Bayswater Medical Centre

Inspection report

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Date of inspection visit: 09/07/2018
Date of publication: 30/08/2018

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 location

Are services safe?	
Are services well-led?	

Overall summary

We carried out an announced comprehensive inspection of Bayswater Medical Centre on 4 June 2015. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. A follow-up announced comprehensive inspection was undertaken on 3 February 2016 following the period of special measures. Although the practice had made improvements, and were removed from special measures, there were still concerns and the practice was rated as requires improvement overall.

We carried out an announced inspection on 27 July 2017 and, although, the practice had addressed the issues of our previous inspection we found new concerns and the practice remained rated as requires improvement. We carried out an announced comprehensive inspection on 10 May 2018 when we found that the practice had not addressed all the findings of our previous inspection and additional concerns were identified. The practice was rated inadequate overall and placed in special measures for a second time for a period of six months. In line with our enforcement procedures we issued two warning notices in relation to regulation 12: safe care and treatment and regulation 17: good governance of the Health and Social Care Act 2008. The full comprehensive report of the June 2015, February 2016, July 2017 and May 2018 inspections can be found by selecting the 'all reports' link for Bayswater Medical Centre on our website at www.cqc.org.uk.

We carried out an announced focused inspection of Bayswater Medical Centre on 9 July 2018. This was to follow-up on the two warning notices the Care Quality Commission served following the announced comprehensive inspection on 10 May 2018. The warning notices, issued on 25 May 2018, were served in relation to regulation 12: Safe care and treatment and 17: Good governance of the Health and Social Care Act 2008. The timescale given to meet the requirements of the warning notice was 6 July 2018.

Prior to this inspection on 9 July 2018, we were told by commissioners they had acted to address the immediate concerns in relation to patient safety and had suspended the practice from administering immunisations and provided clinical and managerial support to the practice. Specifically, this included full-time practice management support to facilitate a significant event and root cause analysis (a systematic approach to the investigation of serious incidents) process and liaise with the appropriate agencies in relation to the cold chain breach and a part-time nurse practitioner to ensure clinical effectiveness of cold chain policies and procedures and staff training. This support was ongoing at the time of our inspection. The practice had also been instructed by commissioners to close the practice list to new patient registrations.

At the inspection we found that the practice, in collaboration with external clinical and non-clinical support, had addressed most of the issues identified at our previous inspection. Specifically, we found the provider had:

- Reviewed its systems and process to manage the cold chain and initiated a formal investigation into the cold chain breach.
- Addressed the actions of the fire and Legionella risk assessments.
- Addressed the actions of the Infection Prevention and Control (IPC) audit and arrangements in relation to IPC to mitigate the risk of infection.
- Calibrated all medical equipment in line with guidance.
- Implemented clinical protocols for healthcare assistants.
- Initiated a formal system to act upon patient safety alerts.
- Commenced some clinical audits.
- Addressed gaps in staff training in line with guidance in relation to safeguarding, fire awareness, infection prevention and control, information governance and sepsis awareness.
- Commenced regular structured clinical and practice meetings which demonstrate shared learning.
- Entered in to a proposed practice merger.

However, we found:

- Up-to-date competence training for ear irrigation for the healthcare assistant was not available.
- Water temperature recordings did not meet the requirements for healthcare premises and there was no documented action taken where the temperatures had fallen outside the recommended ranges.
- There was no evidence of a programme of continuous quality improvement.

Our inspection on 9 July 2018 focussed on the concerns giving rise to the warning notices issued on 25 May 2018. We found the practice had acted to address most of breaches of regulation set out in the warning notices.

Overall summary

However, the current rating will remain and the practice will remain in special measures until the provider receives a further comprehensive inspection to assess the improvements achieved against all breaches of regulation identified at the previous inspection.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a second CQC inspector and a GP specialist adviser.

Background to Bayswater Medical Centre

Bayswater Medical Centre operates from 46 Craven Road, London W2 3QA. The practice has access to six consulting rooms, three are located on the ground floor and three in the basement. The basement is accessible by stairs.

