New Invention Health Centre

Quality Report

New Invention Health Centre
66 Cannock Road
Willenhall
West Midlands
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Tel: 01922 475100
Website:

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Inadequate**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at New Invention Health Centre on 23 October 2014. We found the practice was in breach of legal requirements.The breaches related to:

- Regulation 10 Health & Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision,
- Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises,
- Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
- Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers.

Following the inspection the practice wrote to us to say what they would do to meet the legal requirements.

We undertook this focused inspection on 9 December 2015 to check that they had followed their plan and to confirm that they now met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for New Invention Centre on our website at www.cqc.org.uk

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. These were discussed at staff meetings however, team meetings were infrequent.
- Systems were in place for the safe handling of medication and vaccines.
- The levelsof the oxygen cylinder were checked on a regular basis, however the oxygen cylinder was out of date.
- We found the prescriptions were being stored securely in a lockable cupboard which was not accessible to the public.
- Fire alarm system and alarm points had been installed at the practice and the fire alarm was tested weekly.
- No Health & Safety risk assessments or environmental risk assessments had been carried out.

Summary of findings

- No audit had been completed for the Equality Act 2010.
- Cleaning schedules were unavailable to confirm that cleaning had taken place consistently.
- Staff training log was available which documented clinical staff had completed level three safeguarding children training.

There were areas of practice where the provider needs to make improvements.

The provider must:

- The provider must comply with Patient Safety Alerts, recalls and rapid response reports issued from the and through the Central Alerting System (CAS).
- Staff who are required to undertake chaperone duties must understand their responsibilities and be supported to follow best practice guidance.
- Develop robust system to monitor and maintain standards of cleanliness within the general environment and take action to address identified concerns with infection prevention and control within the practice. Implement systems to assess, monitor and mitigate the risks relating to the health, safety and welfare for example acting on actions identified in infection control audits

  The provider must ensure that the premises are safe to use for their intended purpose and meet the requirements of the Equality Act 2010.
- Ensure recruitment arrangements include the necessary employment checks for all staff.

There were areas of practice where the provider should make improvements:

- Organise regular team meetings to discuss significant events and share learning.

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

The practice is rated as inadequate for providing safe.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, meetings to communicate and support improvements were infrequent.
- Systems were in place to check and monitor emergency medicines and oxygen, but the system was not robust as there was out of date equipment.
- Safety alerts were reviewed by staff, but there is no mechanism in place to ensure that relevant information was discussed and actioned appropriately
- There was no evidence of cleaning schedules being in place and regular checks being carried out. The latest infection control audit showed a decrease in the cleanliness of the clinical environment by 9%; no action plan was present
- Health & Safety and Environmental audits had not been done including an Equality Act 2010 audit.
- Staff are asked to act as chaperones but they have had no formal training and were unaware of the correct procedures to follow.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The provider must comply with Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare Products Regulatory Agency (MHRA)and through the Central Alerting System (CAS).
- Staff who are required to undertake chaperone duties must understand their responsibilities and be supported to follow best practice guidance.
- Develop robust system to monitor and maintain standards of cleanliness within the general environment and take action to address identified concerns with infection prevention and control within the practice.
- Implement systems to assess, monitor and mitigate the risks relating to the health, safety and welfare for example acting on actions identified in infection control audits.
- The provider must ensure that the premises are safe to use for their intended purpose and meet the requirements of the Equality Act 2010.
- Ensure recruitment arrangements include the necessary employment checks for all staff.

Action the service SHOULD take to improve

- Organise regular team meetings to discuss significant events and share learning.

New Invention Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included CQC Inspection Manager.

Background to New Invention Health Centre

Dr Sinha, Rischie, Sinha, Shanker practice are the registered provider for New Invention Health Centre. They are registered for primary medical services with the Care Quality Commission (CQC) and have two registered locations (practices). They are 'Pleck Health Centre' and more recently New Invention Health Centre.

This inspection focused on New Invention Health Centre, 66 Cannock Road, Willenhall, West Midlands WV12 5RZ. The practice is based inside a converted house. The registered patient list size is approximately 6300 patients.

