Dr Azmeena Nathu

Inspection report

Pennygate Health Centre
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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.

Overall summary

We carried out an announced comprehensive inspection at Pennygate Health Centre on 19 October 2017.

Breaches of legal requirements were found in relation to the governance arrangements within the practice. We issued the practice with a warning notice requiring them to achieve compliance with the regulations set out in the warning notices by 12 January 2018.

We undertook an unannounced focussed inspection on 19 April 2018 and a further announced inspection on 25 April 2018 to check that they now met the legal requirements. This report only covers our findings in relation to those requirements.

At the inspection on 19 and 25 April we found that not all the requirements of the warning notice had been met. The Care Quality Commission has written to the lead GP and asked for further information on how they will meet these requirements.

Our key findings across the areas we inspected for this focussed inspection were as follows:

- The practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe in relation to patient safety alerts, dispensary, monitoring of the cold chain, infection prevention and control, training requirements of staff, fire safety, management of legionella, portable appliance testing, Electrical Installation Condition report and actions, information technology systems and the documentation of discussion and actions from meetings that had taken place. Further work was required to ensure meeting minutes were detailed to include the discussion and actions taken, fire alarm and emergency lighting is carried out monthly, practice nurse received clinical supervision which is clearly documented and dispensary and locum staff undertake training identified relevant to their role,
- The practice did not have an effective system in place for the management of high risk medicines which included regular monitoring in accordance with national guidance.
- The practice did not have an effective process in place for medicines reviews.
- We could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment.
- At this inspection we still had concerns in regard to the leadership capacity and clinical oversight of the practice.

The areas where the provider must make improvements are:

- Put in place an effective system for the management of patient on high risk medicines
- Improve the system in place for patients that require a medication review
- Improve the system in place for safeguarding service users from abuse and improper treatment.
- Ensure there is leadership capacity and clinical oversight in the practice.

In addition the provider should:

- Continue to embed the formalised process for the recording of meeting minutes and ensure they are detailed and evidence that learning is shared and actions are put in place. For example, in relation to significant events and complaints.
- Ensure there is monitoring for external training required by staff members relevant to their role.

Our inspection team

The inspection was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a member of the CQC medicines team and second CQC inspector on 19 April 2018.

Background to Dr Azmeena Nathu

Dr Azmeena Nathu, Pennygate Health Centre, is a GP practice and is located in the South Lincolnshire town of Spalding and has 3,460 patients at the practice.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is situated amongst the 20% of the most deprived neighbourhoods in the country. Within the practice population there was clear evidence of deprivation, particularly associated with migrant workers and their families. Both male and female life expectancy were comparable with the national average. The age distribution of people living in the South Lincolnshire Clinical Commissioning Group is an area that reflects that of the national profile. The age profile of the practice showed that there was a higher percentage of younger patients and 8% aged 75 or over. 18% of the patient list were of non-British nationality, being predominantly Eastern European.

The practice has one principal GP (female), two locum GPs (male), one practice nurse, two members of staff who have dual roles as dispensers / administrators. There are two receptionists and a cleaner who is employed directly by the practice.

The practice offered a full range of primary medical services and was able to provide dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises

The practice is located over two floors, though all areas accessed by patients were located on the ground floor.

Pennygate Health Centre were open from 8am to 6.30pm Monday to Friday.GP Appointments were from 8.45am to 11am and 3.30pm to 5.30pm Monday to Friday.

In addition to pre-bookable appointments that could be booked up to six months in advance, the practice had extended hours on a Tuesday evening from 6.30pm to 8.30pm.

The practice lies within the NHS South Lincolnshire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

Are services safe?

We conducted a follow up inspection of Pennygate Health Centre to check compliance with the warning notice for Regulation 17, Good Governance served in November 2017. The practice was required to comply with the notice by 12 January 2018.

Safety systems and processes

At the inspection in October 2017 there was not an effective system in place for reporting and recording significant events. Three significant events had been identified. The significant events needed further work in terms of consideration on the impact for the patient and a review to ensure all actions had been completed. Following that inspection the practice had completed a themes and trends analysis but the meeting minutes still did not evidence what lessons were shared to make sure actions were taken to improve safety to patients.

At this inspection we found that the practice had reviewed and improved meeting minutes and there was some evidence of shared learning. Minutes still need further work to ensure there was a detailed discussion and evidence of the learning shared with staff.

