# Long Street Surgery - Two Steeples Medical Centre

## Quality Report

Two Steeples Medical Centre
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Wigston
Leicester
LE18 2EW
Tel: 0116 2883314
Website: www.**longstreetsurgery**.org.uk

Date of inspection visit: 7 and 15 December2015
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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.

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Are services safe? | **Inadequate** |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

This practice was placed in to special measures on 22 October 2015 following an inspection on 22 April 2015, which was carried out as part of our new comprehensive inspection programme. At that inspection, we found the practice inadequate for providing safe, effective, caring, responsive services and being well led. It was also inadequate for providing services for the older people, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

We carried out a focused inspection of Long Street Surgery with an unannounced visit on 7 December 2015 and an announced visit on 15 December 2015. The inspection in December 2015 was carried out during a period in which the provider was already in special measures and ahead of a scheduled inspection because of concerns received in respect of providing safe care and treatment for patients.

The report from our last comprehensive inspection, can be accessed by selecting the 'all reports' link for Long Street Surgery on our website at www.cqc.org.uk

Our key findings across all the areas we inspected on 7 and 15 December 2015 were as follows:

- Patients were at risk of harm because there was a lack of monitoring of the care and treatment of patients. There was a failure of the GPs to treat patients in accordance with national clinical guidelines.
- There was a heavy reliance on secondary care provision and recommendations for treatment and an abrogation of responsibility taken for managing patient care.
- Some staff were carrying out tasks but they did not have the required skills and competencies and without appropriate indemnity.
- There were many examples of inappropriate prescribing.
- Children were not protected as there was not an effective system in place to highlight or identify safeguarding concerns.
- Staff did not always report incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The provider is no longer providing care or treatment from Long Street Surgery.

# Summary of findings

**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

At our inspection on 7 and 15 December 2015 we were very concerned about patient safety in this practice. This report is a summary of our findings.

- Patients were at risk of harm because there was a lack of monitoring of the care and treatment of patients. There was a failure of the GPs to treat patients in accordance with national clinical guidelines.
- There was a heavy reliance on secondary care provision and recommendations for treatment and an abrogation of responsibility taken for managing patient care.
- Some staff were carrying out tasks but they did not have the required skills and competencies and without appropriate indemnity.
- There were many examples of inappropriate prescribing.
- Children were not protected as there was not an effective system in place to highlight or identify safeguarding concerns.
- Staff did not always report incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The provider is no longer providing care or treatment from Long Street Surgery.

# Long Street Surgery - Two Steeples Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

The inspection team over the two days consisted of a combination of four primary care inspectors, one primary care inspection manager, two pharmacy inspectors, two specialist advisor general practitioner doctors and a specialist advisor practice manager.

## Background to Long Street Surgery - Two Steeples Medical Centre

Long Street Surgery delivers primary medical services under a personal medical services (PMS) contract between themselves and NHS England. The practice serves a patient population of 2904. There are roughly equal numbers of patients aged over 65, under 18 and of working age.

There are two partner GPs one male, one female plus a locum GP, who provide 16 sessions a week between Monday and Friday. The practice is open from 8.30am – 7pm on Monday, Tuesday 8.30am – 6.30pm, Wednesday 7.30am - 6:30pm, Thursday 8.30 – 6.30pm and Friday 8.30am – 6.30pm.

The clinical sessions of individual doctors and nurses vary within these hours. The practice does not open at weekends.

The GPs do not provide an out-of-hours service to their own patients and patients are signposted to the NHS 111out-of-hours service when the surgery is closed at the weekends and in the evenings.

The doctors are registered to carry out minor surgical procedures. There is a nursing team consisting of one nurse, a health care assistant and a phlebotomist. The nursing team are all employed on a part time basis. At the time of our inspection, there was a practice management consultant in place.

Long Street Surgery was opened in September 2014 at Two Steeples Medical Centre a modern, purpose built Health Centre after a move from the old surgery at Long Street, Wigston. The surgery facilities are provided on the ground and first floor levels with a lift available to provide accessibility to both floors. A disabled toilet is provided adjacent to the waiting room area.

A team comprising of four reception/ administration staff were employed to support the day to day running of the practice. They are all employed on a part time basis.

## Why we carried out this inspection

We carried out an unannounced focused inspection of Long Street Surgery on 7 December 2015. A further announced visit was made on 15 December 2015. The inspection was carried out to follow up a number of concerns raised:

- By NHS England and East Leicestershire and Rutland CCG.

# Detailed findings

and

- By a former member of staff at Long Street Surgery.

We were concerned about the safe care and treatment of patients.

When we inspected this practice on 22 April 2015 as part of our new comprehensive inspection programme, specifically, we found the practice inadequate for providing safe, effective, caring, responsive services and being well led. It was also inadequate for providing services for the older people, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Inadequate

# Are services safe?

## Our findings

Our findings

At our inspection on 7 and 15 December 2015 we were very concerned about patient safety in this practice. This report is a summary of our findings.

