Dr Daya Nand Das

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Dr Das on 25 February 2016. Breaches of regulations were found and two warning notices were issued. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (Safe Care and Treatment)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 (Good Governance)

We undertook this focused inspection on 29 July 2016 to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the warning notices we issued. 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 Dr Daya Nand Das on our website at www.cqc.org.uk.

Our key findings were as follows:

Summary of findings

- The practice had introduced health and safety risk assessments including for control of substances hazardous to health (COSHH), infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All staff who undertake chaperoning duties had a Disclosure and Barring Service check.
- The practice manager was the lead for infection control and updated cleaning schedules were in place.
- There was a fire risk assessment, newly installed smoke alarms and regular fire drills.
- The premises was clean and tidy, and remedial works and decorating had been undertaken.
- The practice had an updated business continuity plan.
- There was now suitable disabled access to the downstairs toilet and treatment room.
- The practice had purchased an oxygen cylinder.
- There was an incident reporting policy in place.
- There were up to date practice meeting minutes produced.
- Practice policies and procedures had been reviewed to ensure they were in date and fit for purpose.
- There was a system in place for disseminating alerts to staff.
- The GP provided cover for the nurse in cases of emergency.
- Staff had an up to date appraisal that included learning and development needs.
- Whilst there was some significant event analysis there was no systematic process to review these.
- The practice had a process in place to identify some vulnerable patients such as those with learning disabilities and homeless people.
- There was no formal process for keeping locum GPs or temporary staff updated with any national guidelines and guidance.
- There was evidence of clinical audits but some had not had a completed cycle.
- There was no evidence presented to indicate actions to address low Quality Outcomes Framework (QOF) scores or a plan to improve these results.

The findings of the this focused inspection demonstrated improvement in response to the warning notices served. It is important that the improvements found are further embedded and sustained. The practice remains in special measures, and we will undertake a further fully comprehensive inspection later in the year. It is at that inspection where the quality rating previously awarded will be reviewed.

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

Summary of findings

Dr Daya Nand Das

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.**The team included an Inspection Manager and a GP specialist adviser.

Background to Dr Daya Nand Das

This practice is located in Leigh and is also known as Direct Access Surgery. The practice provides services from a modified terrace house. Consultation rooms are on both ground floor and first floor (for suitable patients). At the time of our inspection there were just under 1500 patients registered with the practice. It is overseen by NHS Wigan Borough Clinical Commissioning Group (CCG).

There are a higher proportion of patients above 65 years of age (21%) than the practice average across England (17%). There are a high proportion of patients registered who have a long standing health condition (68%) compared to the CCG (57%) and National (54%) averages. Data showed there was a 25% turnover of patients per year.

There is one GP (male) supported by a locum practice nurse. There is also a practice manager and two supporting administration and reception staff. There was no regular and consistent access to a female GP in the practice for the patient population.

The practice delivers commissioned services under the Personal Medical Services (PMS) contract. It offers direct enhanced services for the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, minor surgery, patient participation, rotavirus and shingles immunisation and unplanned admissions.

The practice is open from 9am to 5.30pm from Monday to Friday with the exception of Thursday when there are extended hours are 6.30pm to 7.30pm and Wednesday when the practice closes at 1pm. Cover is provided through the out of hours service on a Wednesday afternoon.

Patients can book appointments in person or via the phone. Emergency appointments are available each day. There is an out of hours service available provided by Bridgewater Community Health Care Trust and commissioned by Wigan Borough CCG.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 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.

Detailed findings

How we carried out this inspection

We carried out an announced visit on 29 July 2016. We spoke with, and interviewed, the GP and the practice manager. We looked at a sample of records the practice maintained in relation to the provision of services and undertook observations around the service

Are services safe?

Our findings

We did not inspect this domain in full at this inspection. We inspected only those aspects mentioned in the warning notices issued on 4 April 2016.

Safe track record and learning

In February 2016 there was a system in place for reporting incidents and recording significant events but this was not effective.