The practice provides NHS primary care services to approximately 7,500 patients and operates under a Personal Medical Services (PMS) contract (an alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract). The practice is part of NHS West London Clinical Commissioning Group (CCG).

The practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services, family planning and surgical procedures.

The practice staff comprises of a principal GP (eight sessions per week), a male and female salaried GP (totalling 11 sessions per week) and a regular male locum GP (four and a half sessions per week). The clinical team is supported by two healthcare assistants (1.7 WTE) and a locum practice nurse one day a week. There is a full-time practice manager, who is a non-clinical partner and the registered manager for its CQC registration, and five administration/reception staff.

The practice is open between 8am and 6:30pm Monday to Friday. Extended hours appointments are available on Tuesday from 6.30pm to 8pm and Saturday from 9am to 1pm. The practice offers on-line services, which include appointment booking and repeat prescriptions which can be accessed through the practice website. Patients also have access to two GP hub services offering appointments from 6pm to 9pm Monday to Friday and from 8am to 8pm on Saturday and Sunday.

The practice population is in the fourth most deprived decile in England, on a scale of one to 10 with one being the most deprived and 10 being the least deprived. People living in more deprived areas tend to have greater need for health services. Data shows that 39% of patients at the practice area were from Black and Minority Ethnic (BME) groups. The highest proportion of the practice population was in the 15 to 44-year-old age category.

Are services safe?

At our previous inspection on 10 May 2018, we issued a warning notice for regulation 12: safe care and treatment of the Health and Social Care Act 2008, as arrangements in respect of being a safe service were in breach of regulation.

Specifically, we found:

- The provider had failed to ensure an effective cold chain for medicines stored in the vaccine fridge. We found that the maximum temperature for one pharmaceutical refrigerator had been consistently recorded at 17oC since August 2017 and the maximum temperature of a second refrigerator had been recorded at 9oC in March and April 2018 and at 14oC on numerous occasions in November 2017. Any vaccine not stored as per its licensing condition is no longer a licensed product and the efficacy of the vaccine may be affected.
- The provider had failed to ensure that all actions in relation to fire and Legionella risk assessments had been addressed. We found in-house fire alarm warning system checks and fire/evacuation drills had not been carried out; and infrequently used water outlets had not been flushed and routine water sampling and temperature testing had not been carried out.
- The provider had failed to ensure that all actions in relation to an Infection Prevention and Control (IPC) audit had been addressed. We found the practice could not demonstrate the immunisation status for all clinical staff in direct patient contact in line with guidance.
- The provider had failed to ensure that arrangements in relation to IPC mitigated the risk of infection. We found that the cleaning storage room was cluttered and colour-coded mop heads were dirty and touching, which posed a risk of cross-contamination, there was no record to evidence decontamination of medical devices, for example the ear irrigator, and there was no Control of Substances Hazardous to Health (COSHH) risk assessment available.
- The provider had failed to ensure that Patient Specific Directions for the administration or supply of medicines by the healthcare assistants met legal requirements. We found the practice had produced a generic instruction to be applied to any patient who may be seen by a healthcare assistant on any particular day who fitted the criteria. We saw that the practice had printed off its entire influenza and pneumococcal patient registers and attached a generic PSD signed by the lead GP.
- The provider had failed to ensure that all medical equipment had been calibrated in line with guidance. We found some equipment had not been included in the June 2017 calibration schedule. For example, two foetal Doppler monitors (a hand-held ultrasound transducer used to detect the foetal heartbeat for prenatal care) and an ophthalmoscope had not been calibrated since January 2016. In addition, the practice did not maintain an inventory of medical equipment.
- The provider had failed to ensure that clinical protocols were available for healthcare assistants outlining the framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment. We found the healthcare assistants undertook contraceptive pill check follow-ups, health checks and wound management/change of dressings but there were no protocols to support these roles.

