Drs P Keating & H Appleton

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs P Keating and H Appleton on 10 January 2017. We found the practice inadequate for providing safe services and being effective. Breaches of legal requirements were found in relation to services being safe and effective in the practice. We issued the practice with warning notices for regulation 12 safe care and treatment and for regulation 18 staffing. The warning notices required the practice to achieve compliance with the regulations by 28 April 2017.

We undertook a focused inspection on 31 May 2017 to check that the practice had addressed the issues in the warning notices and now met the legal requirements. This report only covers our findings in relation to those requirements.

At the inspection, we found that the requirements of the warning notice had been met.

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

- We found that the practice implemented a system to monitor and investigate patient safety alerts; however when we checked three recent alerts only two had been documented in line with the new system.
- We found that the practice had put systems and process in place to keep patients safe from harm. For example, the practice had improved the system for safeguarding children and adults, checks to assess additional risks to the premises such as infection control and fire safety had been completed.
- There was a system in place for managing the learning needs and development of staff.
- There was evidence of a training programme to keep all staff up to date with mandatory training.
- We found that all staff had records of Disclosure and Barring Service (DBS) checks in their personnel files or evidence that the DBS check was underway as outlined in the practice recruitment policy.

The areas where the provider should make improvements are:

- Ensure all staff follow the practice protocol for acting on patient safety alerts.

Summary of findings

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?

- There was a system in place to act on patient safety alerts. However, focus on fully embedding the new system is required.
- There were systems which supported multi-disciplinary working to effectively safeguard children and adults.
- Systems were in place to ensure the premises were safe; the practice completed a fire risk assessment and infection control audit.
- All staff had records of Disclosure and Barring Service (DBS) checks in their personnel files or evidence that the DBS check was underway as outlined in the practice recruitment policy.

Are services effective?

- There was a system in place for managing the learning needs and development of staff.
- There was evidence of a training programme to keep all staff up to date with mandatory training.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff follow the practice protocol for acting on patient safety alerts.

Drs P Keating & H Appleton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second CQC inspector, and two GP specialist advisors.

Background to Drs P Keating & H Appleton

The Drs P Keating and H Appleton practice is located in Enfield, North London within the NHS Enfield Clinical Commissioning Group. The practice holds a Personal Medical Services contract (an agreement between NHS England and general practices for delivering primary care services to local communities). The practice provides a full range of enhanced services including childhood vaccination and immunisation, extended hours access, facilitating timely diagnosis and support for people with dementia, supporting patients with learning disabilities, influenza and pneumococcal, minor surgery, patient participation, rotavirus and shingles Immunisation and unplanned admissions. The practice had a patient list size of 4,750 at the time of our inspection.

The practice is registered with the Care Quality Commission to carry on the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and family planning.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 10 January 2017 as part of our regulatory functions. The inspection was planned to check whether the provider is 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.

Breeches of legal requirements were found and warning notices were issued in relation to the practice providing safe and effective services. As a result, we undertook a focused inspection on 31 May 2017 to follow up on whether action had been taken to address the breaches outlined in the notices.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 31 May 2017. During our visit we:

- Spoke with a range of staff including, GP partners, practice manager and administrative staff.
- Reviewed documentation relating to the practice including policies and procedures.

Are services safe?

Our findings

Safe track record and learning

At the inspection on 10 January 2017 we found that the practice was unable to evidence an effective system was in place to act on patient safety alerts. We looked at systems in place to manage alerts received at the practice relating to patient safety including those from the Medicines and Healthcare Products Regulatory Agency (MHRA). We were told that alerts come into each clinician at the practice through the e-mail system. Staff told us that prior to November 2016 all patient safety alerts were received by the practice manager who distributed hard copies to clinical staff; however, the practice was unable to provide any evidence to demonstrate this process was followed. On the day of our inspection the practice was unable to produce any examples of recent patient safety or MHRA alerts that were relevant to the practice. The partners at the practice told us that alerts were discussed at clinical meetings; however, the practice was unable to provide minuted evidence of these discussions.

At the inspection on 31 May 2017 we found that the practice had implemented a system to monitor and act on patient safety alerts. We asked the practice to demonstrate how effective the new system was by showing us the three most recent safety alerts. We found that the practice did act on the three most recent alerts however there were some inconsistencies with the new system. For example, one of the most alerts had been actioned however this was not recorded and the actions taken were only known by the clinician that undertook the search. We searched the patients the alert was relevant for and found that no patients were at risk. The practice safety alert protocol states that all alerts should be saved centrally in the designated electronic folder to be discussed at the practice clinical meeting. We found that a second alert had been acted upon but the alert itself had not been saved in the patient safety shared folder as per practice policy.