- The practice did not undertake significant event analysis (SEA). On this inspection we saw evidence that SEAs had been discussed at a practice meeting but there was still no annual review of them or systematic analysis.

In February 2016 there was no evidence that any alerts, for example medicines or patient safety alerts, were being cascaded to staff in the practice. On this inspection we reviewed the folder for alerts that was now kept by the practice manager. These are passed to the GP for their disposal and signature. We noted that some but not all alerts had been signed to by the locum GP.

Overview of safety systems and processes

In February 2016 we determined the practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Notices were displayed in the consultation rooms advising patients about chaperones, if required, but not in the waiting area. Some staff had been undertaking chaperone duties but did not have a disclosure and barring service (DBS) check or risk assessment in place. However on this inspection we saw evidence that all staff required to undertaken chaperone duties had a current DBS check and had received in house training on chaperone duties from the GP.
- The premises were not clean and tidy. It was unclear who was the infection control lead in the practice. There was a current infection control audit but we did not see any evidence that action was taken to address any improvements identified as a result. For example we saw broken tiles and peeling paint, and the treatment room to the rear of the building, used for minor surgery, was extremely dusty and there were stains on the floor tiles. There was no plan to rectify this. There were cleaning rosters in place but these were dated 2014 and there were no checklists to indicate that the schedules had been completed. However on this inspection we noted the infection control policy had been updated and the practice manager was the lead staff member for this function. We also observed the premises was clean and tidy and there were cleaning schedules in place. All empty boxes and old, unserviceable equipment was removed from the premises. The practice had also had work completed to redecorate, and replace the broken tiles and flooring in the treatment room.

Monitoring risks to patients

In February 2016 we determined that risks to patients were not assessed and well managed.

- The practice did not have an up to date fire risk assessment, did not test any alarms and did not carry out regular fire drills at the initial inspection on 25 February 2016. However during this inspection we saw evidence that a risk assessment had been undertaken, smoke alarms fitted and regular fire drills undertaken. Adequate records were kept for the fire drills. The fire safety policy had also been updated to reflect these changes.
- The practice manager was asked to provide the practice health and safety risk assessments at the initial inspection on 25 February 2016. These were not provided because the practice had no risk assessments in place to monitor safety of the premises such as Control of Substances Hazardous to health (COSHH), infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However during this inspection we noted that there was a legionella risk assessment undertaken by an external company on 9 May 2016. We also noted that COSHH and infection control assessments had been undertaken and all these had been discussed in practice meetings.

Arrangements to deal with emergencies and major incidents

In February 2016 it was determined the practice had inadequate arrangements in place to respond to emergencies and major incidents.

Are services safe?

- The practice had adult and children's oxygen masks but no oxygen and could provide no reasonable explanation why they did not have this. However on this inspection we saw the practice had purchased oxygen which was accessible to staff.
- The practice did not have a business continuity plan in place for major incidents such as power failure or building damage. On this inspection it was noted that there was a business continuity plan dated June 2016 in place and that all staff had signed to say they had seen this.

Are services effective?

(for example, treatment is effective)

Our findings

We did not inspect this domain in full at this inspection. We inspected only those aspects mentioned in the warning notices issued on 4 April 2016.

Effective needs assessment

During the inspection in February 2016 the practice did not have systems in place to ensure all clinical staff were up to date with national guidelines and guidance. There were also no assurances in place that any locum staff had received updated information. During this inspection it was noted that there was still no formal process in place for keeping the clinical team up to date. There were no records or processes to ensure the practice nurse is up to date as they are employed as a locum. The GP told us they were confident in the ability of the locum GP and practice nurse because they work in other local practices. These staff members were not available for interview this inspection.

In February 2016 the GP was asked about the formal process to highlight and follow up vulnerable patients in particular those with a high hospital attendance rate. They could not provide an answer to this. On this inspection there was still no formal process of identifying this patient however we noted that in minutes of a meeting the practice recorded they will invite patients with a high hospital attendance rate to attend the practice to discuss this. The practice did keep a register of vulnerable patients who had a learning disability and those who were homeless.

