Urgent Care Centre Oadby & Wigston Walk-In Medical Centre

Quality Report

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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced focussed inspection at Oadby and Wigston Walk-In Medical Centre on 31 March 2016. The inspection was carried out because we had

received information of concern relating to the safe storage, stock control and responsibility for managing medicines, infection control procedures, managing emergencies and equipment, safeguarding and learning from significant events. Concerns were also raised regarding safe staffing levels, complaints management and governance procedures.

We found the service was not meeting some of the fundamental standards and had breached regulations.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events although some staff were not aware of the process.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
  - The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Information about services and how to complain was not available for patients within the practice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
  - Medicines were stored securely but were not easily accessible to all staff. Some medicines were past their expiry dates.
  - Processes were lacking for checking the expiry dates of stored medicines, the medicines fridge temperature, security of blank prescription forms and the emergency equipment.

The areas where the provider must make improvement are:

- Implement a process to ensure that patient safety alerts are acted upon and the process is audited to show continued actions are taken for patients to receive treatment in accordance with best practice.
- Ensure that emergency equipment and oxygen is checked to see if it is in date and fit for use.
- Ensure that emergency medicines are easily accessible to all members of staff and processes are in place to check the expiry dates of medicines and to monitor the medicines fridge temperature. Ensure blank prescriptions are stored securely at all times and there is a system in place to monitor the use of the blank prescription forms.
- Improve security at the reception desk to ensure the public do not have access to patient information and paper records.

The areas where the provider should make improvement are:

- Ensure all staff are aware of how to access policies and procedures and know how to log incidents and significant events.
- Be clear who the infection control lead is and ensure that clinical waste is disposed of correctly.
- Remove equipment that was left by the previous provider that is not for current use.
- Formalise the process for identifying if a patient requires a GP or nurse consultation.

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?

- There was an effective system in place for reporting and recording significant events however, some staff were not aware of the correct process.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, an explanation, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There was no process in place to check if patient safety alerts had been acted on.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. Some of the staff did not know how to access the policies.
- It was not clear who the infection control lead was but there were infection control procedures in place with the exception of disposal of sharps and specimen receptacles.
- Medicines were stored securely but were not easily accessible to all staff. Some medicines were past their expiry dates.
- Processes were lacking for checking the expiry dates of stored medicines, the medicines fridge temperature, security of blank prescription forms and the emergency equipment.
- A Vocare recruitment team completed all the appropriate recruitment checks prior to staff employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).
- A needs analysis of staffing levels had been completed with the local clinical commissioning group (CCG) to ensure the practice had appropriate staffing levels.

Are services effective?

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- We were informed that all staff had received an appraisal.

Are services caring?

This domain was not inspected as part of the inspection.

Summary of findings

Are services responsive to people's needs?

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was no information available to help patients understand the complaints system in the practice.
- We found that complaints were satisfactorily handled and dealt with in a timely way.

Are services well-led?

- There was an overarching governance framework which supported the delivery of the strategy and good quality care.
- Vocare clinical governance meetings were held monthly.
- Practice specific policies were implemented and were available to all staff although not all staff knew how to access them.

Urgent Care Centre Oadby & Wigston Walk-In Medical Centre

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 specialist adviser, and two further CQC inspectors.

Background to Urgent Care Centre Oadby & Wigston Walk-In Medical Centre

Oadby and Wigston Walk-In Medical Centre provides urgent care for minor injuries and illnesses for the residents of Oadby and the surrounding areas. Services are delivered from the urgent care centre at 18 The Parade, Oadby, Leicestershire, LE2 5BJ.

The service is one of four urgent care centres in the Leicestershire area commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG). They are managed and operated by the registered provider Northern Doctors Urgent Care Limited which is owned by Vocare. Vocare is a provider of outsourced clinical healthcare services in collaboration with the NHS. Vocare were commissioned to run the service from April 2015. This inspection is for Oadby and Wigston Walk-In Medical Centre only.

Vocare employs a clinical services manager who oversees the day-to-day running of the four urgent care centres. They employ a number of GPs, 2.5 whole time equivalent and a nursing team consisting of Emergency Care Practitioners, Advanced Nurse Practitioners and Nurse Practitioners, 10.2 whole time equivalent. There is also a team of reception staff.

Oadby and Wigston Walk-In Medical Centre is open from 8am to 9pm Monday to Friday and 8am to 8pm Saturdays, Sundays and Bank Holidays.

Why we carried out this inspection

We carried out a focussed inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service.

The inspection was carried out in response to concerns raised about systems and processes in place at the urgent care centre.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an unannounced visit on 31 March 2016.

