Dr G Celikkol's Practice

Quality Report

Grange Park Health Centre
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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 service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive to people's needs?	**Inadequate**
Are services well-led?	**Inadequate**

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 G Celikkol's Practice on 15 April 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment, basic life support training had not been given to staff in a timely manner to recommended guidelines and there was no documentation of actions taken to address infection control audit findings.
- There had been no staff appraisals undertaken in the last 12 months and one staff member reported insufficient training for the role.
- Staff were not clear about reporting incidents, near misses and concerns and there was no formal training for staff in recognising emergency situations.
- There was no system to monitor clinical supplies in the practice and many were out of date.
- Emergency medicines were not easily accessible. There was no schedule for checking emergency equipment and emergency medicines had not been checked for over three months. There were no masks for children available for use with the emergency oxygen or children's pads for the defibrillator.
- Not all practice policies were easily available to all staff and some policies had not been reviewed and updated following practice changes. Knowledge of and reference to national guidelines was inconsistent. There were no practice specific clinical protocols.
- Clinical staff were not seeing all items of communication coming into the practice from other services.
- The practice did not maintain some patient information securely.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others, either locally or nationally. Where patient outcomes had been identified as low, the practice had not addressed this.

Summary of findings

- There was a lack of coding of patient diagnoses on the computerised patient record which led to inadequate care and treatment of patients' chronic conditions. Recorded patient consultations lacked detail.
- Staffing arrangements were not adequate to cover clinical staff long-term absence. There were no routine patient health checks and non-urgent reviews of patients' chronic health conditions during this time.
- The practice had limited formal governance arrangements and no overview of patient complaints or significant events. There were no regular governance meetings and the practice did not record verbal complaints. There were no regular formal meetings with staff from other services.
- Patients' views were mixed. Comments left on the CQC comment cards reported that staff were caring and treated patients with dignity and respect, however, data from the national GP patient survey showed that the number of patients who would recommend their surgery was significantly less than the national and CCG averages.
- There was little evidence to suggest that the practice was engaging with patients to seek their views of the service. They did not have a patient representative group.
- The practice did not have a clear vision for the future and did not have a succession plan.

The areas where the provider must make improvements are:

- Introduce and embed processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure recruitment employment checks are undertaken for all staff.
- Put systems in place to ensure clinical practice reflects up to date national guidance and guidelines and develop practice specific clinical guidelines.
- Carry out clinical audits including re-audits or other quality improvement activities to ensure improvements in treatments have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure that mechanisms are in place to seek feedback from patients and feedback is acted upon to ensure the practice improves services and the quality of care given to patients.
- Ensure policies and procedures are easily accessible to staff, are updated to reflect current guidelines and legislation and contain, where necessary referral pathways. For example, the safeguarding children and vulnerable adults reporting processes.
- Ensure that there are sufficient numbers of suitably qualified staff at all times, particularly in relation to practice nursing staff.
- Ensure all staff have timely basic life support training to recommended guidelines and that they receive regular appraisals.
- Ensure that all patients' records are complete with history, medical examinations and diagnostic reasoning adequately recorded. This must include coding of conditions and illnesses.
- Ensure that processes are in place to regularly monitor emergency medicines, equipment and clinical supplies in the practice. Make emergency medicines easily available to all staff and update emergency equipment to allow for treatment of children.
- Ensure that all communications received by the practice are seen by clinical staff.

The areas where the provider should make improvement are:

- Ensure the practice is able to demonstrate effective management of complaints.
- Ensure that actions taken to address identified concerns with infection control are clearly documented.
- Take action to ensure that looped blind cords or chains are modified or secured out of reach in areas that could be accessed by children.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a

Summary of findings

further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Staff were not clear about reporting incidents, near misses and concerns. In the event of an incident occurring, people received reasonable support and a written apology and staff were informed of lessons learned. However, although there was some documentation of incidents and complaints, there was no overview of significant events and complaints or summary of actions taken, lessons learnt and ongoing monitoring.
- Recruitment checks on staff had not been undertaken prior to their employment. There were no references taken up or Disclosure and Barring Service (DBS) checks or risk assessments done, including for the practice nurse.
- Non-clinical staff had not received basic life support training in a timely manner to recommended guidelines, including for a new staff member.
- The practice had carried out infection control audits but there was no evidence that identified concerns had been addressed. The practice did not regularly monitor clinical supplies in the practice and many items were out of date.
- There was no formal schedule to check emergency equipment. Staff had not received formal training to recognise emergency situations. Emergency medicines were not easily accessible in an emergency and had last been checked three months ago. There were no child masks for use with the oxygen or pads for children for the defibrillator.
- The practice had not calibrated temperature recorders in the refrigerators to ensure accuracy since 2010.
- There was no risk assessment of blinds in the practice and cords were unsecured.
- There were no regular formal meetings with staff from other services to discuss safeguarding concerns or care for vulnerable patients.

