss in practice meetings, their antibiotic prescribing patterns. GPs are aware of TARGET: Treat Antibiotics Responsibly. Guidance, Education, Tool.

True	Questions	EQR or BP	Response	Issues Identified	Remedial action recommended to resolve problem	Action Agreed	Action for Detailed Risk assessment	Reference
S14Q 1	Are GP prescribers in the practice aware of the TARGET toolkit?	EQR	Yes					65

S14Q2	Have all GP prescribers completed the Antimicrobial Stewardship Self-Assessment Checklist available in TARGET? (Give number of GP prescribers using the self-assessment checklist against those who do not)	EQR	Yes					66
S14Q3	Is the document “Antimicrobial prescribing and stewardship competencies” available and/or has it been read by prescribers in the practice? (Give number of prescribers who are aware of this document against those who are not)	EQR	Yes					67
S14Q4	Are all the prescribers in the Practice aware of the Public Health England AMR local indicators?	EQR	Yes					68
S14Q5	Is the practice aware of how they may access their antibiotic prescribing data online?	EQR	Yes					69
S14Q6	Are all prescribers in the practice aware of the NICE guidelines on AMS.	EQR	Yes					
S14Q7	Do all prescribers give information to their service users of how they should correctly use antimicrobial medicines and the dangers associated with their overuse and misuse?	EQR	Yes					71
S14QE1	Are all prescribers aware of the UK’s 5-year Antimicrobial Resistance Strategy?	EQR	Yes					72
S14QE2	Does the practice actively participates in the European Antibiotic Awareness Day/Week (EEAD) held in November each year?	EQR	Yes					73
S14QE3	Are all clinical staff in the Practice aware of the PHE Antibiotic Guardian campaign?	EQR	Yes					74

S14QE3	Are all clinical staff in the Practice aware of the PHE Antibiotic Guardian campaign?	EQR	Yes					74
Additional Comments / Notes								

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RISK ASSESSMENT

Risk Management

It is not possible to provide healthcare in a risk free environment, indeed it can be argued that it is in fact undesirable to attempt to function in this way as resources focus on avoiding harm rather than providing benefit.

The challenge of risk management is to identify those significant risks to which the practice is exposed and to put in place appropriate controls to reduce them to an acceptable level while at the same time not compromising the ability of clinicians and other staff to provide effective healthcare.

Ideally, risks will be proactively identified and managed appropriately. Nevertheless, adverse events and 'near misses' will occur and their consequences must be managed. In addition and of equal importance is the analysis of the root cause of any adverse event, the consequent learning and, where appropriate, introducing change to reduce the risk of recurrence of similar adverse events.

Risk management ***can be considered as the systematic processes and procedures that the practice puts in place to ensure that it identifies, assesses, prioritises and takes action to manage risks which compromise its ability to achieve its objectives.***

Risks may be managed in a variety of ways:

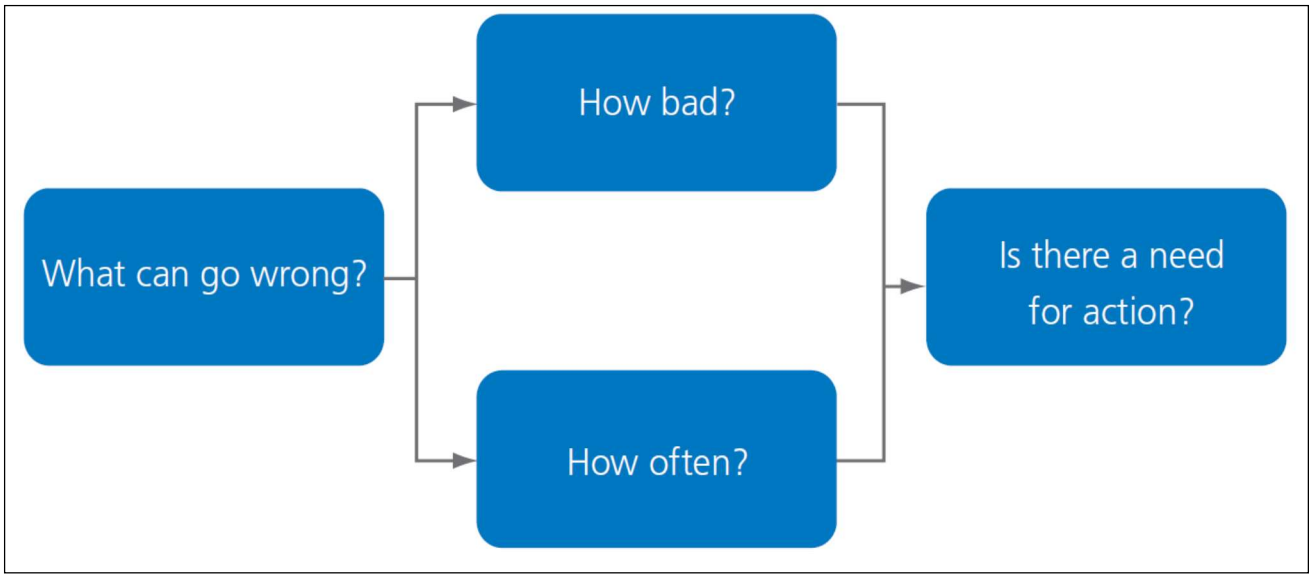
- Reduction: **Taking action to reduce the risk. This will, in many case be the preferred approach. Action taken may reduce the expected impact of realisation (the event happening), the likelihood of occurrence, or both.**
- Avoidance: **Undertaking the activity a different way or not carrying on the activity so as to prevent the risk occurring. It must be remembered that not carrying out an action may itself pose risks which need to be balanced against benefits.**
- Transfer: **Movement of the risk to another individual/organisation. This is 'insurance' or the transfer of some of its serious risks by becoming a member of an appropriate organisation which exists to mitigate risk.**
- Acceptance: **All of the above options are not applicable and a contingency plan is prepared**

Risk assessment

If risks to patient safety and to the organisation of the practice can be identified and assessed, appropriate control measures can often be implemented and maintained.

Risk assessments carefully examine systems to identify factors that could potentially cause or contribute to harm. They highlight whether adequate precautions are being taken to ensure timely and safer provision of care, or if further measures are needed to prevent harm.

A risk assessment seeks to answer four simple, related questions:



Flow Chart from NPSA Risk Assessment Programme

Risks may be identified through a variety of sources both internal and external and practices should take a broad approach to identify as many risks as possible. Risks should be identified at all levels throughout the practice from senior partner and practice manager downwards and identified risks can then be collated and logged to produce a 'risk register'.

Risk Evaluation

Not all risks are of equal importance and using a risk assessment matrix will enable the practice to assess the level of risk based upon measurement of the likelihood and consequence of the occurrence.

The proposed prioritisation tool is based on the National Patient Safety Agency (NPSA) guidance and assigns a risk category (i.e. severity score) to each risk identified which then allows prioritisation of risk and appropriate use of resources.

The following criteria are proposed for evaluation:

- Impact Assessment:
  The effect that realisation of the risk (the event happening) will have on the practice. It must be recognised that an effect which may be severe for an individual may be relatively less significant for the Practice.

- Likelihood:
  The possibility that the identified impact will actually materialise. This assessment will of necessity be subjective but can be guided by common sense and past experience. For example, you may never have had a fire in the practice. It could happen at any time but the likelihood of a fire occurring is very unlikely.

- Risk Rating:
  The product of the impact and likelihood of realisation of a risk. Numerical scores can be used to prioritise risk management resources but all they do is put the risks in some sort of order – a score of 10 does not mean that the risk is twice as bad as a risk rating of 5.

- Assignment of Responsibility:
  What needs to be done and who will be responsible for ensuring that it is done – not necessarily who will do it.

