Stuart House Surgery

Quality Report

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Date of inspection visit: 17 August 2015
Date of publication: 12/11/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 16 and 21 October 2014. Breaches of legal requirements were found. After the comprehensive inspection the practice wrote to us to say what they would do to meet the legal requirements in relation to care and welfare of people who use the services, requirements which related to workers, records and assessing and monitoring the quality of the service provided. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for GP practices on our website at www.cqc.org.uk

We carried out a focussed inspection on 17 August 2015 to check that the practice had followed their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. The practice has been rated inadequate for Safe and requires improvement for Effective and Well-led services. It was also requires improvement in providing services for all the population groups.

Our key findings across the areas we inspected were as follows:

- There was a system in place for identifying, reporting on and learning from significant events. However the quality of the recording of the significant events was not satisfactory and did not demonstrate the steps taken by the practice to safeguard patients and prevent a reoccurrence.
- Since the last inspection the practice had carried out an infection control audit however they had not completed an action plan to address the areas identified. Minutes of practice meetings showed that the findings of the audits had not been discussed.
- Audits which the action plan showed would be carried out had not been completed since the last inspection therefore we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had a system in place to manage and learn from complaints.
- The practice had not proactively sought feedback from staff or patients since 2013.

Summary of findings

The areas where the provider must make improvements are:

- Ensure there is a robust system to manage and learn from significant events
- Ensure an action plan and actions identified in the Infection Control audit are completed.
- Have a robust system in place for the recruitment of staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to enable them to deliver the care and work they carry out in the practice.
- Ensure suitable arrangements are in place to assess, monitor and improve the quality of the services for provided, in particular, undertake completed clinical audits to demonstrate improvements in patient care.

In addition the provider should:

- Ensure there are mechanisms in place to seek feedback from staff and patients.
- Regular checks to ensure that the upstairs filing room door remains locked at all times.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

This inspection was conducted in order to review issues that were found at the comprehensive inspection carried out on 16 and 21 October 2014. At this previous inspection it was found that overall the practice was rated as requires improvement.

Patients were at risk of harm because systems and processes for significant events and infection control had weaknesses and we could not be assured that patients were safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services and improvements must be made.

This inspection was conducted in order to review issues that were found at the comprehensive inspection carried out on 16 and 21 October 2014. At this previous inspection it was found that overall the practice was rated as requires improvement.

We saw no evidence that audit was driving improvement in performance for patient outcomes as the practice had not completed any clinical audits since the last inspection. Staff had not received an appraisal since 2013.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. This inspection was conducted in order to review issues that were found at the comprehensive inspection carried out on 16 and 21 October 2014. At this previous inspection it was found that overall the practice was rated as requires improvement.

The two GP partners and the practice manager had not played an active role in overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people.

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students).

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement 

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

The provider was rated as inadequate for safe and requires improvement for effective and well-led. On the previous inspection it was rated requires improvement for safe, effective and well-led and good for responsive and caring services. The concerns which led to those ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

During this focussed follow-up inspection we spoke with four patients and reviewed 15 comments cards.

All the patients we spoke with and all 15 comments cards we reviewed told us that they were happy with the service provided by the practice. Staff were caring and professional and provided care to a high standard. Four of the 15 comments cards also contained negative comments. They told us they experienced problems getting through by telephone and obtaining a routine appointment.

Areas for improvement

Action the service MUST take to improve

- Ensure there is a robust system to manage and learn from significant events
- Ensure an action plan and actions identified in the Infection Control audit are completed.
- Have a system in place to ensure audit cycles have been completed and actions identified are followed up and completed
- Have a robust system in place for the recruitment of staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to enable them to deliver the care and work they carry out in the practice.
- Ensure suitable arrangements are in place to assess, monitor and improve the quality of the services provided, in particular, undertake completed clinical audits to demonstrate improvements in patient care.

Action the service SHOULD take to improve

- Ensure there are mechanisms in place to seek feedback from staff and patients and this feedback is responded to.
- Regular checks to ensure that the upstairs filing room door remains locked at all times.

Stuart House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a GP practice manager specialist advisor.

Why we carried out this inspection

We undertook an announced focussed inspection on 17 August 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection had been made. We inspected the practice against the key questions in relation to whether the services were safe, effective and well-led.

How we carried out this inspection

Before we visited Stuart House Surgery we reviewed a range of information we held about the practice.

and asked other organisations to share what they knew. We asked the practice to put out a box and comment cards in reception where patients and members of the public could share their views and experiences.

We carried out an announced inspection on 17 August 2015. During this inspection we used information from the provider's action plan and spoke with six members of staff which included two GP's, practice manager, reception manager and two administration and reception staff.