At the inspection in October 2017 we found that the practice did not have an effective system in place to ensure patient safety alerts were received, disseminated and actioned appropriately. There was no log of alerts received and no clear evidence of how they had been shared and actioned. The practice was unable to evidence that all staff were aware of any relevant alerts to the practice and where they needed to take action.

At this inspection we found that practice now had a system in place where the patient safety alerts were received by the lead GP. A log was kept by the assistant practice manager with actions recorded where appropriate

At the inspection in October 2017 we found that some of the systems, processes and practices in place to keep people safe and safeguarded from abuse were not effective.

- We could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment. There was a lead GP for safeguarding. The practice had only identified one vulnerable adult from their patient record system. There were no safeguarding multi-disciplinary meetings held by the practice or minutes of any meetings that had taken place in regard to safeguarding discussions. We also found there was no children on the at risk register, looked after children or under a child protection plan. We found that the locum GPs did not have the relevant safeguarding training but the practice provided evidence that this would be completed in the next three months.

At this inspection we reviewed the safeguarding process. We were still unable to establish if there was an effective system in place to safeguard service users from abuse and improper treatment as they had only one patient on the vulnerable adult register despite 27% of the patients registered at the practice being over the age of 65 years of age. We saw some communication from a health visitor who had identified that there was no currently no children on from the practice who had safeguarding issues. There were no safeguarding multi-disciplinary meetings held by the practice or minutes of any meetings that had taken place in regard to safeguarding discussions. Since the inspection we have been told by the practice that further safeguarding training had been completed and a meeting had been planned with the local clinical commissioning group safeguarding lead'.

- At the inspection in October 2017 the infection control leads had not completed any infection control lead training. Following the inspection we were told that most staff had completed on-line infection control training but link practitioner training for the lead nurse was still outstanding

At this inspection we were told and we saw that the practice nurse had attended the link practitioner lead training for infection control and now attended the link practitioner meetings held on a regular basis to provide information and guidance to staff.

Appropriate and safe use of medicines

- In October 2017 we found that the practice did not have an effective process in place for medicines reviews. We found that this was done opportunistically which was not in line with the practice repeat prescribing policy which stated that repeat prescriptions would last for an agreed length of time before a medicine review is carried out.

At this inspection we found that the system was still not effective. In patient records we reviewed we found that documentation was poor and inconsistent. In one patient

record we found the record was not detailed and did not include any notes on the examination or if they felt it was a safeguarding issue. We also found that lifestyle information had been added to the patient record incorrectly. After the inspection the practice sent us a significant event in relation to this patient. They told us that going forward all notes would be written in records in a contemporaneous manner and in full detail. They also told us they would complete a peer review of patient records in September 2018 to assess the documentation in patient records following this significant event.

We found that letters from secondary care were not always acted upon in a timely manner. For example, we found a patient was on one strength of medicine when the secondary care letter clearly stated that they should be on two different strengths of the same medicine. After the inspection the practice sent us a significant event in relation to this patient. They told us they would now ensure that care was taken when communication is received by the practice, with regard to medication changes recommended by secondary care. Changes will be acknowledged by the Doctor and added to the patient drug screen in a timely way manner.

We found in some patient records that the documentation had been completed or changed late at night. One record we looked at we found that the wrong allergy had been added to the patient record. In further records we found limited information written in relation to the consultation or when a medicine review had taken place no observations, such as blood pressure, pulse or weight had been completed. After the inspection the practice sent us information that they now had a Medication Review policy put in place which included a screening tool and British National Formulary guidelines to follow for individual long term conditions. They also told us alerts had been added to the patient records. Since the inspection the practice have told us that medicine reviews dates were now in place on all patient records'.

- In October 2017 we found that the practice did not have an effective system in place for the management of high risk medicines which included regular monitoring in accordance with national guidance. The practice were unable to demonstrate that the system they had in place was effective to protect the health and safety of patients on these high risk medicines. We found that patients did not have an icon or alert in place to ensure prescribers were aware of the medicines a patient was being given. We also found that the practice policy in respect of high risk medicines did not provide sufficient guidance to staff.

