Dr Kandasamy Sundaram

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kandasamy Sundaram on 1 July 2016. The overall rating for the practice was inadequate. The full comprehensive report on the 1 July 2016 inspection can be found by selecting the 'all reports' link for Dr Kandasamy Sundaram on our website at www.cqc.org.uk. Following that inspection Warning Notices were served in relation to breaches of the regulations we identified. These breaches related to issues around safety (Regulation 12), governance (Regulation 17) and staffing (Regulation 19).

The specific issues we identified at that inspection were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. Areas of concern were found in relation to significant events, staff training, chaperoning, infection control,

Summary of findings

medicines management, recruitment checks, health and safety, fire safety, management of unforeseen circumstances in relation to the business continuity plans and dealing with emergencies.

- The practice systems to keep patients safe and safeguarded from abuse were inadequate.
- The arrangements for seeking consent to care and treatment in line with legislation and guidance were inadequate.
- There was no effective programme of quality improvement to monitor and improve clinical outcomes.
- GP satisfaction scores were lower than average and no action had been taken to address this.
- There were no curtains in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- There were limited facilities to help patients become involved in decisions about their care, such as interpreting services.
- The practice had inadequate formal governance arrangements and the leadership arrangements in place were not effective enough to ensure safe and high quality care.

This inspection was an announced focused inspection carried out on 6 December 2016 to follow up on the concerns identified in the Warning Notices and confirm that the practice was now meeting the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 1 July 2016. This report covers our findings in relation to those requirements and also any additional improvements made since our last inspection. Other areas of non-compliance found during the inspection undertaken on 1 July 2016 will be checked by us for compliance at a later date.

Following the inspection on 6 December 2016 the practice remains rated as inadequate. We found the provider had made improvements in some areas of Regulations 12 and 17 as set out in the Warning Notice.

However, there were still areas relating to the Warning Notice that required improvement. The ratings for the provider will remain in place until a comprehensive inspection is undertaken.

Our key findings were as follows:

- Areas of concern remained in relation to chaperoning, infection control, health and safety, fire safety, medicines management, dealing with emergencies and some aspects of infection control.
- Processes around risk management were inadequate for example there was no evidence of electrical safety testing, fire safety training or legionella safety.
- There was limited evidence of clinical audit. There was no evidence of completed audits where the improvements made were implemented and monitored
- Some policies had been reviewed however, a number of policies remained out of date or requiring review.
- Awareness of the Duty of Candour was limited.
- Steps had been taken to address concerns around the leadership of the practice. However, these were yet to be formalised.

The other key lines of enquiry will be reassessed by us at another inspection when the provider has had sufficient time to meet the outstanding issues. At that time a new rating will be assessed for the provider.

The outstanding issues that the practice must address are:

- Review the system for reporting, recording and sharing learning from significant events to ensure it was effective and that it supports the recording of notifiable incidents under the duty of candour.
- Ensure staff have a suitable understanding of significant events and how to handle them.
- Ensure documents related to the management of regulated activities (practice policies) are created and amended appropriately.
- Ensure patient group directions (PGDs) are completed appropriately.

Summary of findings

- Assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. This specifically relates to health and safety, fire safety, electrical safety and legionella testing.
- Ensure a programme of quality improvement, including audit, to improve patient clinical outcomes.

The areas where the provider should make improvement are:

- Include staff contact numbers in the business continuity plan.

Following the inspection on 1 July 2016 the practice was placed into special measures for a period of six months following the publishing of that report. We will inspect the practice again within six months of that publishing date to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

The practice is rated as requires inadequate for providing safe care until a further comprehensive inspection takes place. Some improvements were found however some issues remain outstanding.

- A new significant events policy had been introduced since the previous inspection.
- Staff had not yet received significant events training; however, staff were aware of the new policy.
- The process for managing patient safety alerts had been improved.

Improvements were still required around chaperone training, dealing with emergencies and major incidents, monitoring of risks to patients and some aspects of infection control.

Are services effective?

The practice is rated as inadequate for providing effective care until a further comprehensive inspection takes place. Some improvements were found however some issues remain outstanding.

- The practice had conducted one further audit since the previous inspection. This was a single cycle audit with no apparent analysis of the results or any improvements made, implemented and monitored.

Are services well-led?

The practice is rated as inadequate for being well-led until a further comprehensive inspection takes place. Some improvements were found however some issues remain outstanding.

