Dr Rajesh Pandey

Quality Report

83 Priory Road
Hastings
East Sussex
TN34 3JJ
Tel: 01424 430800
Website: www.prioryroadsurgery.co.uk

Date of inspection visit: 6 April 2016
Date of publication: 17/08/2016

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
Are services effective?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused warning notice follow up inspection at Dr Rajesh Pandey on 6 April 2016 following an inspection on 8 December 2015 where the practice was rated as inadequate in safe and well-led and overall.

Our key findings across all the areas we inspected were as follows:

- There were improvements to the support staff received to enable them to fulfil the requirements of their role. For example mandatory staff training was in progress and annual appraisal and continuing professional development plans were in place. Staff with lead roles such as infection control had attended the relevant training to carry out this role.
- The GP had attended training in relation to joint injections although was not carrying these out at the time of our inspection. They had also developed protocols for obtaining consent and were planning to attend further training in records management to ensure continued improvements.
- The practice had made improvements to their recruitment policies and appropriate checks on staff had been undertaken. For example, all staff had received a disclosure and barring service (DBS) check and all clinical staff were checked to ensure their appropriate registrations were up to date.
- The practice had made improvements in relation to promoting cleanliness and hygiene and there were improved procedures in relation to infection control.
- Risk assessments had been carried out in relation to fire safety, infection control, control of substances hazardous to health (COSHH) and legionella. However, the practice had not yet carried out the recommended action following their legionella risk assessment.
- The practice had sourced appropriate emergency equipment for the practice including a defibrillator and oxygen. These were subject to appropriate regular check. The practice had also sourced basic life support training for all staff.
- The practice had improved their overall governance systems. For example regular staff meetings were being held where issues such as significant events and complaints were discussed. The practice had worked with external contractors and had sought expert advice in relation to improving fire safety, evacuation procedures and disability access within the practice.
- The practice was in the process of developing their patient participation group (PPG) and had their first meeting planned with four patients who had volunteered later in April.
- The practice had begun the process of clinical audit and had plans in place to develop these into full cycle audits over time.

Summary of findings

The areas where the provider must make improvements are:

- Ensure that action taken as a result of the legionella risk assessment is completed in a timely way.

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

In December 2015 the practice was rated as inadequate for providing safe services and we told them that improvements must be made. Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when things went wrong, lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, recruitment practices were not in line with best practice guidance, infection control processes were not in place, medicine management policies were not in place and medicines were not stored securely, areas of risk had not been identified and subsequently managed, equipment was not in place for medical emergencies and the practice did not have fire safety procedures (including drills, evacuation plan and training) in place. There was insufficient information to enable us to understand and be assured about safety because the practice did not have appropriate systems in place.

In April 2016 we saw that the practice had taken action to improve the areas identified as inadequate in our previous inspection. For example they had made improvements to the way significant events were managed and there was evidence that learning was leading to improvements in safety. Recruitment practices had improved and were in line with best practice guidance. Medicines management procedures were in place and medicines were stored securely and monitored appropriately. Equipment for use in medical emergencies had been sourced and improvements made to fire safety and infection control procedures. The practice had undertaken a legionella risk assessment; however they had not taken action to address the issues raised in the assessment.

Are services effective?

Requires improvement

In December 2015 practice was rated as requires improvement for providing effective services, as there were areas where improvements should be made. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Processes for recording consent were unclear and there was limited understanding within the practice about the Mental Capacity Act (2005) and how this impacted on decision making regarding patients who did not have capacity to consent. The GP had not attended training or updates relating to the administration of joint injections.

Summary of findings

In March 2016 we saw that the GP had attended training relating to the administration of joint injections and although they were not currently administering joint injections they had in place improved systems in relation to obtaining informed consent. The practice had begun the process of undertaking clinical audit and had plans in place to complete full cycle audits over time.

Are services well-led?

Inadequate

In December 2015 the practice was rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was a leadership structure in place with named members of staff in lead roles. However it was not clear how effective the structure was in terms of supporting safe care as staff had not always received up to date training for their lead roles and while staff felt listened to, changes were not always made in a way that valued the input of staff. The practice had a number of policies and procedures to govern activity, but many of these were over four years old and had not been reviewed since. The practice did not have a comprehensive or adequate approach to the management of risk. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG).