At this inspection we found that the system was still not effective. We saw that the practice now carried out monthly searches but they did not include all the necessary medicines. We found there was an inconsistency in the alerts and icons on the patient electronic record and there was no effective process to ensure patients received their blood monitoring in a timely manner. We found one patient who had been on an injection for psoriasis since 2013 and their patient record did not have an alert to alert other prescribers/dispensers of potential interactions. Records we looked at identified that secondary care letters had been received but prescribing of medicines did not in each case have the correct dosages on the patient record and not all had icons/alerts added. We also found one example of a secondary care letter that had not been scanned correctly. One page had been scanned on 13 February 2018 and second page on 28 February 2018.Three patients did not have icons/alerts on their patient record or a future date for a high risk medicine review. After the inspection we received a significant event form from the practice in regard to high risk medicines. They told us actions had already been taken. For example, all records for patient on high risk medicines had been checked to ensure all recommendations from secondary care were in place, alerts and icons were now in place, monthly searches would take place to ensure patients were contacted about their blood monitoring. The practice will review this in three months' time to ensure it is effective. We were also told that a new policy was in relation to Disease-modifying antirheumatic drugs (DMARDs) which included the monitoring requirements expected for each medicine.

- At the inspection in October 2017 records showed that all members of staff involved in the dispensing process were appropriately qualified but the practice did not support them to keep up to date. We were told that competence was checked regularly by the GP through observation and questioning. We also found that the dispensary provided weekly medicines packed into blisters for patients who needed this level of support. Dispensers were not aware of certain medicines that should not be packed in this way. We saw that the process for packing medicines into the blisters ensured staff were not disturbed to reduce the risk of errors.

Are services safe?

At this inspection we saw that the staff who carried out the role of a dispenser had completed medicine management modules on the e-learning system. The lead GP had also provided training on cytotoxics and a protocol had been put in place with a list of medicines that were not appropriate for inclusion in compliance aids created. We were told that the dispensers had contacted another GP practice to arrange to attend training events but none had been attended at the time of the inspection. Records we looked at showed that training and assessment of competence was last undertaken by external consultant in June 2017.

- At the inspection in October 2017 the system in place to monitor the cold chain and ensure fridge temperatures were being checked and reset on a daily basis was not effective. We found the practice did not complete monthly calibration or have a second thermometer independent of mains power so temperatures can be measured in the event of electricity loss. This would enable the practice to document what temperature the fridge interior rose to in order for a decision to be made on whether there has been a break in the cold chain. After the inspection we were told that the practice had ordered secondary thermometers.

At this inspection we found secondary thermometers where in place in both the treatment room vaccine refrigerator and dispensary refrigerator. Weekly audits had been completed by the assistant practice manager and kept a printed record. Temperatures had been recorded for both refrigerators and were seen to be within range.

Risks to patients

At the inspection in October 2017 we found that not all risks to patients were assessed and well managed.

- The practice could not find the health and safety risk assessments which looked at areas such as slips, trips and falls, manual handling or lone working. Following that inspection the practice us two health and safety risk assessments dated 12 July 2017. It was documented that staff would receive annual training but on the day of the inspection we did not see any evidence that this had taken place.

At this inspection we were shown a general Health and Safety Risk Assessment carried out by an external company. Since the inspection the practice told us they had now put a risk register in place but it still needed further work to cover areas such as general slips, trips and falls, DSE, COSHH, lone working etc.

- At the inspection in October 2017 we saw that the practice did not have an effective system in place in relation to Fire Safety. we asked to look at the fire risk assessment and the practice were unable to find it. After the inspection the practice carried out their own fire risk assessment. We found that they had not made a suitable and sufficient assessment of the risks to which relevant persons are exposed for the purpose of identifying the general fire precautions needed as set out in the Regulatory Reform (Fire Safety) Order 2005. Risks had been assessed, however no actions had been identified and no action plan had been put in place. We referred the practice to the Lincolnshire Fire and Rescue service. We also saw a document dated 13 October 2017 which stated that the GP had instructed staff on what to do in the event of a fire and they had had a fire drill but no information had been documented of what the training entailed or the outcome and any actions from the fire drill. There was no fire evacuation plan in place and the fire safety policy did not identify if fire marshals were in place and did not provide enough guidance to staff. Following that inspection an updated version of the fire policy was sent in which a nominated fire officer, deputy fire officer and fire marshall had been identified. However the policy still does not provide enough guidance for staff, for example, in regard to fire risk assessment, testing of emergency lighting and staff training.

At this inspection we were shown a fire risk assessment carried out by an external company on 3rd November 2017. The building had been identified as Medium Risk. Fire wardens were now in place and a fire drill report was seen. Fire detection points plan was in place. Fire alarm and emergency lighting was carried out monthly but had not been done since February 2018. A fire policy was in place but needed further work to ensure it provided full guidance to staff. We spoke with the assistant practice manager who told us that they had planned to set up a weekly reminder on the new computer management system which had been put in place since the last inspection but this had not been done. This was immediately put in place. We also saw evidence that Lincolnshire Fire and Rescue had visited the practice on 9 January 2018 to carry out a fire safety review.