During our visit we:

- Spoke with a range of staff, including the clinical services manager, a locum GP, nurses and reception staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at the policies and procedures used to govern activity at the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Please note that when referring to information throughout this report, for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- There was a Serious Incident policy in place that all staff had access to on the Vocare computer intranet system. However, staff we spoke with on the day of the inspection were unclear how to log an incident or when they should do so.
- The service used a Healthcare Incidents, Patient Safety & Risk Management Software to log all incidents and significant events.
- Incidents and significant events were discussed at monthly Vocare clinical governance meetings. Lessons learnt from events were emailed to all relevant staff.
- The incident recording form and software supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The practice carried out a thorough analysis of the significant events.

Patient safety alerts were emailed to all relevant staff but there was no process in place to check if identified actions had been completed. We did see evidence of recent alerts in the consulting rooms.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, but they were not all embedded within the practice. The systems in place included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff on the Vocare intranet system. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Some of the staff we spoke with were not aware of how to access the policies but they did inform us they would raise any concerns with the clinical services manager. Vocare had a lead member of staff for safeguarding based in Newcastle. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3. We were informed that the nursing staff were trained to level 2 and the practice had recently planned for them to complete level 3 training.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. A member of the nursing staff was identified as the infection control lead and they had received additional training for this role. On the day of the inspection, it was unclear whether the nurse was aware that they would continue in this role following a period of absence. There was an infection control protocol in place and staff had received up to date training. Quarterly infection control audits were undertaken and shared with the local clinical commissioning group (CCG) infection prevention teams. We saw evidence that action was taken to address any improvements identified as a result. For example, the chairs in the waiting area had been changed to ones with wipeable surfaces. The building was owned by NHS Property Services who employed the services of a cleaning company. The practice was cleaned daily and there were check lists in place for the cleaning staff to follow. Any communications between the practice and the cleaning staff was done verbally as they were often on site at the same time. The cleaning company had a supervisor who attended the practice monthly to check the level of the work completed and to discuss any issues with the practice. Clinical waste was disposed of in the practice in the correctly coloured waste bags and sharps were disposed of in the correct bins. We noted that one of the sharps bins was filled over the recommended limit. There was a separate room for the completion of urine testing. This room contained a flushable toilet for the disposal of urine but it did not contain the correct coloured waste bag for the disposal of specimen receptacles. Clinical waste for collection was stored in a locked bin outside of the practice. We noted that the bin was not secured to the fence or building but the practice showed us evidence that they had submitted a requisition for this work to be completed.
- There were some arrangements for managing medicines, including emergency medicines and

vaccines, in the practice to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However, some of the arrangements were not adhered to correctly. All medicines were stored securely in a locked room and we did not see any unsecured medicines in the practice. The locked room contained boxes labelled as emergency drugs but when we examined these, some of them, for example, the diabetic SOS box, were empty. There was no process in place for checking the contents of the different emergency medicines boxes. Essential emergency medicines were available in the medicines room but not easily accessible and all together in one place. All staff we spoke with knew the location of the emergency medicines but access to the room was via an electronic key fob. Clinical staff were required to ask the reception staff for this to gain access to the emergency medicines. We were informed by the practice that they planned to resolve this issue by changing to a key pad system so all relevant staff could access the room. There was a medicines fridge that contained medicines and one type of vaccine that required storage at a specific temperature range. There was not a robust system in place to monitor the temperature of the fridge to ensure it was in the correct range to maintain the efficacy of the medicines. We found there was not a process in place to check the expiry dates of stored medicines, including emergency medicines, and on inspection of these, we noted that some of the medicines had passed their expiry dates. Blank prescription pads were securely stored in the locked medicines room. However, we found blank prescription forms were left unsecured in the computers in the clinical rooms. These rooms were left unlocked throughout the day, which meant that visitors to the walk in centre had access to them. There was no system in place to monitor the use of the blank prescription forms. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We examined a selection of these and found them to be in date and signed by the relevant staff members.

- We were informed that Vocare had a recruitment team who completed all the appropriate recruitment checks prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). 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. Personnel files were held at a central location within Vocare so they were not reviewed as part of the inspection. The clinical services manager informed us that nursing staff undertook a written assessment prior to interview and provided an example of this assessment which demonstrated that nurses' knowledge and competency was assessed in different clinical scenarios. After employment, clinical staff competency was monitored by a review of a selection of patient notes. When staff left employment with the practice, they were offered an exit interview to establish if there were any trends to staff wishing to cease employment.
- Each of the consulting rooms had a diagnostics box containing equipment that the clinicians may require during consultations with patients. There was not a checklist to say what should be in the boxes and no evidence that these were checked regularly to ensure they contained the appropriate equipment. The practice had some equipment in the consulting rooms that was not working or had not been calibrated. We were informed that this equipment was left by the previous provider and Vocare had supplied new equipment when they took over the running of the service in April 2015. There was a plan in place for all equipment to be calibrated in April 2016.
- During the inspection, we noted that at times, the reception desk was left unattended with patient details on the computer screen and the receptionist's smart card left in the keyboard. These were not clearly visible to patients or visitors to the practice but could have been accessed.
- There was a process in place to use paper records in the event of failure of the electronic record system. Clinicians were responsible for inputting their notes on to the system when it was restored. Once the notes had been put on to the electronic system the paper copy was passed to the clinical services manager for shredding. We were informed that this process had been implemented recently when there had been a failure over a bank holiday weekend. We noted that the paper records that had been completed and were waiting for input were kept unsecured in the reception office. When a patient attended the walk in centre, a notification of their consultation was sent to their own GP