We spoke with four patients who used the service.

We reviewed 15 comment cards and all were overwhelmingly positive and described excellent care given by staff who were kind, caring and considerate.

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Inadequate

Are services safe?

Our findings

Learning and improvement from safety incidents

At the last inspection in October 2014 we found that the practice did not have a robust system in place to ensure that learning from significant incidents was cascaded to staff and prevent any reoccurrence. The CQC action plan completed after the inspection in October 2014 stated that significant events would be discussed at a weekly practice meeting. The registered manager would review significant events every six months to enable learning. Six monthly meetings would be held to review actions and to determine themes and trends.

Before this inspection we asked the provider to send us a record of significant events and incidents since the last inspection. We were sent a record log of 17.

At this inspection we found that the practice had used a significant event analysis (SEA) template to record information such as detail of incident, what and why it happened, learning and changes made. The practice had a template for significant event monitoring and analysis which stated that the manager will review the incident and deal with any further needs immediately arising. The document indicated that a review of the form would take place at a weekly partner/clinical/staff meeting. Discussion of the event would take place and actions would be assigned to an individual for completion. Completed forms are passed to the practice manager to be signed off.

We looked at a sample of four taken from the record log. Three were on the SEA template and one on a health care professional feedback form. The quality of the recording of the SEA was not satisfactory. We found that the documented SEA's lacked clinical detail which made it difficult to quantify from the records the level of risk or harm. There was limited or no written information to confirm what action had been taken to resolve the issues or what systems had been put in place to prevent a similar occurrence and safeguard patients. For example**,** the practice protocol was not followed for a patient with high blood pressure and a vaccination given twice.

We were also given one other completed template form which was not on the record log. This showed a member of staff who had not used appropriate PPE when taking blood from a patient.

There appeared to be a lack of understanding by some staff as to what constituted an incident that should be reported.

We reviewed clinical staff meeting minutes for 13th May 2015. A significant event was identified in regard to a patient with cancer and an issue with 2 week wait appointment. It was documented that a significant event form would be completed. On the day of the inspection the practice could not find one.

We reviewed clinical staff meeting minutes from 24 July 2015. It was documented that there had been an error with a medicine and the patient had been informed. We asked to see the significant event form but the practice could not find one.

We looked at notes of a significant event review meeting held 1 May 2015. It was documented that they looked at 17 SEA forms. There was limited evidence to demonstrate that the SEA's had been analysed or that the effectiveness of learning and actions had been reviewed. There was no evidence that learning had been shared will all staff. We could not see how the practice had used these events to learn from the mistakes in order to ensure they did not happen again. Therefore patients were at risk of harm because systems and processes were not in place to keep them safe.

Reliable safety systems and processes including safeguarding

At the last inspection in October 2014 we found that the practice had not ensured that staff who undertake a formal chaperone role had received training in order to develop the competencies required for the role.

The CQC action plan completed after the inspection in October 2014 stated that all staff who act as a chaperone will complete chaperone training.

Reception staff would act as a chaperone as required. We saw evidence that the receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had recently purchased a training system which all staff could access on the practice intranet. We were told by the practice manager and we saw that all nursing staff, including health care assistants had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether

a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

Cleanliness and infection control

At the last inspection in October 2014 we found that the practice had completed an audit tool for 2013/14. An action plan was produced but none of the actions had been completed. We found that infection control was not discussed at practice meetings and there staff were not kept up to date on the findings or actions required from the audit. The CQC action plan completed after the inspection in October 2014 stated that an external infection control audit carried in February 2015 would be reviewed at a practice meeting. Audits would be carried out annually in line with the infection control policy. Staff would be given time to develop and implement an action plan.

At this inspection we were told that there was no documentation for the external audit undertaken in February 2015. We saw evidence that the infection control leads had carried out audits of two areas within the practice in May 2015. The audits showed that for some areas, the practice adhered to some of the expected standards set out in the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. However there were areas where improvements were required. For example, areas in the practice were found to be dusty, floors and waste bins not visibly clean. Audits had not taken place for all areas of the practice and the practice had not completed an action plan to address the areas identified in their own audit in May 2015. Minutes of practice meetings showed that the findings of the audits had not been discussed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Staffing and recruitment

When we inspected in October 2014 we found that the practice did not have a robust system in place for the recruitment and retention of staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Files we looked at did not contain recruitment checks undertaken prior to employment. The CQC action plan completed after the inspection in October 2014 stated that all staff files would be updated and organised to include a front index sheet with a list of documents to be included.

