Houghton Primary Care Centre

Quality Report

Brinkburn Crescent
Houghton Le Spring
Tyne And Wear
DH4 5HB
Tel: 0191 5025660
Website: www.houghtonucc.nhs.uk/

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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 focused inspection at Houghton Primary Care Centre on 24 May 2016. The inspection was carried out in response to some information of concern we had received.

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

Our key findings were as follows:

- The provider had systems, processes and practices in place to keep patients safe and safeguarded from abuse, but they were not all embedded within the service. For example, although there were arrangements in place to safely manage medicines, we found some of the arrangements were not adhered to correctly. We found two of emergency medicines had gone out of date within the last three months and not been replaced or disposed of.
- We found the provider had arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, we found on a small number of occasions the minimum number of staff the provider had assessed as being required were not present.
- Although the provider had access to a range of suitable emergency equipment, we found they had not fully assessed the risk of the range of equipment they required to deal with emergencies.
- We found the provider had arrangements in place to offer staff a variety of mandatory and additional training to ensure they had the knowledge and skills to deliver effective care and treatment. However, they could not provide us with assurances they were monitoring that individual staff had received the appropriate mandatory and additional training required to carry out their role and responsibilities safely.

The areas where the provider must make improvement are:

- Ensure there are appropriate medicines to provide treatment to patients in a medical emergency. Review the process for checking medicines are within expiry dates to ensure it is effective.
- Ensure appropriate records relating to the staff employed are maintained.

The area where the provider should make improvements is:

- Review and monitor the arrangements for the number and mix of staff needed to meet patients' needs. The provider should be able to demonstrate a safe environment is maintained for staff and patients.

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 provider had systems, processes and practices in place to keep patients safe and safeguarded from abuse, but they were not all embedded within the service. For example, although there were arrangements in place to safely manage medicines, we found some of the arrangements were not adhered to correctly. We found two of the emergency medicines held had gone out of date within the last three months and not been replaced or disposed of.
- We found the provider had arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. However, we found on a small number of occasions the minimum number of staff the provider had assessed as being required were not present.
- Although staff had access to a range of suitable emergency equipment, we found the provider had not fully assessed the risk of the range of equipment required to deal with emergencies.

Are services effective?

- We found the provider had arrangements in place to offer staff a variety of mandatory and additional training to ensure they had the knowledge and skills to deliver effective care and treatment. However, the provider could not provide us with assurances they were monitoring that individual staff had received the appropriate mandatory and additional training required to carry out their role and responsibilities safely. They did not provide us with requested information relating to this within a timely way.

Summary of findings

What people who use the service say

We did not speak with any patients as part of this inspection.

Areas for improvement

Action the service MUST take to improve

- Ensure there are appropriate medicines to provide treatment to patients in a medical emergency. Review the process for checking medicines are within expiry dates to ensure it is effective.
- Ensure appropriate records relating to the staff employed are maintained.

Action the service SHOULD take to improve

- Review and monitor the arrangements for the number and mix of staff needed to meet patient's needs. The provider should be able to demonstrate a safe environment is maintained for staff and patients

Houghton Primary Care 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 advisor who had experience of delivering out of hours and urgent care services.

Background to Houghton Primary Care Centre

Houghton Primary Care Centre provides urgent care for minor injuries and illnesses for the residents of Houghton-le-Spring and the surrounding areas. Services are delivered from the Urgent Care Centre at Brinkburn Crescent, Houghton Le Spring, Tyne And Wear, DH4 5HB.

The service is one of three urgent care and minor injury centres in the Sunderland area commissioned by Sunderland 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. This inspection is for Houghton Primary Care Centre only.

Vocare employs a clinical services manager who oversees the day to day running of the three urgent care and minor injury centres. They employ a number of GPs, advanced nurse practitioners, nurse practitioners and junior nurse practitioners. There is also an operational team in place to support delivery of the service during opening hours.

Houghton Primary Care Centre is open from 10am to 10pm Monday to Friday and 8am to 10pm Saturdays, Sundays and Bank Holidays.

Why we carried out this inspection

We carried out a focused 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an unannounced visit on 24 May 2016. We also asked other organisations to share what they knew.

During our visit we:

- Spoke with a range of staff, including the clinical services manager, GPs and nurses.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

Detailed findings

- 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 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?

As this was an inspection to follow up concerns we had received, we focused our inspection on these areas.

Are services safe?