Are services effective?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Data showed some patient outcomes were low compared to the national average. For example, 71% of patients diagnosed with dementia had had their care reviewed in a face to face

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meeting in the last 12 months which was worse than the clinical commissioning group (CCG) average of 85% and national average of 84%. Also, 51% of patients were screened for breast cancer in the last 36 months compared to the CCG average of 66% and national average of 73% and figures for patients attending screening for bowel cancer in the last 30 months were 49% compared with the CCG average of 53% and national average of 58%.

- Knowledge of and reference to national guidelines were inconsistent. The CCG pharmacist had identified that some patients with atrial fibrillation (a heart condition) were not being treated with appropriate medication according to NICE guidelines. This had been escalated to the GP and work was being done to rectify this situation. The practice had not developed practice specific clinical protocols.
- Little reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- The practice did not have an adequate system for dealing with communication received. Non-clinical staff removed some items of post before sending it to the GPs for consideration. Post removed included some attendances at the local walk-in service.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.
- There had been no staff appraisals in the last 12 months and one staff member reported insufficient training for the role.
- There was evidence of a lack of coding of patient diagnoses on the computerised patient record. This meant that the prevalence of patients with a long term condition was considerably below local and national averages for all chronic diseases (prevalence relates to the number of patients with a particular condition). The practice had identified that it was under reporting patients with chronic disease and was working on improving patient identification. There was also lack of recorded information relating to patient consultations.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. For example, 77% of patients said the GP was good at listening to them compared to the CCG average of 88% and the national

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average of 89%. Also 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%. 67% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

- Results from the national GP patient survey showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment when they saw or spoke to a GP. For example, 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national averages of 86%, and 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect. We saw evidence however that patient information was not always stored securely.

Are services responsive to people's needs?

Inadequate

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

- The practice did not have a patient participation group (PPG). We were told that efforts had been made in the past to recruit patients but there had been no success with this. The practice had made no further efforts in the last 13 months to engage with patients save for an audit of patient satisfaction with access in March 2015. Results from this survey were very positive, however, the number of patients completing the survey was not documented. We asked for this figure and were told that it was very low, approximately ten patients.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Patients could get information about how to complain in a format they could understand. We found that not all complaints were recorded by the practice. Staff told us of incidents when patients had complained verbally and there was no documentation of these events.
- There was no provision of cover for the practice nurse's extended leave of four months. Although the GPs were providing some services including child health clinics and

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urgent care for patients with long term conditions, there was no provision of routine care or monitoring for patients with chronic disease and no routine health checks for new or existing patients.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice did not have a clear vision and strategy. There was no succession planning for the future of the practice although the GP was over retirement age.
- Some practice specific policies were implemented and were available to all staff although others had not been put onto the practice intranet. Some protocols were out of date and needed review. There were no practice specific clinical protocols.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. There was no systematic approach to identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- An understanding of the performance of the practice was maintained however, there was no evidence of any actions taken to address deficiencies in service provision. We asked for examples of improvements in quality of care in the last year but staff were unable to give us any.
- A programme of continuous clinical and internal audit was not present to monitor quality and to make improvements.
- Practice policies were not all easily available to all staff and were not all up to date or comprehensive.
- The practice had no formal system to assess the need for staff training and monitor its use and effectiveness.
- The practice did not maintain some patient information securely.

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

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- Results from nationally reported data indicated that there was poor uptake of cancer screening services which the practice had not addressed.
- Routine health checks were not always available at the practice because of staff shortages.

However

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- The prevalence of patients with a long term condition was considerably below local and national averages for all chronic diseases (prevalence relates to the number of patients with a particular condition). The practice had identified that it was under reporting patients with chronic disease and was working on improving patient identification. We reviewed five patient medical records and found evidence that indicated that patient diagnoses were not being coded correctly.
- Knowledge of and reference to national guidelines were inconsistent. The CCG pharmacist had identified that some patients with atrial fibrillation (a heart condition) were not being treated with appropriate medication according to NICE guidelines and work was being done to rectify this situation. There were no practice specific clinical protocols.

However

Summary of findings

- Performance for diabetes related indicators was better than the clinical commissioning group (CCG) and national averages. For example blood measurements for diabetic patients showed that 85% of patients had well controlled blood sugar levels compared with the CCG average of 83% and national average of 78%.

Families, children and young people

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- The practice's uptake for the cervical screening programme was 66%, which was worse than the CCG average of 71% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

However

- Immunisation rates were relatively high for all standard childhood immunisations. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 100% and five year olds from 81% to 100%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered urgent access and appointments were available for children as well as those with serious medical conditions.

Working age people (including those recently retired and students)

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- There was limited access to new patient health checks and health checks to identify any potential health problems because of staff shortages.