The practice is open Mondays, Tuesdays, Wednesdays and Fridays 8:30am to 6:30pm although it is closed between 1-2pm during these days. The practice is also closed alternate Tuesdays from 1200pm until 2pm and every Thursday from 1pm. There is extended opening hours on Mondays

from 6pm to 8.15pm. During the period of time when the practice is closed in normal working hours the practice subcontracts GP access for patients through a local GP provider. The practice has also opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours service contracted by the CCG.

There are four GPs working at the practice (two male and two female). Two of the GPs work as locum GPs on a regular basis Mondays to Fridays and the other two GPs are partners at the practice and also work at Pleck Health Centre. A locum GP is employed on a sessional basis

covering for any absences. The practice employs a nurse practitioner (female), a practice nurse (female) and a health care assistant (female) who also undertakes phlebotomy (the taking of blood). There are also eight administrative staff and an assistant practice manager. There is a practice manager who covers both practices although she is predominantly based at 'Pleck Health Centre.'

The practice has a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care.

We had previously inspected the practice in October 2014 where we found that aspects of the premises were not safe or suitable for the purpose of carrying on regulated activity. This focused inspection was based on the registration of the current providers who are the only providers delivering regulated activity at the location New Invention Health Centre. We found that the there are still aspects of the premises that are not safe or suitable and certain actions from the action plan that had been submitted after the comprehensive inspection in 2014 had not been completed.

Inadequate

Are services safe?

Our findings

Safe track record

The current providers Dr Sinha, Rischie and Shanker had taken over the practice in April 2014 as part of a 'care taking' arrangement with NHS England.

The practice had in place a system for reporting and recording significant events and the staff told us they were encouraged to inform the practice manager of any incidents. Meetings were scheduled to be held every three months to discuss events and incidents and compile an action plan, however we did see evidence that the last meeting was in June 2015 and the next one was scheduled for December 2015.

Staff told us that safety alerts were printed out by the practice manager and circulated amongst the staff who signed them once seen. However there was no evidence that these alerts were acted upon or any system in place to ensure that anything relevant was discussed and actioned appropriately.

Learning and improvement from safety incidents

During this inspection we found that although all staff did attend meetings where significant events were discussed, the meetings were infrequent and there was no formal process to share learning from incidents. The practice were unable to demonstrate how plans were created and actioned and how outcomes were improved.

Reliable safety systems and processes including safeguarding

During the inspection we spoke with staff who were aware of the safeguarding policies and knew how to access them. There was a log of staff training and we looked at a sample of staff files and saw training certificates that demonstrated they had completed the relevant training. Clinical staff had completed safeguarding children training to a level relevant to their role.

The practice manager informed us that all staff acted as chaperones. The practice had a chaperone policy in place, but this did not detail the requirements of the role. In the absence of training the practice was unable to demonstrate that all staff had the necessary knowledge and understanding to undertake this role.There were posters displayed informing patients that they could have a chaperone if they wished, however staff who we spoke with were unaware of where they should stand when examinations were taking place. At the comprehensive inspection in October 2014 we were told that the practice was in the process of arranging training, however the staff still have not received this.

Medicines Management

There was evidence that regular checks of the fridge temperatures were undertaken and recorded to provide assurance that vaccines and patient samples were stored within the correct temperature ranges. At our previous inspecion in October, the practice had no system in place to monitor the temperature, however this has now been rectified and a thermometer was in place and regular readings were recorded.

Checks were in place for checking emergency medicines and equipment. However these were not robust as we identified out of date equipment, for example an oxygen cylinder. Since the inspection the provider has confirmed that the procedure for checking equipment has been amended and new equipment obtained.

Cleanliness and infection control

During this inspection we saw two infection control audits which had been completed by Walsall Healthcare NHS trust. The audits stated that the poor environment made maintaining the required standards difficult in the practice.

The audit carried out in March 2014 had highlighted some aspects of infection control that needed to be addressed. At the last audit in May 2015 there were still visible signs that the actions from the audit had not been rectified.The practice employed a cleaner to carry out daily cleaning duties, but there were no cleaning schedules available to ensure cleaning standards for the general environment and medical equipment were monitored and maintained consistently. The assistant practice manager informed us that spot checks were not carried out and the effectiveness of the cleaning was not monitored.

We saw that some areas of the environment were not visibly clean and needed further attention.

The carpets and sinks at the practice were identified in the audit as being a concern, but no risk assessment had been completed to address the concern or to mitigate any risks. The Infection Control lead for the practice informed us that

they had completed training in 2013, however there was no record of training available for staff and no evidence of training being completed within the staff files that we reviewed.