- Some policies had been updated such as for significant events and Mental Capacity Act, whereas some others, for example relating to the Duty of Candour, were due to be reviewed in 2015 and still had not yet been reviewed. We were told the process of reviewing and updating policies was still underway.
- Leadership at the practice was under review and the practice was due to merge with another neighbouring practice for additional support. We saw evidence of co-working between the practices but this was still in the early stages.

Summary of findings

There was no evidence of support training for all staff on communicating with patients about notifiable safety incidents or evidence of what steps would be taken in the event of something going wrong involving a patient.

Dr Kandasamy Sundaram

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a lead inspector, a GP specialist adviser and a second inspector.

Background to Dr Kandasamy Sundaram

Dr Kandasamy Sundaram is a single handed GP practice located at Roding Lane Surgery, Redbridge, Essex and holds a General Medical Services (GMS) contract with NHS England. The practice's services are commissioned by Redbridge Clinical Commissioning Group (CCG). They are registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

The practice is staffed by one male GP who provides nine sessions a week. Another GP (female) had recently started doing four to six sessions per month at the practice to support the GP and provide patient choice. The practice also employs a locum nurse, who works eight hours a week, and two reception staff. At the time of this inspection there was no practice manager.

The practice is open between 8.00am and 6.30pm on Monday, Tuesday, Wednesday and Friday and between 8.00am and 1.00pm on Thursday. Extended hours appointments are offered on Monday between 6.30pm and 7.00pm. Outside of these hours, the answerphone redirects patients to their out of hours provider.

The practice has a list size of 3,536 patients and provides a range of services including minor surgery, immunisations, screening, health checks, chronic disease management and family planning services.

The practice is located in an area where there is a diverse population of mixed ethnicity and the majority are relatively young, particularly aged between 25 and 49 years of age.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Kandasamy Sundaram on 1 July 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on 1 July 2016 can be found by selecting the 'all reports' link for Dr Kandasamy Sundaram on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Dr Kandasamy Sundaram on 6 December 2016. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with GPs and a receptionist.
- Reviewed a sample of the personal care or treatment records of patients.

Detailed findings

- Visited the practice location
- Looked at information the practice used to deliver care and treatment plans.

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

At our previous inspection on 1 July 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of significant events, medicines and risk management were not adequate.

We issued a Warning Notice in respect of these issues and found there had been some improvement when we undertook a follow up inspection of the service on 6 December 2016. However, we did not review that rating at this inspection as the purpose of this inspection was solely to follow up on the concerns identified at the previous inspection. As such the practice remains rated as inadequate for providing safe services.

Safe track record and learning

We were told there had been no significant events since the previous inspection. We saw that a new significant events policy had been introduced since the previous inspection. Staff had not yet received significant events training but this was due to take place in December 2016. However, staff were aware of the new policy.

Whilst there had been no significant events since the last inspection we saw that the new policy set out the requirement to keep patients informed about any incidents and the resulting action being taken. The policy also detailed the requirement to ensure all adverse incidents were recorded and reported and that staff cooperated with investigations, actions were implemented and fed back to staff and that learning was disseminated and shared amongst the practice team.

We saw that since the last inspection the process for managing patient safety alerts had been improved. We saw an example of a recent alert and noted that appropriate action had been taken to identify any patients affected and ensure they were safe.

As there had not been any significant events since the previous inspection, none had been discussed. However, the lead GP said they planned to discuss these at monthly meetings.

Overview of safety systems and process

There were no notices on display advising patients of the availability of chaperones. One of the two receptionists was a chaperone. They had received a Disclosure and Barring Service (DBS) check and had some understanding of the role. However, they had not received specific training for the role. (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). We were told this member of staff had not actually acted as a chaperone as yet and was due to receive training. There was no specific date planned for this training to be received. We were told that in the meantime, only the practice nurse acted as a chaperone. We saw a chaperone policy dated 1 August 2015. However, we saw this policy was incomplete and was not tailored specifically to the practice. Following the inspection we were sent a chaperone policy dated 10 December 2016, however this was identical to the one dated 1 August 2015.

Following the inspection we received confirmation that notices were now on display informing patients about the availability of chaperones. We were also sent copies of certificates confirming that staff had received chaperone training.

We saw several separate policies that related to various aspects of infection control including blood borne viruses, decontamination and clinical waste management. These policies had various dates and did not include a control sheet with information about when they would next be reviewed.

Since the last inspection staff were now aware of where spillage kits were kept (in the nurse's room) and knew how to use them. Evidence of infection control training for staff other than the lead GP was not available. Evidence of Hepatitis B immunity was evident for the practice nurse. None of the other staff handled specimens.

Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw these were signed by the nurse; however, the declaration did not include the name of the organisation. They were signed by the lead GP giving authorisation; however, they did not include the GP's printed name, designation and the date of authorisation, as is necessary to make the PGDs valid.

Monitoring risks to patients

We found there was still no health and safety poster which identified local health and safety representatives. No action

had been taken since the last inspection regarding the failure of the health and safety risk assessment to identify hazards within the practice. We saw that a fire risk assessment had still not been carried out. However, fire drills were now taking place, the most recent on 5 December 2016. There was no evidence that the fire alarm system had been checked. Following the inspection we received evidence of fire safety training for one member of staff. This had been carried out on the day of the inspection. However, there was no evidence of fire safety training for any of the other members of staff. No fire risk assessment had been carried out. We saw that a gas safety check had been carried out the day before the inspection. No issues had been identified. We were told electrical safety testing was due to have taken place the day before the inspection; however, the engineer had failed to attend. We were told this would be rearranged as soon as possible. With regards to Legionella testing, we were told the lead GP had taken initial steps to address the issues identified in the Legionella risk assessment carried out in October 2015. However, no evidence of this was provided on the day of our inspection.

Arrangements to deal with emergencies and major incidents

- All staff had now received annual basic life support training.
- The practice now had a defibrillator, we were told it had been purchased in August 2016. Staff had received Basic Life Support Training in December 2016 which included how to use a defibrillator. The practice had introduced a system for checking the defibrillator on a daily basis. This had been started the day before the inspection.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, the plan did not include emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 1 July 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), clinical audits and staff training on the Mental Capacity Act 2005.

We issued a Warning Notice in respect of these issues and found there had been some improvement when we undertook a follow up inspection of the service on 6 December 2016. However, we did not review that rating at this inspection as the purpose of this inspection was solely to follow up on the concerns identified at the previous inspection. As such the practice remains rated as inadequate for providing effective services.

Effective needs assessment

We saw evidence of MHRA alerts being formally tracked and acted upon. Affected patients were contacted and appropriate action was taken.

Management, monitoring and improving outcomes for people

We saw that since the last inspection the practice had carried out an audit relating to prescribing for chronic obstructive pulmonary disease (COPD). This audit had been initiated by the local Clinical Commissioning Group (CCG) and was just a single cycle audit with no apparent analysis of the results or any improvements made, implemented and monitored.

Consent to care and treatment

At the last inspection we found the GP had not undertaken Mental Capacity Act training. At this inspection we found this was still the case; however, we received evidence this training was completed two days after the inspection.

Are services well-led?

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

Our findings

At our previous inspection on 1 July 2016, we rated the practice as inadequate for providing well-led services as there was no overarching governance structure.

We issued a Warning Notice in respect of these issues and found there had been some improvement when we undertook a follow up inspection of the service on 6 December 2016. However, we did not review that rating at this inspection as the purpose of this inspection was solely to follow up on the concerns identified at the previous inspection. As such the practice remains rated as inadequate for being well-led.

Governance arrangements

At the last inspection we found practice policies and procedures were incomplete and out of date. At this inspection we found some policies had been updated such as for significant events and Mental Capacity Act, whereas some others, for example relating to the Duty of Candour were due to be reviewed in 2015 and still had not yet been reviewed. We were told the process of reviewing and updating policies was still underway.

At the previous inspection we found patient confidentiality could be compromised due to patient records (red books) being stored insecurely. At this inspection we did not see any evidence of a repetition of this concern.

Leadership and culture

On the day of the inspection we were met at the practice by a partner from a neighbouring practice and told that they had signed a letter of intent to merge this practice with the neighbouring practice. That GP was also the lead for the local GP Federation which was planning to conduct a diagnostic review of the practice to support the lead GP to make the necessary improvements. They would also provide managerial support to the practice in the intervening period. We saw evidence of the agreement for this merger to take place. This merger was reportedly due to take place by 2018. Since the previous inspection that practice had also provided additional GP cover; a female GP to provide additional support as well as to provide patients with a choice of GP. It was anticipated the additional GP would provide four to six sessions per month at this practice.

The provider had a policy relating to the duty of candour. This was dated August 2015. (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). However, there was no evidence of support training for all staff on communicating with patients about notifiable safety incidents. Staff told us the GP encouraged a culture of openness and honesty. There was little evidence to demonstrate that when things went wrong with care and treatment people were given reasonable support, truthful information and a verbal and written apology and that records of verbal and written interactions were kept.