Dr KM Al-Kaisy Practice

Quality Report

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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

Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr KM Al-Kaisy's Practice on 17 May 2016. The overall rating for the practice was requires improvement. The full comprehensive report on 17 May 2016 inspection can be found by selecting the 'all reports' link for Dr KM Al-Kaisy Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 15 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 17 May 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

At our previous inspection on 17 May 2016, we rated the practice as requires improvement for providing safe and effective services. Most systems and processes for monitoring and mitigating risks to patients had improved, but some had gaps such as recruitment checks, fire safety and not all staff who acted as chaperones had a Disclosure and Barring Service (DBS) check. In addition, the practice told us that not all verbal concerns were recorded. At this inspection we found that some of these issues had been addressed, however we found that risks to patients were still not managed effectively in relation to recruitment arrangements, staff training and fire safety. The practice is still rated as requires improvement for providing safe and effective services.

Our key findings were as follows:

- We found that not all staff had completed basic life support (BLS) training as per Resuscitation council guidelines.
- Clinical audits now demonstrated quality improvement.
- All practice procedures and guidance we checked had been recently updated and specific to the practice, for example, the practice had reviewed the Business Continuity Plan in March 2017.
- Appointments with a female GP would be available from May 2017.
- All staff had now completed fire and infection control training.
- The practice did not have an up to date fire risk assessment, however we saw evidence which confirmed that this had been booked to take place in May 2017.

Summary of findings

- The practice had not risk assessed staff needing a DBS check to carry out chaperoning duties andwe did not see evidence that pre-employment checks had been completed on staff specific to schedule three regulation.
- The complaints system and processes had been reviewed and the practice told us that verbal complaints were reviewed and discussed during monthly meetings. However, the evidence we reviewed did not confirm this was ongoing, for example, the practice could not provide us with minutes of meeting where these had been discussed for months January through to March 2017.
- Not all staff who acted as chaperones had been DBS checked. The practice had not followed up with the agency when disclosures were not received.
- Staff appraisals had lapsed for all staff members; the practice manager told us that staff appraisals were postponed due to internal employee relation issues. All appraisals were scheduled to take place between May 2017 and July 2017.

The areas where the provider must make improvement are:

- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure effective systems to assess monitor and mitigate risks to patients such as fire risk assessment and DBS checks.

The areas where the provider should make improvements are:

- Ensure the systems in place to identify the learning needs of staff are current, for example, staff appraisals.
- Review the induction programme to include topics such as safeguarding and information governance.
- Ensure mandatory training namely basic life support is completed in a timely manner and according to current guidelines.
- Strengthen the current system in place so as to ensure that verbal concerns are reviewed and discussed in accordance with practice policy.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- Most systems, processes and practices were in place to keep patients safe and safeguarded from abuse, however, personnel files we sampled demonstrated that the provider had not sought to conduct the necessary pre-employment checks.
- The systems and processes for assessing, monitoring and mitigating risks to patients had improved, but there were gaps in relation to fire safety; and the practice had not risk assessed the risks for not having a Disclosure and Barring Service (DBS) check for non- clinical staff who acted as chaperones.
- The practice had some arrangements to respond to emergencies, however not all staff had received refresher annual basic life support training.

Are services effective?

Requires improvement

The practice is still rated as requires improvement for providing effective services.

- The practice had implemented a training matrix system to monitor training for all clinical and non-clinical staff.
- The induction programme covered topics such as infection prevention and control, fire safety and health and safety; however other topics such as information governance and safeguarding were not covered.
- Clinical audits now demonstrated quality improvement.
- Staff had not received annual appraisals. The practice showed us that these had been scheduled to take place between May and July 2017.

Dr KM Al-Kaisy Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Dr KM Al-Kaisy Practice

Dr Al-Kaisy's Practice provides primary medical services to approximately 4750 patients. The practice is in a purpose built building located in a residential area of Dagenham and is commissioned by Barking and Dagenham Clinical Commissioning Group (CCG). The practice holds a General Medical Services (GMS) contract with NHS England. The practice is registered with the Care Quality Commission as a partnership to provide the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and family planning. The practice runs a number of services for its own patients and patients registered in other practices within the same CCG including family planning services and the practice is a Yellow Fever Centre.

The practice has two male GP partners providing 14 GP sessions a week. The practice employs two part time female nurses providing seven nursing session per week and a part-time healthcare assistant. The clinical team are supported by a practice manager, assistant practice manager and five administration staff. The practice is open between 8.00am and 6.30pm Monday to Friday and 9am to 12pm on Saturday with the exception of Thursday when the practice is closed from 1.30pm. Nurse appointments are available during the week and on Saturday between 9.00am and 12 noon. In addition to pre bookable appointments that can be booked up to four weeks in advance, urgent appointments and telephone consultations are also available for people that need them on the day. Out of Hours service are delivered by a different provider, which could be accessed by calling the surgery telephone number.

Information taken from the Public Health England practice age distribution shows the population distribution of the practice is similar to that of other practices in CCG. The life expectancy of male patients is 76 years, which is lower than the CCG average of 77 years and the national average of 79 years. The female life expectancy at the practice was 81 years, which is the same as the CCG average and lower than national average of 83 years. Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

The practice was previously inspected under the Care Quality Commission's current inspection regime.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr KM Al-Kaisy's Practice on 17 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated requires improvement. The full comprehensive report following the inspection on 17 May 2016 can be found by selecting the 'all reports' link for Dr KM Al-Kaisy's Practice on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up announced focused inspection of Dr KM Al-Kaisy's Practice on 15 May 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew including the local CCG. We carried out an announced visit on 15 May 2017.