**Safe track record and learning**

There was not an effective system in place for reporting and recording significant events.

- Staff were not able to explain how they would report incidents and when concerns had been raised by staff they had not been recorded. During the visit of 7 December 2015 we asked one of the GP partners for details of significant events which had been recorded in the last year. They provided copies of two significant event records. We saw a number of examples during our inspection of incidents which had occurred in this timeframe and should have been recorded as significant events. For example; delayed referrals and a patient that had not had their INR monitored for three months.
- The practice did not carry out robust analysis or learning when significant events were identified.

When the provider identified when things went wrong we did not see any evidence of the provider acknowledging issues, involving patients or learning from issues. We saw evidence of a complaint from March 2015. There was no response or documentation following the initial complaint. We asked the registered manager why it had not been responded to and they told us the practice manager was going to deal with it. We saw a number of examples of incidents that should have been recorded as significant events and had not been, such as referrals that had not been made and a patient who had not had their international normalized ratio (INR) monitored for three months which resulted in hospital admission with high INR.

**Overview of safety systems and processes**

The practice did have some systems in place to keep patients safe and safeguarded from abuse, however we found examples of when children had been put at risk because inadequate actions had been taken:

- The practice failed to take the appropriate action to protect a child, and there was a lack of action and of responsibility taken by the practice. There was nothing to suggest the GPs were proactive with identifying potential risks to children or taking any action themselves. They were reliant on issues being identified by other healthcare professionals. In addition, there was nothing recorded on patient records relating to communication with district nurses or health visitors.

Medicines were poorly prescribed, not properly monitored and were not safely administered:

- Some medicines were over-prescribed to patients and there were no systems in place to highlight when this occurred so that appropriate action could be taken. One patient had been prescribed 3,000 dihydrocodeine 30mg tablets in 74 days. At the prescribed dose of two, four times a day, they would have only have needed 296 tablets. Additionally guidance states that patients should not be prescribed more than six tablets per day.
- There was repeat prescribing of medication without proper reviews. There were approximately 98 patients on repeat prescriptions with no review recorded in the last 18 months. The lack of reviews included those for patients with high blood pressure, diabetes and epilepsy. Often when a medication review was recorded there were no notes to support any rationale in respect of a review.
- Alerts generated through the computer system which indicated action was required regarding prescribing and monitoring were ignored. We saw numerous examples of icons on patient records which indicated that an action was required but no record that the relevant action had been taken.We also saw evidence that tasks had been sent to a member of staff that no longer worked at the practice and were therefore not acted on
- A healthcare assistant (HCA) was administering flu vaccines and other medication when not authorised to do so. The HCA was found to have been administering flu vaccines under a Patient Group Direction, which allows prescription only medicines to be administered in certain circumstances by non-prescribers. This does not include Healthcare Assistants. The same HCA was found to have been administering hydroxocobalamin (Vitamin B12), a practice that requires assessment by a healthcare professional, not a Healthcare Assistant, before administration.
- When patient safety alerts were received into the practice there was no system in place to enable discussion, plan the required action and to evaluate if

the actions had been implemented. An MHRA alert that was dated 2012 had not been acted on, medicines were still being prescribed in an unsafe way and the provider lacked understanding of the seriousness of this.

- There was inadequate monitoring and review of patients receiving certain medications. ACE/A2RB patients were identified who have had no renal monitoring in the last 18 months. The total number of patients on inhibitors was 335, which is approximately 10% of the practice's patient list. 37 patients were identified who have not had screening in last 18 months, which is approximately 10% of those on inhibitors. 50 patients were identified who have not had screening in the last 12 months, which is approximately 15%. GPs at the practice had ignored iconised alerts on screens for six patients we sampled in this group which stated 'AThe risk associated with this lack of monitoring is impairment of kidney function or even end stage renal failure.

Risks to patients were poorly managed and there was not a safe system in place to manage the care and treatment of patients. The practice did not effectively use the computer system to record when correspondence was reviewed; this meant there was a risk to continuity of care should other clinicians carry out care and treatment.

- When a patient was identified as a carer by the ambulance service the practice did not take the required action of reviewing the patient and developing a care plan, despite the patient being diagnosed as having ventricular tachycardia and supporting their partner who had dementia.
- We saw evidence that patients were recorded as having a care plan in place but the plan had been populated from existing information on the computer system but not completed in full.
- We saw evidence from patient records of referrals to secondary care being required but the referral not being made in a timely manner, in two cases up to three months late. One of these related to a referral to a neurologist for a six year old who had been suffering absent episodes. The delay in referral placed the child at serious risk.

The practice did not have an effective system in place for monitoring and tracking the use of blank prescriptions in line with the NHS guidance on security of prescription forms (August 2013).