Our findings

Overview of safety systems and processes

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

- There were arrangements for managing medicines in the service, including emergency medicines and vaccines, to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However, some of the arrangements were not adhered to correctly. Most medicines were stored securely in a locked room. The emergency equipment and medicines were stored in a trolley kept in the passageway near to consultation rooms. Access to the corridor was controlled and patients were escorted into and out of consultation rooms. The emergency trolley was locked with a plastic tag to enable staff to identify if it had been tampered with. We saw there was a full range of emergency medicines available, in line with current guidelines. However, we found the process in place to check the expiry dates of stored medicines, including emergency medicines, was ineffective. We found two of these medicines had gone out of date within the last three months. We noted this had been identified within the services own checking process, but these medicines had not been replaced or disposed of.

Monitoring risks to patients

- We found the provider had arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. However, we found on a small number of occasions the minimum number of staff the provider had assessed as being required were not present. The majority of the six members of staff we spoke with raised concerns with us about staffing levels.
- The clinical services manager told us the minimum staffing for the centre was two clinicians. This was normally one GP and one nurse practitioner or one GP and two nurse practitioners. We reviewed the last three months of staffing levels and found there had been three occasions in March 2016 where there was only one clinician deployed by the provider to work at the location. On two separate days, there were 90 minutes each day when only a GP was deployed by the provider to work within the location. On one occasion there had been 180 minutes when only a nurse practitioner was deployed at the location. At these times there were other people working in the building, although they were not employed by the service. The records we reviewed showed there had been no further instances where only one clinician was working in the location in April or May 2016. The provider told us clinicians have access to GP advice via the 24 hour on call service or by contacting another local centre or the clinical support manager.
- We asked the clinical services manager if they had carried out a capacity and demand audit to determine if staffing levels were sufficient. They confirmed, as this had not been requested by the commissioners of the service, they had not carried out an assessment of this type. They did provide us with analysis of number of attendances, but there was no evidence to demonstrate the provider had used this information to determine staffing levels.
- Following a review of the draft inspection report prior to publication, the provider told us they did carry out capacity and demand audits. However, at the time of the inspection local staff were unaware of this. They did not provide us with a copy of these audits.
- The service provided an extract of their incident report system, through which staff raised any concerns, incidents and events. We saw that of the 33 incidents raised within the last year connected to the three urgent care centres in the Sunderland area, 15 related to concerns about staffing levels or the redirection of patients to other services as there was no GP available on site. Of these, eight related to the Houghton location.

Arrangements to deal with emergencies and major incidents

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

- The provider had a defibrillator available on the premises and oxygen with adult and children's masks. There was a system in place for checking the emergency equipment and oxygen.
- There was information in each consultation room giving staff information about resuscitation techniques and emergency procedures for adults and children in a medical emergency. This included advanced techniques in resuscitation for both adults and children.

Are services safe?

- Emergency medicines were in a secure area of the centre and all staff knew of their location. Some of the medicines we checked were past their expiry date.
- The provider had access to a range of suitable emergency equipment. A recent event had highlighted a lack of availability of appropriate equipment to deal with very small babies. Following the incident the service had made improvements, for example, face masks suitable for small babies had been obtained. However, there were no paediatric pads available for the defibrillator for older children. We asked if the provider had carried out a risk assessment to determine the type of equipment they should have available. The provider did not supply us with this information within a reasonable timescale.

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

- We saw there was a fully documented induction policy and process in place. However, we did not see any records for individual staff members to assure us this was being followed.
- The provider had a desktop aid which was available in all clinical rooms, which set out the information clinical staff may need to refer to quickly.
- The provider supplied us with the list of those training courses which they deemed mandatory for all staff and particular job roles. We found this covered the key areas we would expect staff to receive training in, such as safeguarding children and vulnerable adults, health and safety, information governance, infection control and basic life support. They also provided a list of the additional training offered to staff over the last year. They provided some evidence to demonstrate training was offered and taken up by staff. For example, discussions in team meetings, staff evaluations from previous training and invites to training courses. We asked to see evidence the provider was monitoring that individual staff had received the appropriate mandatory and additional training required to carry out their role and responsibilities safely. They did not provide this information to us within an agreed timescale.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for service users. The provider had not sufficiently assured themselves there was appropriate and safe equipment and medicines to provide treatment to patients in a medical emergency. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems and processes were not operated effectively to ensure compliance with the requirements in this part. The provider did not maintain sufficient records as necessary to demonstrate effective management of the regulated service and those in relation to staff employed to deliver the regulated activities. Records to support the completion of induction and training by staff were not available for review.

This section is primarily information for the provider

Requirement notices

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