A legionella risk assessment completed in May 2014 had showed that there were 38 priority areas at the practice.A contract was in place to address and manage the risk of legionella. We saw evidence of weekly water hygiene taking place by weekly flushes and temperature checks.

Equipment

During this inspection we saw that emergency medicines and equipment such as the defibrillator were in date and regular checks were undertaken to ensure they were safe and effective to use in a medical emergency. Neveretheless, we did find out of date hypodermic needles and skin cleansing swabs on site. We also found that the oxygen cylinder was out of date, even though regular checks on the oxygen levels were carried out. Since the inspection the provider has confirmed that the procedure for checking equipment has been amended and new equipment obtained.

Staffing and recruitment

At this inspection we looked at the recruitment records of four of the staff employed at the practice.We found that a Disclosure and Barring Service (DBS) check had been completed for both clinical and non-clinical staff. The Disclosure and Barring Service (DBS) check helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. We did however find that there were gaps in the recruitment arrangements, for example lack of references for a clinical member of the team.

Monitoring safety and responding to risk

Staff spoken with were aware of their role in responding to a medical emergency and knew the location of the emergency medicines and equipment. Non clinical staff had received training in children and adult safeguarding.

We saw that fire extinguishers had been checked to ensure they were in a good working order, except one which was significantly out of date.

A fire risk assessment completed in September 2014 identified a number of actions. This included a fire warning system which had been put in place. There was also a recommendation for the gas hob to be removed,but this has not been done. There were no assessments or checks in place for gas in the property. Since the inspection the provider has confirmed that action has been taken to address this and a copy of the gas safety record has been received which states that the gas hob has been disconnected.

No review of the fire risk assessment had been made and there was no evidence to show that all identified actions had been reviewed and completed. We also found that there was no evidence that regular fire drills were taking place. Staff have not received fire training, but the staff we spoke with on the day of the inspection were aware of the fire procedures and the actions to take in the event of a fire.

There was no Health & Safety risk assessments carried out and no environmental risk assessment had been completed. This included checks on oxygen cylinder, gas certificate.

The practice was based inside a converted house and the premises was in need of refurbishment.During the previous inspection in October 2014 there was no evidence that an Equality Act 2010 audit had been completed. During this inspection we found that this was still outstanding.This act ensures providers of services do not treat disabled people less favourably and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service.

Arrangements to deal with emergencies and major incidents

The practice manager had a business continuity plan in place. This covered a wide range of areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. 12 (2)(b) doing all that is reasonably practicable to mitigate any such risks The practice does not comply due to the following; No health & safety risk assessments Practice has limited procedures in place to act on patient safety alerts which did not demonstrate that risks to patients had been considered and appropriate action taken

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. 18 (2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform The provider does not meet this regulation due to: Staff had not received the appropriate training for chaperoning duties and were unaware of the procedures to follow.

This section is primarily information for the provider

Enforcement actions

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **You are failing to comply with Regulation 9 (1)(a)(b)(c) (3) (b) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states:** **Person-centred care** 9 – (1) The care and treatment of service users must – (a) Be appropriate (b) Meet their needs, and (c) Reflect their preferences (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met (h) making reasonable adjustments to enable the service user to receive their care or treatment Why you are failing to comply with this regulation: During our inspection of 9 December 2015 we found that there was no evidence that an Equality Act 2010 audit had been completed. This act ensures providers of services do not treat disabled people less favourably and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

You are failing to comply with Regulation 17 (1) (2) (a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states:

Good Governance

17 – (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –

(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Why you are failing to comply with this regulation:

1. We found that you are not ensuring compliance with the requirements as you have no system in place to monitor the effectiveness of the cleaning at the practice and no records of a cleaning schedule.
2. The carpets and sinks at the practice were identified in your latest infection control audit of May 2015 as being a concern, but no risk assessments had been completed and no action had been taken to address these concerns.
3. An infection control audit you carried out in March 2014 had highlighted some aspects of infection control that needed to be addressed. At the last audit

This section is primarily information for the provider

Enforcement actions

in May 2015 there were still visible signs that the actions from the audit had not been rectified. The audit showed a decrease in the cleanliness of the clinical environment by 9%