It was clear that the practice was proactively managing patient safety alerts however, the system needed to be fully embedded to ensure a clear audit trail for each alert and effectively mitigate risk.

Overview of safety systems and process

At the inspection on 10 January 2017 we found that the practice did not have systems in place to ensure appropriate levels of safeguards for children and adults. We also found that not all staff at the practice who acted as chaperones had a Disclosure and Barring Service (DBS) check in place. Specifically, we found that:

- The practice did not have a child protection register in place.
- The practice were unable to demonstrate that clinical and non-clinical staff were trained to the appropriate level for safeguarding children and adults.
- The computer patient management system used by the practice had the capability to identify vulnerable patients; however, the practice were unable to provide evidence that this was being utilised.
- There was a safeguarding children's policy in place but we noted that it had last been reviewed in December 2013. There was no policy available for safeguarding adults.
- Staff who acted as chaperones had not received a risk assessment to determine if a Disclosure and Barring Service (DBS) check was appropriate.

At the inspection on 31 May 2017 we found that the practice had taken the following actions in relation to safeguarding and DBS checks for staff:

- The practice had a child protection register in place and were able to evidence multi-disciplinary working with health visitors in relation to child protection.
- All staff at the practice had completed the required level of safeguarding training relevant to their role.
- The practice were able to demonstrate that vulnerable patients were flagged on the computer patient management system.
- The practice had up to date policies for safeguarding children and adults; staff knew where to access these policies.
- Only staff at the practice that had DBS checks in place were acting as chaperones. Most staff at the practice had been DBS checked; the practice was able to provide evidence that a DBS check was underway for remaining members of staff.

Monitoring risks to patients

At the inspection on 10 January 2017 the practice did not have an up to date fire risk assessment, had not

Are services safe?

undertaken regular fire drills and were unable to demonstrate that staff had received fire safety awareness training. The practice was also unable to evidence that annual infection control audits were completed.

At the inspection on 31 May 2017 the practice provided evidence that a fire risk assessment had been completed. We reviewed the action plan for the fire risk assessment and found that the practice had acted on the risks identified and noted progress on the action plan. For example, the fire risk assessment recommended a 'turn to open' sign near the lock on the front door of the practice to assist with escape. We noted that the practice had a laminated sign in place next to the lock as per the recommendation.

All staff at the practice completed online fire safety training, additionally the practice brought in an outside company to provide in house fire safety training for all members of staff.

The practice implemented a procedure for fire drills; the new procedure stated that drills will be carried out every six months. The most recent drill was completed on 3 May 2017, details of the drill were recorded in a fire safety log.

There were three members of staff identified as fire marshals at the practice. A weekly fire safety check was conducted by a fire marshal at the practice and a log of these weekly checks was maintained.

As the lead for infection control at the practice had not carried out an annual infection control audit, the practice brought in a specialist company to complete an infection control audit to support the infection control lead. The specialist company provided comprehensive information about the standard of the infection control audit. The practice planned to have the infection control lead adopt the system used by the specialist company to complete future infection control audit. The practice were able to evidence that it acted upon recommendations in the action plan. For example, an update manual was given to the cleaners at the practice and the practice nurse and health care assistant were booked on an infection control training course as recommended in the audit. The infection control training was booked for 28 June 2017; this was in addition to the completed mandatory infection control training completed by staff at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

At the inspection on 10 January 2017 we found that there was limited evidence to demonstrate an effective training programme to ensure all staff were up to date with mandatory training for their roles. We found that the learning needs of staff were not consistently identified through a system of appraisals.

At the inspection on 31 May 2017 we found that there was a comprehensive training programme in place. All staff at the practice had access to online training, in addition to online training the practice brought in specialist companies to provide in house training for fire safety and basic life support training. We saw evidence that members of staff were booked to attend external training, for example the practice nurse and health care assistant were booked to attend infection control training.

We found that the training matrix used to monitor staff progress on the programme of training was also utilised to identify annual appraisals. We found that most staff at the practice had been appraised. There were two members of staff that had not yet been appraised; the practice was able to evidence that appraisals for these members of staff were scheduled. For example, the training matrix had the date of the scheduled appraisals. When we checked the diaries for these members of staff we found that the scheduled appraisals were booked.

The practice confirmed that all appraisals and training would be completed by 17 July 2017.