Derbyshire CCG themes from recent CQC inspections

- Coding on safeguarding cases not being undertaken comprehensively on electronic records; therefore, an up to register of safeguarding patients was not available.

- Staff unaware who the safeguarding lead was in practice and how to report concerns.

- Failed hospital attendance and non-attendance for immunisations were not coded on the system, meaning the information was easily retrievable

- A staff immunisations database was not kept in line with PHE guidance

- Ensure significant event reviews take place and are documented and acted upon.

- Failure to keep a log of the safety alerts received and the actions taken.

- The monitoring of vaccine refrigerators must be maintained in line with guidance and supported by the appropriate documentation and actions if required.

- Ensure training is up to date for all staff and is available.

- Formal recording of oxygen cylinder checks.

- Effective systems and processes to ensure good governance.

- Improve uptake of annual checks for LD patients

- Failsafe for Cytology recall systems

- A large number of patient records required summarizing – therefore not having access to the patient's full medical history had potential to compromise effective patient care.

- Ensure appropriate checks are carried out on all staff prior to employment including DBS checks and that professional registration is updated annually

- Prescription stationary serial numbers were not logged on receipt or stored securely

- Complaints and concerns should be handled in line with guidance and documented when responded too and actions taken.

- All staff need to be aware of the plans in place for major incidents

- Risk assessments and actions in place eg Fire and Legionella

- Evidence of PAT testing required