At our inspection on 9 July 2018, we reviewed the requirements of the warning notice and found the provider had made some improvements to the provision of safe services in relation to the warning notice. Specifically, we found:

- Following our previous inspection, the practice had been suspended by its commissioners from administering vaccines until an effective cold chain process had been established. To achieve this, a series of measures had been agreed with the practice which included the purchase of a new vaccine fridge, ordering of new vaccines, implementing cold chain best practice guidelines and staff training. The practice had been provided with the support of a full-time practice manager and part-time nurse practitioner to undertake a significant event and root cause analysis (a systematic approach to the investigation of serious incidents) and liaison with appropriate agencies in relation to the cold chain breach, ensure clinical effectiveness of policies and procedures and staff training. The investigation into the cold chain breach was still ongoing at the time of our inspection. However, the suspension from administering vaccines had been lifted the week prior to our inspection. On the day of the inspection we saw the practice had decommissioned its two existing pharmaceutical fridges and had procured a new fridge. We saw evidence that the fridge had been in use since 3 July 2018 and the fridge temperatures, which included actual, minimum and maximum, were within recommended ranges and there was a secondary thermometer. We saw evidence that vaccines affected

by the cold chain had been disposed of and new vaccines had been obtained, which were appropriately stored. The practice had updated its cold chain policies and procedures and staff we spoke with who were responsible for recording the fridge temperatures were aware of the action to take in the event of temperatures falling outside the recommended ranges.

- The provider had addressed the outstanding actions of the fire risk assessment and we saw there was a process in place to check and record the fire alarm warning system and a fire evacuation drill had been carried out on 20 June 2018. A further fire risk assessment had been undertaken on 5 July 2018 by an external provider which included additional recommendations. For example, some additional 'Fire Action' notices to be prominently displayed in relevant areas.
- The provider had addressed the outstanding actions of the Legionella risk assessment and we found a record that infrequently used water outlets had been flushed on a weekly basis and monthly hot and cold-water temperature checks had been carried out of the 'sentinel' outlets (furthest and closest to each tank or cylinder). However, we noted that the water temperature log sheet indicated that the standard compliant temperature for hot water should be recorded at 50oC. However, hot water for healthcare premises should reach a temperature of 55oC. We noted that the practice had recorded hot water temperatures in May at 46.2oC and 50.1oC and in June at 49.8oC and 50.8oC; and cold-water temperatures in May at 21.2oC and 22.2oC and in June at 21.1oC and 22.1oC (standard temperature to meet 20oC). There was no documented action taken on the log sheet where the temperatures had fallen outside the recommended ranges. A further Legionella risk assessment had been undertaken on 5 July 2018 by an external provider and we saw that additional recommendations had been made. For example, limescale build-up in the water outlets which required cleaning and Legionella awareness training to be undertaken by at least the responsible person.
- The provider demonstrated the immunisation status for all clinical staff in direct patient contact in line with guidance.
- We saw evidence that the provider had sought clarity from the supplier of its spill kits that these were suitable for all bodily fluid spills, for example blood and vomit.
- We saw that the cleaning storage room had been decluttered. However, the storage of colour-coded mop heads still posed a potential risk of cross-contamination. After the inspection the provider sent photographic evidence that they had installed a wall-mounted bracket for the appropriate storage of mops.
- The provider demonstrated the decontamination of an ear irrigator but not a nebuliser (a medicine delivery device used to administer medication in the form of a mist inhaled into the lungs). The practice sent evidence after the inspection that the nebuliser had been included in its medical devices cleaning schedule.
- The provider had undertaken a Control of Substances Hazardous to Health (COSHH) risk assessment but this was limited to the cleaning storage room. We saw data safety sheets were available for the cleaning products available. However, the practice had not considered or determined any additional risks to health from any other hazardous substances used or created by the practice's activities.
- The provider had not at the time of our inspection sought enhanced infection prevention and control (IPC) training for the IPC lead.
- The provider told us they had suspended the healthcare assistants (HCAs) undertaking immunisations until it had reviewed its procedures to support the safe administration of medicines by HCAs under an appropriate Patient Specific Direction (PSD). This review included the update of clinical protocols and appropriate training being in place. For example, annual immunisation-specific training, basic life support and anaphylaxis training. Staff we spoke with told us immunisations were currently being undertaken by GPs and the practice nurse.
- We saw evidence that all medical equipment had been calibrated in line with guidance on 4 June 2018. In addition, the practice had implemented an inventory of medical equipment.
- The provider had reviewed the roles and responsibilities of the healthcare assistants (HCAs) and told us that contraceptive pill checks were no longer undertaken by the HCAs. The practice provided clinical protocols for phlebotomy, ear irrigation and wound care management, which included the local wound care management formulary. Both HCAs we spoke with told us they had access to the protocols and were supported by the GPs in their role. We saw that both HCAs had undertaken phlebotomy training in 2017 and wound care management training in the last 12 months. Only

