Dr Samuel Bhasme

Inspection report

The Surgery
19 Railway Street
Gillingham
Kent
ME7 1XF
Tel: 01634853667
Website: None

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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 location

Are services safe?	
Are services well-led?	

Overall summary

We carried out an announced comprehensive inspection at Dr Samuel Bhasme on 11 July 2017. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all reports' link for Dr Samuel Bhasme on our website at www.cqc.org.uk.

After our inspection in July 2017 the practice wrote to us with an action plan outlining how they would make the necessary improvements to comply with the regulations.

We carried out a second announced comprehensive inspection at Dr Samuel Bhasme on 20 March 2018. The overall rating for the practice was inadequate and the practice was placed in special measures for a further period of six months. A Warning Notice was served in relation to breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance found at this inspection. The full comprehensive report on the March 2018 inspection can be found by selecting the 'all reports' link for Dr Samuel Bhasme on our website at www.cqc.org.uk.

After our inspection in March 2018 the practice wrote to us with an action plan outlining how they would make the necessary improvements to comply with the Warning Notice.

This inspection was an unannounced focussed follow-up inspection carried out on 19 June 2018 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 20 March 2018. This report only covers findings in relation to those requirements. The practice was not rated as a consequence of this inspection.

At this inspection we found:

- The practice was unable to demonstrate there was a consistent approach to their management of significant events.
- There was insufficient evidence of learning and improvement within the practice from significant events.
- There was insufficient evidence of improvements to the assessment and management of risks to patients, staff and visitors in relation to fire safety.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

As our inspection on 19 June 2018 found that the practice had not fully met the Warning Notice issued on 12 April 2018 we imposed conditions on Dr Samuel Bhasme's registration with the Care Quality Commission. The conditions were:

Condition One: the registered person must not register any new patients at Dr Samuel Bhasme without the written permission of the Care Quality Commission unless those patients are newly born babies, or are newly fostered or adopted children of patients already registered at Dr Samuel Bhasme.

Condition Two: the registered person must submit to the Care Quality Commission, on a monthly basis, copies of significant events management and fire safety management action plans, including dates for completion of each action.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Population group ratings

Our inspection team

Our inspection team was led by a CQC lead inspector.

Background to Dr Samuel Bhasme

- The registered provider is Dr Samuel Bhasme.
- Dr Samuel Bhasme is located at The Surgery, 19 Railway Street, Gillingham, Kent, ME7 1XF. The practice has a general medical services contract with NHS England for delivering primary care services to the local community. The practice is in the process of setting up a practice website.
- As part of our inspection we visited Dr Samuel Bhasme, The Surgery, 19 Railway Street, Gillingham, Kent, ME7 1XF only, where the provider delivers registered activities.
- Dr Samuel Bhasme has a registered patient population of approximately 2,500 patients. The practice is located in an area with a higher than average deprivation score.
- There are arrangements with other providers (Medway Doctors On Call Care) to deliver services to patients outside of the practice's working hours.
- The practice staff consists of one GP (male), one practice manager, one practice nurse (female) as well as reception and cleaning staff. The practice also employs locum GPs directly.
- Dr Samuel Bhasme is registered with The Care Quality Commission to deliver the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; treatment of disease, disorder or injury.

Are services safe?

At our inspection on 11 July 2017, we rated the practice as inadequate for providing safe services.

- The practice did not have an effective system to manage significant events.
- Risks to patients, staff and visitors were not always assessed and managed in an effective and timely manner.

At our inspection on 20 March 2018, we rated the practice as inadequate for providing safe services.

- The practice had not made sufficient improvements to the system for reporting and recording significant events.
- The practice had not made sufficient improvements to the assessment and management of risks to patients, staff and visitors.

The practice had not sufficiently responded to these issues when we undertook a focussed follow up inspection on 19 June 2018.

Safety systems and processes

The practice had not made sufficient improvements to the system for reporting and recording significant events.