Are services safe?

We looked at the summary sheet and found that the practice had been rated as compliant and had one action which was to record in detail the fire drill including the time from the start of the drill to completion.

- At the inspection in October 2017 we looked at the arrangements in place for the management of legionella. We saw that the practice had carried out their own legionella risk assessment on 6 January 2015. It was undertaken by the GP who had not undertaken any relevant training. We also found that regular water temperature monitoring was carried out by a member of staff but we did not see any evidence that they had the relevant training to undertake this role.

At this inspection we found that a Legionella risk assessment had been carried out on 2/11/17. The building had been identified as Medium risk. The external company had advised the practice that they only need to monitor the water temperatures on a quarterly basis as they had low volume water heaters. The practice told us that they also had the cleaner run the taps on a regular basis and it was documented on the cleaning schedules in each room. We saw that the external company planned to commence quarterly monitoring of the water temperatures within the practice.

- At the inspection in October 2017 we found inconsistencies and gaps in the recruitment checks undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and appropriate checks through the Disclosure and Barring Service (DBS) were not available in all files. (These 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). Following that inspection two further members of staff had DBS certificates in place.

At this inspection we reviewed two staff files and found appropriate checks had been taken prior to their employment.

- At the inspection in October 2017 we found that clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. However the practice could not evidence that all the electrical equipment in the building had been checked. We found pieces of equipment that had last received an electrical check in 2008.

At this inspection we saw that PAT testing had been carried out in January 2018.

- At the inspection in October 2017 we found that the practice were unable to show us that they had a five year Electrical Installation Condition Report (EICR) in place. Following the inspection the practice sent evidence that an EICR report had taken place on 1 October 2016. In the summary of the report it was documented that the installation appeared to be satisfactory with recommendations for improvement. The practice did not provide any evidence that the recommendations had taken place.

At this inspection we saw the practice had an Electrical Installation Condition Report (EICR) in place. The remedial work recommended had been carried out on 26 February 2018.

See evidence table for more information.

Are services effective?

Effective needs assessment, care and treatment

At the inspection in October 2017 we found that the practice did not have a formal system in place to keep staff up to day with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Meeting minutes we looked at did not contain discussions on NICE guidance and from sample records we looked at we found that the practice did not monitor these guidelines.

At this inspection we found that a range of meetings had been held. Agendas were in place and discussions had taken place on SEA, complaints, Safety alerts, safeguarding, and one meeting had a discussion on NICE guidance. We acknowledged the improvements made to the meeting minutes but further work was required to capture the discussions held and learning shared'.

Effective staffing

At the inspection in October 2017 we found that the system in place to identify and monitor the

training needs of all staff was not effective. They were not able to demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes, asthma and COPD and no evidence of updates for dispensers once they had obtained their NVQ2 qualification. Following that inspection we were told that the practice nurse had supervision with the lead GP in which long term conditions were discussed and a plan was in place to ensure relevant training was provided'.

At this inspection we found that the practice nurse had kept records of the discussions and supervision with the lead GP but the records were not detailed and did not identify what areas had been covered in the supervision. The practice nurse had also attended training sessions on COPD and dementia since the last inspection.

- At the inspection in October 2017 we found that the system in place in relation to the identification and monitoring of the training needs of all staff were not effective. For example, safeguarding, fire safety, basic life support, infection control and information governance.

At this inspection we found a training matrix in place and all staff had completed 100% of the required e-learning training. We saw that the training matrix from April 2018 would include locum GPs and cleaner to ensure that records were kept and reminders to complete specific training would be sent when appropriate.

- In October 2017 we asked to see the GP locum induction pack and were told it was in the process of being updated.

At this inspection we saw evidence that the process for the recruitment and training of Locums had been reviewed. The policy had been reviewed but had not been fully updated. We also found that some mandatory training records were not available, for example, safeguarding training. Since the inspection the practice sent us evidence that they had now booked training for one locum GP and a further locum GP had advised the practice they had carried out the training but still needed to submit their certificate.

See evidence table for more information

Are services well-led?

At the comprehensive inspection in October 2017, we rated the practice as inadequate for providing well-led services as we found that arrangements to improve the quality and safety of services provided required significant improvements in oversight and monitoring of governance arrangements.

We issued a warning notice for Regulation 17 of the Health and Social Care Act 2008 in relation to Good Governance.