At this inspection we found that in the six files we looked at a front index sheet had been added and disclosure and barring records (DBS) were in place. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had made some improvements but not sufficient to fully meet the requirements of the regulations as they had not completed all the files for staff who had commenced employment since the practice registered with the CQC in 2013. Proof of identification, references and Nursing and Midwifery checks were still missing in two of the files.

Arrangements to deal with emergencies and major incidents

When we inspected in October 2014 we found that the practice did not have a robust business continuity plan in place. The CQC action plan completed after the inspection in October 2014 stated that the plan would be reviewed and updated.

At this inspection we found that the practice now had a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in May 2015.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

When we inspected in October 2014 we found that the practice had three clinical audits that had been undertaken in the 2013, for example, treatment of Gout, post-operative vasectomy audit and the use of Cefaloxin. In all three audits there was no action plan or a date to review actions. The lead GP told us that the practice had not carried out any audits in 2014 due to the decreased number of GP's and it was an area that needed development now that the number of GP's had increased.

The CQC action plan completed after the inspection in October 2014 stated that the registered manager had reviewed the practice audit cycle and put together a plan to undertake six audits in 2015.

At this inspection we found that four had not been commenced, one was in progress and one had been looked at formally but not minuted. We could therefore see no evidence that audit was driving improvement in performance for patient outcomes.

Effective staffing

Information we received from the practice identified that staff had not had appraisals for at least two years. We spoke with the practice manager who told us that no staff had received an appraisal in 2014 but all staff appraisals were planned for October and November 2015.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Governance arrangements

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding.

When we inspected the practice in October 2014 we found that the practice reviewed complaints on an annual basis to detect themes or trends. There was no action and no information to show if any lessons had been learnt. Minutes of practice meetings did not show that complaints had been discussed. There was no robust system in place to ensure that all staff were able to learn and contribute to determining any improvement action that might be required. The CQC action plan completed after the inspection in October 2014 stated that six monthly meetings would be held to examine and review all complaints. A review of actions from any previous meetings would also take place. At this inspection we looked at two complaints received in January 2015 and found that the practice had a good system. The complaints were dealt with in a timely way and with openness and transparency. The practice had put a system in place to review complaints every six months to detect themes or trends.

When we inspected the practice in October 2014 we found that there was not a robust system in place for the management and security of paper patient records (medical records). We found an unlocked cabinet on the first floor as well as an unlocked room which also contained paper medical records which meant that any person who had access to the first floor could obtain personal information about a patient. We asked the practice to take immediate action to ensure the safety and security of confidential patient information. Before the inspection had finished the room had been locked and the notes had been removed from the unlocked cabinet. The CQC action plan completed after the inspection in October 2014 stated that the filing cabinet would no longer contain patient records and the door to the upstairs filing room would remain locked. At this inspection we found that the cabinet was empty but the upstairs filing room door was open. We spoke with the practice manager who told us that since the last inspection it remained locked and she felt that this was an isolated incident and would look into why it was unlocked on the day of the inspection. When we spoke to staff they told us that it was always kept locked and was checked on a regular basis.

Leadership, openness and transparency

The two GP partners and the practice manager had not played an active role in overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective.

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

Seeking and acting on feedback from patients, public and staff

Information provided by the practice showed that they had not gathered feedback from patients since 2013.

However results of the July 2015 national patient survey showed that 84% of patients who responded would recommend the practice to others. 97% of respondents had confidence and trust in the last GP they saw or spoke to

We spoke with the practice manager who told us that they would schedule a survey for October 2015 to ensure that they were able to improve the services provided and the quality of care.

Management lead through learning and improvement

We looked at six staff files and saw that appraisals had taken place. The practice manager confirmed that staff had not had an appraisal for two years. We could not be assured that staff had had an opportunity to update and improve their knowledge and skills. They told us they planned to complete all the appraisals in October and November 2015. A member of staff we spoke with told us they had an appraisal booked for October 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not have a system in place to demonstrate that potential employees were:- a) be of good character, (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. For example, appropriate checks, such as registration with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) had been carried out prior to employing staff and after to ensure registration was maintained. This was in breach of Regulation 19 1(a)(b) and 4 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that Persons employed by the them in the provision of a regulated activity must:- Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, This was in breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not ensuring that Care and treatment was provided in a safe way for service users, in that: - (2) (b) doing all that is reasonably practicable to mitigate any such risks; (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and that they are used in a safe way (h) assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated This was in breach of Regulation 12(1), 12(2) (b) (d) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established systems or processes and they were not operated effectively to ensure compliance with the requirements, in that: - (2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

This section is primarily information for the provider

Enforcement actions

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This was in breach of Regulation 17 (1) (2) (a) and (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.