In March 2016 we saw that the practice had implemented structured staff meetings and were involving staff in planning for the future. Improvements had been made in relation to staff training and staff told us there was greater clarity about their roles. Policies and procedures were being developed and many of these had been established including fire safety, medicines management and recruitment policies. The practice had made improvements in relation to the management of risk, for example control of substances hazardous to health (COSHH), infection control and fire safety. The practice were working with identified patients to develop a PPG and had their first PPG meeting planned for the end of April 2016.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that action taken as a result of the legionella risk assessment is completed in a timely way

Dr Rajesh Pandey

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 8 December 2015 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Breaches of legal requirements were found and four warning notices were issued. As a result we undertook a focused inspection on 6 April 2016 to follow up on whether action had been taken in response to the warning notices issued.

Inadequate

Are services safe?

Our findings

During our inspection on 8 December 2015 we checked the emergency equipment kept in the practice and found that emergency equipment such as a defibrillator and oxygen cylinder were not kept on the premises. The provider had not carried out an assessment of risk relating to this lack of emergency equipment.

When we returned on 6 April 2016 we found that oxygen and a defibrillator were stored on the premises. The emergency equipment was stored appropriately, subject to regular checks and appropriate training for staff had been organised in relation to its use.

During our inspection on 8 December 2015 we found that an examination couch was too high for patients to climb onto without the use of a step and assistance and there was no recorded risk assessment relating to this.

When we returned on 6 April 2016 we found that the examination couch had been replaced with one that was height adjustable and appropriate for use.

During our inspection on 8 December 2015 we found that policies and procedures were not in place relating to the safe management of medicines, including procedures for maintaining the cold chain of vaccines. We also found that the vaccine fridge was kept in a hallway between the patient waiting area and the nurses' treatment room and was unlocked.

When we returned on 6 April 2016 we found that a cold chain policy had been adopted by the practice in March 2016. We also found that the vaccine fridge had been moved from a public place within the practice into the nurse's treatment room and that the fridge was kept locked.

During our inspection on 8 December 2015 we found that there was no system in place for checks relating to certain high risk medicines, such as disease-modifying anti-rheumatic drugs as there was no system in place to safety check whether patients had received relevant blood tests and checks.

When we returned on 6 April 2016 we found that the practice had adopted a system where blood results were monitored and where if bloods had not been carried out this would be flagged on the patient record system so that patients would be recalled for the test. Repeat prescriptions were only issued where the relevant tests had been carried out and appropriate monitoring had taken place.

During our inspection on 8 December 2015 we found that the infection control policy within the practice had not been updated since 2011 despite there being a clear review date of 2013 recorded.

When we returned on 6 April 2016 we found that the practice had contacted the Clinical Commissioning Group (CCG) as the policy/guidance they used had been issued by the CCG. We saw communication between the practice nurse and the CCG where they had requested a more up to date version and drawn attention to the fact that the one issued was out of date.

During our inspection on 8 December we found that there had been no completed infection control audit carried out since 2012 and no evidence of action having been taken as a result of this audit. We also found that there was no cleaning schedule, there was visible dust and clutter and there were no records of infection control training for staff having been carried out and that the lead for infection control had yet to have appropriate training for this role.

When we returned on 6 April 2016 we found that an infection control audit had been carried out in February 2016 and that action had been taken as a result. For example, gloves and sanitisers had been placed in the reception area, cleaning schedules had been adopted and an infection control policy had been adopted. The practice had worked to reduce clutter and there was no dust visible during the inspection. The practice nurse who was the infection control lead and the practice manager had both attended training in infection control. The practice nurse had signed up to attend CCG led infection control champion meetings.

During our inspection on 8 December 2015 we found that there were no records of a legionella risk assessment having been carried out.

When we returned on 6 April 2016 we found that a legionella risk assessment had been carried out in January 2016. However, there were action points identified as a result of the risk assessment which the practice had not yet carried out.

Inadequate

Are services safe?

During our inspection on 8 December 2015 we found that there was no control of substances hazardous to health (COSHH) procedure in place, no risk assessment relating to this and no data sheets relating to the products used in the practice.

When we returned on 6 April 2016 we found that the practice had undertaken an inventory of hazardous substances and carried out a subsequent risk assessment. There were appropriate data sheets in place with clear instructions on what action to take should contact with a substance take place. All cleaning substances used within the practice were now kept in a locked cupboard and staff had received instruction in the safe use and storage of these substances.

During our inspection on 8 December 2015 we found that action in response to significant events was insufficient and there was little evidence of incidents being fully explored or having influenced change in practice. The practice had not held regular meetings where significant events were discussed and could not evidence that they were identifying and responding to trends or themes.