At this inspection we found that the practice had made improvements and had taken some of the appropriate steps required to ensure patients remained safe. However as the legal requirements of the warning notice for Regulation 17 had not been met in full the Care Quality Commission wrote to the lead GP and asked for further information on how they will meet these requirements.

Leadership capacity and capability

- At the inspection in October 2017 we found a lack of focus on the clinical leadership and the governance systems required which resulted in significant issues that threatened the delivery of safe and effective care which had not been identified or adequately managed.

At this inspection we found that the leadership and clinical oversight needed to be strengthened further to support the improvements required and the lead GP still needed to demonstrate strong leadership in respect of safety and good governance.

Vision and strategy

- At the inspection in October 2017 we found evidence that some meetings took place but these did not include all areas of practice governance, for example, significant events and complaints. Practice meetings had also taken place but these meetings did not have set agendas and minutes were limited. It was therefore difficult to identify what had taken place, what actions and learning had been shared and who was responsible for actions and a timeframe.

At this inspection we found that a range of meetings had been held. Agendas were in place and discussions had taken place on SEA, complaints, Safety alerts, safeguarding, and one meeting had a discussion on NICE guidance. We spoke with the management team as the minutes needed to have more detail added on the discussions held and learning shared.

Governance arrangements

At the inspection in October 2017 we found that overall leadership was not effective. We found a lack of accountable leadership and governance relating to the overall management of the service. Systems and processes in place were not established or operated effectively to ensure compliance with good governance. The practice was therefore unable to demonstrate strong leadership in respect of safety.

At this inspection we found:-

- The practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe in relation to patient safety alerts, dispensary, monitoring of the cold chain, infection prevention and control, training requirements of staff, fire safety, management of legionella, portable appliance testing, Electrical Installation Condition report and actions, information technology systems and the documentation of discussion and actions from meetings that had taken place. Further work was required to ensure meeting minutes were detailed to include the discussion and actions taken, fire alarm and emergency lighting is carried out monthly, practice nurse received clinical supervision which is clearly documented and dispensary and locum staff undertake training identified relevant to their role,
- The practice did not have an effective system in place for the management of high risk medicines which included regular monitoring in accordance with national guidance.
- The practice did not have an effective process in place for medicines reviews.
- We could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment.
- In October 2017 we found that the information technology system (IT) in place was not fit for purpose as staff were unable to retrieve documents from an external drive. This was referred to the South Lincolnshire Clinical Commissioning Group as a concern.

At this inspection we found that the practice had installed Intradoc which was a document management system where all relevant information could be stored and was

Are services well-led?

accessible to staff. The practice still had IT issues but we saw correspondence that the practice were in contact with external organisations to try and resolve the ongoing issues.

- At the inspection in October 2017 we had concerns in regard to the leadership capacity and clinical oversight of the practice.

At this inspection we still had concerns in regard to the leadership capacity and clinical oversight of the practice.

Appropriate and accurate information

Prior to the inspections taking place we received information of concern from various parties which included the appointment system, dispensing of medicines, training and induction, prescription stationary and unsummarised notes.

At the inspection we found:-

We found inconsistencies in the appointment system which included lack of documentation, changes to records made out of surgery hours. This information will be shared with the South Lincolnshire Clinical Commissioning Group and NHS England for them to make a decision on any further investigations and actions.

We looked at the dispensing of medicines to patients within 1.6Km of the practice. We were told by the practice that NHS England had contacted them in November 2017 and told them that patients who did not fit the criteria could not have medicines dispensed. We saw that the number of patients who had medicines dispensed had been significantly reduced since November 2017.

We looked at the training and induction provided by the practice. Concerns were raised in regard to lack of training and induction to the practice as part of the warning notice. There was now a training matrix in place and all staff had completed 100% of the required e-learning training. Staff meetings had taken place since the last inspection. Agendas were in place and an improvement was seen in the documentation of meeting minutes.

We looked at the process in place in regard to prescription stationary and found no issues on the day of the inspection.

We looked at the process the practice had in place for the summarisation of patient records. On the 19 April 2018 we found that the practice had a backlog of 28 sets of notes and did not have a process in place to ensure they were summarised in line with the practice policy. On the second day of the inspection we found that 23 sets of notes had been summarised by the lead GP and further sets of notes were still waiting to be received by the practice.

Whilst on the inspection we found an issue in relation to Information Governance where a member of staff had accessed their own patient record. We discussed this with the management team on the second day of the inspection and they have since completed a significant event. They have told us learning will take place and lessons have been learnt. We have shared this information with the South Lincolnshire CCG for them to discuss with the management team.

See evidence table for more information