Are services safe?

one of the HCAs undertook ear irrigation and we noted that the protocol stated that update training should be undertaken every two years in the form of external formal training or in-house by a clinician observing practice and technique and recording competency. However, we saw from training records that the HCA had last undertaken ear care training in 2013 and a competency check list dated October 2017 did not include assessment of ear care or ear irrigation competency. After the inspection we asked the practice to provide evidence of the most recent training. The practice could not provide evidence of any further training and told us that the HCA undertook infrequent ear irrigation and so asked a doctor to examine the patient prior to them performing the procedure. The practice did not confirm whether the absence of recent update training, competency assessment and infrequent practice of the procedure demonstrated that staff had the appropriate skills, knowledge and experience to deliver safe and effective care and treatment.

Are services well-led?

At our previous inspection on 10 May 2018, we issued a warning notice for good governance as arrangements in respect of being a well-led service were in breach of regulation. Specifically, we found:

- There were no formal systems to act upon patient safety alerts.
- There was little evidence of quality improvement, including clinical audit being carried out within the practice.
- There were gaps in staff training and some training, including role-specific training, had not been undertaken at a level and frequency outlined in its own policy.
- There was no formal strategy and business plan written in line with health and social priorities of the area or to meet the needs of the practice population.
- There was no evidence of regular structured or formalised clinical or practice meetings to demonstrate shared learning.

At our inspection on 9 July 2018 we reviewed the requirements of the warning notice and found the provider had addressed most of the improvements identified to the provision of well-led services in relation to the warning notice. Specifically, we found:

- The practice demonstrated it had put a system and process in place to receive and act upon patient safety alerts. Staff we spoke with could describe the process and we saw that a log of all alerts received was maintained and action taken. We saw that some outcomes of alerts relevant to the practice had been discussed in a practice meeting.
- The practice provided some CCG medicine management-led prescribing audits and a single-cycle audit on Tamoxifen (hormonal therapy drug used to treat breast cancer) and antidepressants. However, the practice could not provide a programme of continuous quality improvement of how it intended to routinely review the effectiveness and appropriateness of care provided to provide effective, safe care.
- The practice had reviewed the training requirements of its staff and we saw that the Healthcare Assistants (HCAs) had undertaken safeguarding children level two training and all staff had now completed annual fire, infection prevention and control and information governance training. We saw evidence from meeting minutes that the practice had delivered internal training for all staff on sepsis symptoms and awareness and implemented a sepsis policy. Non-clinical staff we spoke with on the day demonstrated an awareness on sepsis and what action to take if they encountered a deteriorating or acutely unwell patient. The practice told us it had discussed duty of candour and whistleblowing in a practice meeting and all staff we spoke with on the day of the inspection demonstrated an understanding of these terms.
- In relation to a formal strategy and business plan, the provider told us that since our last inspection they had entered in to a proposed practice merger.
- The practice had commenced regular structured and formalised clinical, practice and MDT meetings. We reviewed minutes of meetings and saw shared learning had been discussed in relation to significant events and patient safety alerts.