

Dr Kaushal Kishore Misra

Quality Report

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Date of inspection visit: 15 September 2015

Website: <http://www.drmisra-boroughmedicalcentre.co.uk/> Date of publication: 22/10/2015

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		Good	
Are services safe?		Good	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the practice on 14 April 2015. Breaches of legal requirements were found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breaches of regulation 12(2)(b)(c)(d)(g)(h) and regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focussed inspection on 15 September 2015 to check that they had followed their plan and to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements and also where additional improvements have been made following the initial inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Dr Kaushal Kishore Misra on our website at www.cqc.org.uk.

Overall the practice is rated as Good. Specifically, following the focussed inspection we found the practice to be good for providing safe services and well led services. As the practice was now found to be providing good services for safe and well-led, this affected the

ratings for the population groups we inspect against. Therefore, it was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those for medicines management, staffing, health and safety, infection control and responding to emergencies.
- The practice had a number of updated policies and procedures to govern activity.
- The practice held regular staff and governance meetings.
- All staff had received updated mandatory training for basic life support and fire safety.

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 practice is rated as good for providing safe services. Lessons were learned and communicated widely to support improvement. Improvements had been made in how information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and managed, including those for medicines management, staffing, health and safety, infection control and responding to emergencies.

Good



Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure in place. The practice had a number of policies and procedures to govern activity which had been updated. Governance systems were in place to monitor staffing, training and to identify and manage risks. Staff had received regular mandatory training and attended staff meetings. Strategies were in place to improve communications and governance of shared responsibilities between the two practices in the premises.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people. As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). As the practice was now found to be providing good services for safe and well-led, this affected the ratings for the population groups we inspect against.

Good



Dr Kaushal Kishore Misra

Detailed findings

Why we carried out this inspection

We undertook a focussed desk-based inspection of Dr Kaushal Kishore Misra on 15 September 2015. This is because the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008. From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, breaches of regulation 12(2)(b)(c)(d)(g)(h) Safe Care and Treatment and regulation 17(2)(b) Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

We found that the practice had not completed a recent infection control audit, so had not identified areas of weakness, such as furniture not being cleaned appropriately, inconsistent cleaning documentation and risks related to the disposal of sharps. We also found the practice did not have appropriate emergency arrangements including updated basic life support training for non-clinical staff, an updated fire risk assessment and

most staff had not received fire training. The monitoring of medicines was not robust. Recruitment processes were not assured; as the practice evidence of up to date professional registration for a new member of staff.

We found that the systems and processes did not enable effective assessment, monitoring and mitigation of risks. There was a leadership structure for some responsibilities, but there was no practice lead for health and safety and fire. This resulted in risks not always being identified. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and not all policies were followed.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 14 April 2015 had been made. We inspected the practice against two of the five questions we ask about services: is the service safe and well-led. We inspected the practice against all six of the population groups: older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia). This was because any changes in the rating for safe as well-led would affect the rating for all the population groups we inspected against.

Are services safe?

Our findings

Safe track record and learning

The practice had implemented a clear system for logging safety alerts, including those related to patient safety, medicines and estates and facilities. We were shown the alert record, which detailed actions and dates for completion and provided a track record of all alerts received into the practice for the last eight months.

Significant events were shared with all staff during the three monthly staff meeting and all staff had been made aware of the practice's incident reporting policy. We saw staff meeting minutes which confirmed this.

Reliable safety systems and processes including safeguarding

There was a chaperone policy in place which had been updated in June 2015 and this contained comprehensive information about the role. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) One reception staff member who acted as a chaperone had received an updated criminal records check through the Disclosure and Barring Service (DBS), dated April 2015 and we were shown evidence of this. The practice had implemented a system whereby staff who were chaperoning were to be DBS checked every three years, so assurances of working with vulnerable adults and children could be maintained. All non-clinical staff who were chaperoning had received criminal records checks in line with the practice policy.

All clinical and non-clinical staff had received training in safeguarding adults.

Medicines management

Processes were in place to check medicines were within their expiry date and suitable for use. The practice reported that medicines kept in the fridge were audited on a monthly basis and we saw evidence from a recent infection control audit that these checks had occurred.