During our visit we:

- Spoke with a range of staff including two GPs, practice manager and assistant practice manager.
- Reviewed policies, protocols and procedures.
- Sampled five employee personal records
- Looked at information the practice used to deliver care and treatment plans.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 17 May 2016, we rated the practice as requires improvement for providing safe services. Requirement notices were issued as it was found that the practice had breached Regulation 12 HSCA (RA) Regulations 2014, Regulation 18 HSCA (RA) Regulations 2014 and Regulation 19 HSCA (RA) Regulations 2014. The practice did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients. For example, the practice had not carried out a fire risk assessment and staff had not received mandatory training such as safeguarding. In addition, the practice had not risk assessed staff needing a DBS check to carry out chaperoning duties and we did not see evidence that pre-employment checks had been completed on staff specific to schedule three.

Some of these concerns had been addressed when we undertook a follow up inspection on 15 May 2017; however improvements were needed in relation to pre-employment checks, DBS checks and mandatory training namely basic life support. The practice is still rated as requires improvement for providing safe and effective services.

Overview of safety systems and process

Most systems, processes and practices were in place to keep patients safe and safeguarded from abuse, but we found there were shortcomings which needed to be strengthened:

- Non-clinical staff had now received safeguarding training relevant to their role.
- Non-clinical staff who acted as chaperones had received formal training for the role. However, we found that applications made to the Disclosure and Barring Service (DBS) in August 2016 for three members of staff including the practice manager had not been followed up with the organisation when they did not receive certificates. Following the inspection, the practice told us that the checks were terminated due to application errors. The practice manager told us new applications had been submitted. (DBS 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).
- We saw that the practice had reviewed its induction programme to now include infection control training and all staff had received up to date training.
- Personnel files we sampled demonstrated that the provider had not sought to conduct the necessary pre-employment checks. For example, there were no records of: proof of identification, references, qualifications, registration with the appropriate professional body and there were no records of the appropriate checks through the Disclosure and Barring Service for some staff.

Monitoring risks to patients

Most risks to patients were assessed or well managed.

- The practice did not have an up to date fire risk assessment, however we saw evidence which confirmed that this had been booked to take place in May 2017. There were designated fire marshals within the practice who had received appropriate training. All other staff had completed fire safety training and the practice kept records which demonstrated fire alarms were tested weekly.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements to respond to emergencies and major incidents.

- We found that not all staff had completed basic life support (BLS) training as per Resuscitation council guidelines. The practice told us they were unaware that the training needed to be completed annually as the training establishment had told them that BLS training completed in February 2016 would be valid for 18 months for clinical staff and 24 months for non-clinical staff. We received evidence following the inspection this training was scheduled to take place on 25 July 2017.
- The business continuity plan we reviewed had been updated and now included emergency contact details for all staff as well as the local buddy practice with whom they had arrangements with in case of an emergency.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 17 May 2016, we rated the practice as requires improvement for providing effective services. Requirement notices were issued as it was found that the practice had breached Regulation 12 HSCA (RA) Regulations 2014, Regulation 18 HSCA (RA) Regulations 2014 and Regulation 19 HSCA (RA) Regulations 2014. The practice did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients. For example, the practice non-clinical staff had not received mandatory training such as safeguarding and infection control. Although the practice carried out audits we were not assured they were used to monitor outcomes or drove improvements.

These concerns had been addressed when we undertook a follow up inspection on 15 May 2017; however, we saw that staff appraisals had lapsed. The practice is still rated as requires improvement for providing effective services.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years, two of these were completed two cycle audits where the improvements made were implemented and monitored. For example, the practice undertook an osteoporosis review audit and identified groups of patients who would benefit from taking calcium and vitamin D3 supplements. The practice used different patient criteria for this audit, for example, house bound patients and found eight out of the 29 patients identified could benefit from taking this supplement. The practice reviewed patient notes then arranged telephone and face to face consultations. The first cycle identified 28% of patients were untreated, but this was reduced to 7% during the second cycle after calcium and vitamin D3 supplements had been added to their prescriptions. Patients were reviewed in line with current guidelines.
- Other quality improvement initiatives related to long acting reversible contraceptive methods (LARC) which could be accessed by any patients residing in the locality.

Effective staffing

The practice could demonstrate that all staff had the skills, knowledge and experience to deliver effective care and treatment.

- Following the comprehensive inspection, the practice reviewed and amended their induction programme for all newly appointed non-clinical staff. The induction programme covered topics such as infection prevention and control, fire safety and health and safety; however other topics such as information governance and safeguarding were not covered.
- The practice management team demonstrated that all staff had received training in safeguarding, fire safety awareness and information governance. The practice now maintained a clinical and non-clinical staff training matrix which was used to monitor staff training.
- We saw that appraisals had lapsed for all staff members; the practice manager told us that staff appraisals were postponed due to internal employee relation issues. All appraisals were scheduled to take place between May 2017 and July 2017.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to patients. • The provider failed to carry out risk assessments for non- clinical staff undertaking chaperoning duties without a suitable DBS. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: • The provider must ensure that the established recruitment procedures are followed to ensure pre-employment checks are undertaken in line with the information specified in Schedule 3. This was in breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.