- After our inspection in March 2018 the practice wrote to us with an action plan outlining how they would make the necessary improvements to comply with the Warning Notice. They sent us a copy of the written guidance available for staff to follow to help them recognise and report significant events. For example, the significant / critical event toolkit. This document was specific to the practice and dated 1 October 2017. During our inspection on 19 June 2018 staff told us that the significant / critical event toolkit was kept in the complaints / significant events folder in the reception office. We found that the significant / critical event toolkit in that folder was not dated, not specific to the practice and not the same document that the practice had sent us. We could not be sure, therefore, that up to date, practice specific guidance on significant events was available for practice staff to follow.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- At our inspection in March 2018 we found that staff were not always following the practice's written guidance when reporting significant events. Records showed that there had been eight significant events since our last inspection in July 2017. However, only one of these had been reported by staff completing a significant event record form. Seven significant events had been reported by staff making an entry in a book kept in the reception office.
- Staff told us, and records confirmed, that there had not been any further significant events at the practice since our inspection in March 2018.
- After our inspection in March 2018 the provider sent us evidence to show that staff had retrospectively completed significant event forms for four of the eight recorded significant events.
- During our inspection on 19 June 2018 we looked at the practice's significant event records. They showed that although there had not been any further significant events since our last inspection, staff had retrospectively identified that there had been 12 significant events between July 2017 and March 2018. One transpired to be a complaint and had been dealt with as such. Six significant events had been reported by staff completing a significant event record form. Records demonstrated that these events had been discussed and that learning from them had taken place. However, five had not been reported by staff completing a significant event record form. The practice was unable to demonstrate that two of these had been discussed or that learning from one of them had taken place.
- Records showed that some of the reported significant events were reportable by the practice to the National Reporting and Learning System (NRLS). For example, a near miss where a patient was prescribed the same medication twice that had the potential to cause the patient harm. However, there were no records to demonstrate that the practice had reported this to the NRLS.
- The practice was unable to demonstrate there was a consistent approach to their management of significant events.

Monitoring risks to patients

Are services safe?

The practice had not made sufficient improvements to the assessment and management of risks to patients, staff and visitors.

- There were procedures for monitoring and managing risks to patient and staff safety.
- At our inspection in March 2018 we found that the practice had a fire risk assessment dated 4 December 2017. The risk assessment contained an action plan to address some of the identified issues. For example, emergency lighting for the first and second floor of the building was due to be installed in June / July 2018. The practice did not have a fire alarm system. The practice did have smoke detectors fitted. However, the fire risk assessment document stated that fire could not be easily detected and the fire alarm could not be raised in all parts of the premises. There were no records to demonstrate that the smoke detectors were tested regularly or that the practice had carried out any fire drills.
- After our inspection in March 2018 the practice wrote to us with an action plan outlining how they would make the necessary improvements to comply with the Warning Notice. They sent us evidence to show that they had revised their fire safety policy and that a new fire alarm system had been installed in the practice.
- During our inspection on 19 June 2018 we saw that a new fire alarm system had been installed in the practice. Staff told us that the new fire alarm system, that included some hard wired smoke detectors, was tested on a regular basis and records confirmed this. Staff told us that the existing battery-operated smoke detectors were also checked on a regular basis. However, there were no records to confirm this. After our inspection the provider wrote to us and told us that the battery-operated smoke detectors would emit a beeping sound if the battery was low on power and therefore regular checking was unnecessary.
- Records showed that the practice had conducted a fire drill on 16 April 2018.
- Staff told us that the fire risk assessment dated 4 December 2017 had not been updated since our last inspection or since the installation of the new fire alarm system.
- Records showed that staff were up to date with fire safety training.

Please refer to the Evidence Tables for further information.

Are services well-led?

At our inspection on 11 July 2017, we rated the practice as inadequate for providing well-led services.

- The practice had failed to assess and manage in an effective and timely manner all identified risks to patients, staff and visitors.
- There was a focus on continuous learning and improvement at all levels. However, records of significant event management were not always complete.

At our inspection on 20 March 2018, we rated the practice as inadequate for providing safe services.

- The practice had not made sufficient improvements to the assessment and management of risks to patients, staff and visitors.
- The practice had not made sufficient improvements to the system for reporting and recording significant events.

The practice had not sufficiently responded to these issues when we undertook a focussed follow up inspection on 19 June 2018.

Governance arrangements

Governance arrangements at the practice were insufficient.

- Up to date, practice specific written guidance on the reporting and management of significant events was not available to all staff.

Managing risks, issues and performance

The practice had not made sufficient improvements to the assessment and management of risks to patients, staff and visitors.

- Although the practice had installed a new fire alarm system since our inspection in March 2018 they were unable to demonstrate that battery-operated smoke detectors were being tested on a regular basis nor that the fire risk assessment had been updated since 4 December 2017.

Continuous improvement

There was evidence of some learning and improvement within the practice. For example, from some but not all of the significant events reported by staff. However, this was insufficient.

- The practice was unable to demonstrate a consistent approach in their management of significant events.
- The practice was unable to demonstrate that discussion of and learning from all significant events reported by staff had taken place.

Please refer to the evidence tables for further information.