When we returned on 6 April 2016 we viewed records relating to significant events and found the practice was maintaining a central log of incidents that included the learning as a result. For example, we viewed an incident relating to a child receiving an incorrect immunisation. We saw that advice had been sought and that the system of accessing vaccines had been reviewed and resultant checks had been reviewed to reduce the risk of a repeat incident. We saw evidence of this incident being discussed at a staff meeting.

During our inspection on 8 December 2015 we found that the practice did not have in place a fire safety policy or risk assessment. The practice had failed to implement an evacuation procedure, fire training for staff or regular fire drills. The practice had failed to undertake a disability access assessment or consider this in relation to fire safety and evacuation. For example, the only fire exit from the building had steps down to ground level.

When we returned on 6 April 2016 we found that the practice had developed a fire safety policy in March 2016. This included a detailed procedure of what staff had to do and an assembly point had been identified. A fire risk assessment had been carried out by an external contractor and the practice had received advice from East Sussex Fire and Rescue on their fire evacuation procedures. A fire alarm had been installed and was subject to weekly checks and we viewed records of these. Fire training had been organised for staff and instructions had been given to all staff of action to take in the event of a fire following the advice given to the practice. A fire drill had been carried out and as a result staff had been reminded to keep all exits clear. Specific action had been taken following a disability access assessment including a reduction in the depth of the steps at the back exit of the building and widening of the ramp at the front.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

During our inspection on 8 December 2015 we found that there was little evidence that information about the proposed care and treatment was provided in a way that informed the person about the risks, complications and any alternatives. In addition we found that informed consent was not recorded where procedures such as joint injections had been carried out. The GP also could not recall having attended training in relation to joint injection procedures that they were carrying out and there was no record of training relating to this held at the practice.

When we returned on 6 April 2016 was saw that the GP had attended relevant training on joint injections in March 2016. The GP informed us they were currently not undertaking joint injections as he was working as part of a performance development plan to improve areas of record keeping. We viewed a proforma that the GP was intending to use in the future that provided a guide on obtaining appropriate consent.

Are services well-led?

Inadequate

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

Our findings

During our inspection on 8 December 2015 we found that there was no evidence of full cycle clinical audits or an annual audit plan.

When we returned on 6 April 2016 we saw that the GP had begun to address the area of clinical audit as part of their process of appraisal. As a result clinical audits had begun on the use of diuretics (a medicine used for patients who are retaining fluid) and the use of inhaled corticosteroids (medicines used to treat asthma).

During our inspection on 8 December we found there was a lack of regularity in relation to practice meetings, minimal meeting minutes and poor action planning.

When we returned on 6 April 2016 we saw that regular monthly meetings were carried out and that minutes were recorded. We saw that discussions included significant events and complaints as part of a standing agenda. We saw that staff were involved in discussions about future planning and that actions were clearly recorded. Staff we spoke with during our inspection told us they felt that things were improving within the practice and they felt more involved.

During our inspection on 8 December 2015 we found that patient records were not maintained securely as they were stored on the floor in an unlocked room.

When we returned on 6 April 2016 we found that patient records were stored securely in a locked cabinet.

During our inspection on 8 December 2015 we found that the practice had failed to obtain references for three members of staff, including a locum GP and nurse prior to employment. They did not have a consistent process in place to check the identity of staff or to ensure that those requiring it had received a disclosure and barring service (DBS) check. They had also failed to check the NMC (Nursing and Midwifery Council) registration of one staff member prior to them commencing in post and there was no evidence of employment history or medical defence cover for a locum who had worked at the practice.

When we returned on 6 April 2016 we found that a recruitment policy had been adopted by the practice in March 2016. There was a new recruit welcome pack and induction checklist in place. We viewed the records of one new member of staff and found that all appropriate pre-employment checks had been carried out. In addition we found that all staff had received a DBS check. The registration of all clinical staff had also been checked, as well as medical defence cover of clinical staff including locums. The GP and practice manager told us they had requested photo identification for a locum nurse working in the practice but were still waiting for this. They told us they were not intending to use locum staff until the appropriate checks were in place.

During our inspection on 8 December 2015 we found that the practice did not have a patient participation group (PPG) in place and had not acted on the results of the national GP patient survey that showed a lower than average score in terms of GP consultations.

When we returned on 6 April 2016 we found that the practice had identified four patients who were willing to help them set up their Patient Participation Group (PPG). They had also been granted an affiliation certificate from the National Association of Patient Participation. We saw that an initial PPG meeting was arranged for later in April and were told that the PPG would support the practice in reviewing patient feedback in the future.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that while the registered provider had ensured that a legionella risk assessment had been carried out they had not ensured that the appropriate recommended actions had been carried out as a result. This was in breach of regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.