Management, monitoring and improving outcomes for people

In February 2016 the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 62% which was significantly below the national average of 88%. The practice could not offer an explanation as to why this was so low or demonstrate a plan to improve these results. On this inspection we found some improvement but this remained work in progress. The figures had only improved to 66% within this reporting period.

Previously clinical audits did not demonstrated quality improvement.

- At the February 2016 inspection there had been a series of clinical audits commenced however none of these were completed audits and there were no improvements made or implemented as a result of these. Most audits were medicine and prescribing audits that were instigated and undertaken by the CCG pharmacy technician. We reviewed audit information on this inspection and whilst the CCG pharmacy technician audits were detailed, there was one undertaken by the GP did not demonstrate a full audit cycle. For example minor surgery audits for 2014-15 and 2015-16 were a log of histology, complications and results rather that a true two audit cycle. However there was an audit completed by the GP on the use of benzodiazepines due to their high prescribing of these. This audit not only demonstrated a full cycle but there was a significant decrease in prescribing noted on the second cycle.

Effective staffing

At the February 2016 inspection we noted staff had an appraisal completed but it did not identify learning and practice development needs. However on this inspection we noted that recent appraisal and induction documentation had identified learning and practice development needs such as safeguarding training for the newest member of staff.

The practice manager was asked how they provided cover for the practice nurse in their absence. We were told that there would not be cover. Therefore there was insufficient succession planning in place to support the absence of the locum practice nurse who only worked one day per week. This had a significant impact on the ability of the practice to meet the needs of patients in terms of availability of practice nurse appointments. At this inspection we were informed that the GP would cover the nurse absence for any appointments that could not be rescheduled. The practice nurse was currently a locum but had been offered a contract with the practice for one day per week as a permanent member of staff. We were told there were plans in place to get nurse provision for a second day but we saw no evidence to support this.

Are services caring?

Our findings

We did not inspect this domain at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect this domain in full at this inspection. We inspected only those aspects mentioned in the warning notices issued on 4 April 2016.

Responding to and meeting people's needs

At the February 2016 inspection the practice had not reviewed the needs of its local population or engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- Previously we found disabled access to the treatment rooms and other facilities was limited. For example the downstairs toilet had a disabled sign on the door but this could not be accessed by a patient in a wheelchair. Also a wheelchair bound patient could not access the downstairs treatment room that was used for minor surgery. However we observed during this inspection that building work had been completed to make the downstairs toiled accessible for wheel chair patients and that the treatment room had been modified to facilitate disabled access.

Are services well-led?

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

Our findings

We did not inspect this domain in full at this inspection. We inspected only those aspects mentioned in the warning notices issued on 4 April 2016.

Practice Policies and Procedures, and Meeting Minutes

- In February 2016 we found the practice had some policies in place. Some of these were not practice specific, for example, some policies were old Primary Care Trust (PCT) policies. Most of the policies we saw were not dated, with any indication of a review date. We received no assurances that any changes to policies and procedures were cascaded to staff such as safeguarding information. The practice manager had updated some policies by just changing the year in pen on the front sheet. On this inspection we reviewed the practice policy file. All policies had been reviewed and staff had signed to say they had seen them. However there was no plan in place to regularly review policies or a system in place to determine which policies where relevant to the delivery of services within the practice.
- At the February 2016 inspection the practice manager was asked to provide an incident reporting policy. The practice manager was unable to present to us an incident reporting policy at that time. However on this inspection we say there was now an incident reporting policy in place dated 12 June 2016. However it needs to be expanded to include reporting incidents to the Care Quality Commission (CQC).
- Previously the practice manager was asked to provide minutes of practice meetings. They were provided but none had been had not been produced since July 2015. However on this inspection we saw evidence that minutes of meetings had now been produced on a regular basis and shared with staff.