Expired and unwanted medicines were disposed of in line with waste regulations. Since the previous inspection, we were provided with evidence that the practice obtained a sharps container specifically for disposal of a hormone injection that requires disposal in line with cytotoxic and

cytostatic sharps disposal guidance. Disposal of these sharps in the neighbouring pharmacy was therefore no longer required. The practice had updated their clinical waste protocol in April 2015 to include the new systems in place for safe disposal of sharps.

Cleanliness and infection control

The practice completed a detailed infection control audit in June 2015 with the clinical commissioning group (CCG) infection control lead. A number of actions had been identified from this audit, and the practice were in the process of implementing these. The infection control audit actions required joint working with another practice who shared the same premises. The practice had implemented an identified action to monitor cleaning in the practice, which was recorded in a staff checking log book on a weekly basis. The infection control audit also identified the need for replacing the fabric covered chairs in the patient waiting areas. During the comprehensive inspection, concerns were also identified regarding the lack of processes in place to ensure adequate cleaning of this furniture. Since the inspection improvements were made as the practice had arranged for their cleaning company to ensure monthly steam cleaning of the waiting room and staff office chairs. We were provided with evidence to demonstrate that both these actions had been carried out.

The practice had a policy for the control of substances hazardous to health (COSHH), which stated clear responsibilities for the practice to identify which substances were used and how they were handled and stored. The practice provided evidence that they had followed this policy by ensuring a COSHH register was available in the practice, detailing all COSHH products used.

An infection control policy and supporting procedures were available and had been updated in April 2015 with key contact numbers and the monitoring and audit processes for infection control in the practice.

Staffing and recruitment

The practice had implemented a new log system to easily view when criminal records checks through the Disclosure and Barring Service (DBS) and professional registration updates were due. The practice had obtained assurances of up to date professional registration with the appropriate

Are services safe?

professional body for one clinical staff member, which had previously not been recorded. All practice staff were to receive updated DBS checks every three years and all staff who required an updated DBS check had received one.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, and these had been regularly updated. The practice had completed a health and safety and fire risk assessment using an external company, in June 2015. Only low risks had been identified. The practice had implemented a new log system to easily view when risks assessments and equipment checks were due.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received updated training in basic life support. Although basic life support training is required to be updated annually;

non-clinical staff had received training every three years and clinical staff had received basic life support training which was updated every 18 months following guidance from the local Clinical Commissioning Group (CCG).

Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. The practice had implemented a thorough emergency medicines log system where checks were completed every three months. The practice recorded expiry dates, date of the check and comments to provide a clear record of emergency medicines checks over time.

The practice had carried out a fire risk assessment through an external contractor in June 2015. Training records showed that all non-clinical staff had received updated fire safety training and the practice manager had received fire marshal training. Clinical staff had completed online fire safety training and the practice advised they were to attend face to face training in the next few months. We were told that clinical staff were always on duty with staff who had received fire safety training, in the event that any incident should occur.

Are services well-led?

Good 

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

Our findings

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Policies such as that for chaperoning, infection control and clinical waste had been updated in June 2015 with new information relevant to the practice, and all these policies included detail about the frequency that they were to be reviewed. We were shown staff meeting minutes where updated policies had been discussed and action points were listed for staff to sign a form that they had read these.

The practice had implemented a clear leadership structure. The practice manager was identified as the health and safety lead and fire marshal with evidence of training to enable them to carry out these roles.

The practice had improved arrangements for identifying, recording and managing risks. Risks including those related to infection control, significant incidents and medicines alerts were discussed in team meetings. The health and safety and fire risk assessments had been updated and an infection control audit had been completed. The practice

had implemented a clear system for the recording and monitoring of safety alerts. A record and schedule of risk assessments and audits had been implemented to allow the practice to monitor when updates were required.

We noted there had previously been a lack of defined responsibilities between the two practices that operated in the same premises but changes had been made. The practice manager had arranged regular meetings with the other practice to improve communications and governance over shared responsibilities, such as cleaning and infection control, buildings and environmental risk assessments.

Management lead through learning and improvement

The practice demonstrated that the three monthly staff meetings included learning and improvement, training requirements, risks and incidents.

We identified from reviewing training records, that the practice had improved systems for ensuring staff were provided with updated mandatory training and all staff had completed the required updates including basic life support and fire training. The practice had also ensured that staff had received training in safeguarding adults.