electronically before 8am the following day. In the event of a failure of the electronic record system, this notification would not be received until the paper record had been put on the system.

- Reception staff allocated patients to GPs and nursing staff according to need. We were informed that the GPs would usually see babies and young children as well as patients with complex needs. It was not clear if there was a formal process in place for this. All clinicians could see the list of patients waiting to be seen and the reason for their visit on their computer system. Nursing staff were supported by the GPs if they needed help or advice when treating a patient.

Monitoring risks to patients

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice had recruited a full time administrator to complete these rotas. They had also completed a needs analysis with the CCG to look at the predicted number of patients attending the walk in centre compared to the actual number of patients and revised the staffing levels accordingly. The site supported the other three locations in the area that were staffed by nurses with telephone access to a GP. We were informed that online video call facilities were also available if needed. Once a week Vocare held a companywide rota meeting to look at rota gaps across all their locations and services with a view to redirecting staff if needed. We reviewed the rotas for the past three months and found one day when the walk in centre did not have a GP on duty until 3pm. The clinical services manager informed us that this was due to short term sickness absence that had been reported on the day. The CCG had been made aware of the situation at the time and the clinical services manager had informed the local NHS 111 service that a GP would not be available if they referred patients to the walk in centre. Vocare provided telephone support from a GP at another service. This was a week day when usual GP cover was available to patients from their own GP practices. Vocare had a policy in place to ensure staff received rest breaks during their shifts; this included a 30 minute break during an eight hour shift plus a discretionary 15 minutes for clinical staff. Staff working a longer 12 hour shift had two 30 minute breaks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was no system in place for checking the emergency equipment and oxygen.
- Emergency medicines were in a secure area of the practice and all staff knew of their location. However, this area was not easily accessible to all staff members. Some of the medicines we checked were past their expiry dates.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The patient assessment system used, contained web links to current NICE guidelines.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Clinical guidelines were available in files in the consulting rooms. These included advice on when patients should be referred to Accident and Emergency (A&E) and the correct procedure for contacting an ambulance via 999.

Effective staffing

- The learning needs of staff were identified through a system of appraisals and meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All staff had received an appraisal within the last 12 months. The practice was currently recruiting a clinical lead who would take responsibility for carrying out one-to-ones and appraisals. Vocare had designed and were implementing a folder for nursing staff to support them with gathering evidence and storing training records for revalidation. We saw a supply of the folders ready for distribution to the staff.

Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training

Are services caring?

Our findings

This domain was not inspected as part of the inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who investigated all complaints in the practice and liaised with the Vocare head office to formulate a response to patients.
- We did not see that any information was available to help patients understand the complaints system in the practice. Staff we spoke with informed us they would ask the patient to put their complaint in writing or they would direct them to the clinical services manager.

We looked at the complaints log and noted that eight complaints had been received in the last 12 months across the four locations. We found that these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, the staff rotas were reviewed following a complaint from a patient who had a long wait to be seen whilst staff took their breaks.

Are services well-led?

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

Our findings

Governance arrangements

Vocare had an intranet system that contained policies and procedures that were accessible to all staff.

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff although not all staff knew how to access them.
- Vocare clinical governance meetings were held monthly.
- Practice meetings were held monthly, all staff were invited to contribute to the agenda and minutes of the meetings were circulated to employed staff via email.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, not all staff were aware of these.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a breach of Regulation 12 because: We found that the provider had not implemented a process to ensure that patient safety alerts were acted upon. There was no audit process to show continued actions were taken for patients to receive treatment in accordance with best practice. There was no process to check the emergency equipment and oxygen was in date and fit for use. We found that emergency medicines were not easily accessible to all members of staff. There was no process in place to check the expiry dates of medicines or to monitor the medicines fridge temperature. Blank prescriptions were stored in unlocked consultation rooms which were accessible to all staff and visitors not employed by the practice. There was no system in place to monitor the use of the blank prescription forms.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a breach of regulation 17 because: We found at times the reception desk was left unattended with patient details on the computer screen and the receptionist's smart card left in the keyboard. Paper records of patient's consultations were kept unsecured in the reception office.