Acceptable Risk

After careful consideration, some risks will be considered acceptable.

Framing a definition of acceptable risk requires consideration of

- **financial costs (of doing or not doing something)**
- **the patient perspective**
- **opportunity costs (the loss of staff and other resources which would otherwise be deployed elsewhere)**
- **reputation (the consequences of adverse publicity)**

Definitions

Risk

Any Practice is liable to adverse events. Such adverse events may have a variety of consequences including direct or indirect financial loss, loss of reputation or failure to achieve the Practice objectives. Adverse events may also compromise its ability to supply safe, effective and timely care to its target population or lead to direct harm to patients or to staff.

Risk ***may be defined as the likelihood of an adverse event occurring.***
The magnitude of the risk is related to the impact and apparent likelihood of the adverse event. The proximity of the adverse event i.e. when the event is likely to impact should also be taken into account in the risk management process.

Risk realisation ***is said to have occurred if/when the risk under consideration materialises.***

An *acceptable risk* is defined as one where at least one of the following is the case:

- ***The consequences of an adverse event occurring are likely to be insignificant*** *OR*
- ***Risk realisation is extremely unlikely*** *OR*
- ***The cost of reducing or eliminating the risk outweighs the cost consequences of risk realisation.***

A risk rating of 6 or less as calculated using the risk matrix tool may indicate an acceptable risk.

Risk Assessment Matrix

		IMPACT				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
LIKELIHOOD	1 Rare	1	2	3	4	5
	2 Unlikely	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Likely	4	8	12	16	20
	5 Certain	5	10	15	20	25

IMPACT	Description
1 Insignificant	**No injury; no impact on service delivery or reputation of the practice; little or no financial loss.**
2 Minor	**Resulting in minor injury or illness; possible of a slight impact on service delivery.**
3 Moderate	**Temporary incapacity requiring medical treatment; some service disruption; potential for adverse publicity; formal complaint expected.**
4 Major	**Major injury; service restriction; adverse publicity impacting on reputation**
5 Catastrophic	**One or more deaths; national media interest resulting in severe loss of confidence in the Practice.**

LIKELIHOOD	Description
1 Rare	**The risk may occur (or re-occur) but only in exceptional circumstances**
2 Unlikely	**Do not expect the risk to occur (or re-occur) but is possible**
3 Moderate	**The risk might occur (or re-occur) at some time**
4 Likely	**The risk will probably occur (or re-occur)**
5 Certain	**The risk is expected to occur (or re-occur) in most circumstances**

Action and Assignment of Responsibility

Score	Risk Level	Risk mitigation measures
1 – 3	Low	**On or below this level a risk may be acceptable. Existing controls should be monitored and adjusted. Manage by routine procedure. Implement any action that will eliminate or reduce the risk. Decision to accept risk may be taken by a ...**
4 – 6	Moderate	**On or below this level a risk may be acceptable. Management action must be specified and assurance must evidence that action to reduce or eliminate the risk are effective. Decision to accept risk may be taken by a ...**
8 – 12	High	**Senior level action must be specified and assurance must evidence that action to reduce or eliminate the risk are effective. Establish more precisely the likelihood of harm as a basis for determining the need for improved control measures. Decision to accept risk should be taken by the senior partner/s and/or the business owner/s.**
15 – 25	Significant	**Immediate action needed. Must be referred to the appropriate senior level and an action plan started immediately to reduce the risk level, either by strengthening controls or eliminating the risk. Assurance must be reported to the contract holders. Significant resources may have to be allocated to reduce the risk. Decision to accept risk must be taken by the senior partners/business owner/s.**

Risk Assessment

This form may be used to assist in assessing an incident and recording actions. Please use the Risk Matrix on previous page

Incident details	Impact	Likelihood	Action

Acknowledgements:

1. **NPSA Risk Assessment Programme. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59813**
2. **NHS Greenwich – Public Health - Risk Matrix Tool**
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