However

- The practice offered an evening 'flu vaccination clinic for working age people unable to attend during the day.
- There were appointments offered outside normal working hours until 6.30pm.

Summary of findings

- Appointments and repeat prescriptions could be accessed online.

People whose circumstances may make them vulnerable

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- There were no regular multi-disciplinary meetings with community staff and information was exchanged on an ad hoc basis.

However

- The practice had identified 57 carers on its list, 2.4% of the practice list.
- Patients with learning disabilities were offered annual physical health checks and medicine reviews. The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients and produced care plans for those patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider is rated as inadequate for providing safe, effective, responsive and well led services and requires improvement for providing caring services. The issues identified as inadequate overall affect all patients including this population group.

- 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is worse than the CCG average of 85% and national average of 84%.

However

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- 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented in their record compared to the CCG average of 93% and the national average of 88%.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages for some of the indicators and below averages for others. A total of 387 survey forms were distributed and 96 were returned. This represented 4% of the practice's patient list.

- 88% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 68% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which were all positive about the standard of care received. One comment card made reference to the poor attitude of a member of staff and one card mentioned long waiting times in the practice before appointments but all praised the service offered by the practice and commented that they felt they were treated with dignity and respect.

Areas for improvement

Action the service MUST take to improve

- Introduce and embed processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure recruitment employment checks are undertaken for all staff.
- Put systems in place to ensure clinical practice reflects up to date national guidance and guidelines and develop practice specific clinical guidelines.
- Carry out clinical audits including re-audits or other quality improvement activities to ensure improvements in treatments have been achieved.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure that mechanisms are in place to seek feedback from patients and feedback is acted upon to ensure the practice improves services and the quality of care given to patients.
- Ensure policies and procedures are easily accessible to staff, are updated to reflect current guidelines and legislation and contain, where necessary referral pathways. For example, the safeguarding children and vulnerable adults reporting processes.
- Ensure that there are sufficient numbers of suitably qualified staff at all times, particularly in relation to practice nursing staff.
- Ensure all staff have timely basic life support training to recommended guidelines and that they receive regular appraisals.
- Ensure that all patients' records are complete with history, medical examinations and diagnostic reasoning adequately recorded. This must include coding of conditions and illnesses.
- Ensure that processes are in place to regularly monitor emergency medicines, equipment and clinical supplies in the practice. Make emergency medicines easily available to all staff and update emergency equipment to allow for treatment of children.
- Ensure that all communications received by the practice are seen by clinical staff.

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Action the service SHOULD take to improve

- Ensure the practice is able to demonstrate effective management of complaints.
- Ensure that actions taken to address identified concerns with infection control are clearly documented.
- Take action to ensure that looped blind cords or chains are modified or secured out of reach in areas that could be accessed by children.

Dr G Celikkol's Practice

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 GP specialist adviser and a practice nurse specialist adviser.

Background to Dr G Celikkol's Practice

Dr G Celikkol's Practice is situated in Grange Park Health Centre in the Normoss area of central Blackpool with a branch surgery in Staining, also in Blackpool. It is housed in a purpose-built building at Grange Park with good parking facilities and in a detached house at Staining. The practice provides services to 2387 patients.

The practice is part of the NHS Blackpool Clinical Commissioning Group (CCG) and services are provided under a Personal Medical Services Contract (PMS). There is one male GP (the registered provider) and one male and one female long-term locum GPs. The practice also employs one practice nurse and is supported by non-clinical staff consisting of a practice manager and four administrative and reception staff.

The practice is open at Grange Park between 8.30am and 6pm Monday to Friday except Wednesday when it closes at 3.30pm. Opening hours at Staining are Monday to Friday 9am to 1.30pm and 2:30pm to 6:30pm. When the practice is closed, patients are able to access out of hours services offered locally by the provider Fylde Coast Medical Services by telephoning 111.

The practice population comprises of fewer patients over 65 years of age (12%) than the CCG average of 20% and the national average of 17%, and more patients under 18 years of age (25%) than the CCG average of 19% and the national average of 21%.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice caters for a lower proportion of patients experiencing a long-standing health condition (58%) compared to the local average of 63%. The proportion of patients who are in paid work or full time education is lower (50%) than the CCG average of 52% and the national average of 62% and unemployed figures are significantly lower, 1% compared to the CCG average of 7% and the national average of 5%.

The practice provides level access to the building and is adapted to assist people with mobility problems. All treatment and consulting rooms are on the ground floor.

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 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 April 2016.

During our visit we:

- Spoke with a range of staff including one GP, the practice manager and two members of the practice administrative team.
- Observed how patients were being spoken to.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting and recording significant events but we did not see evidence that this system was fully understood and documented. There was no overview of significant events.

- We were told that staff would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. However, a new staff member we spoke to was unable to describe this process. We were told that the practice supported the duty of candour when dealing with significant events although there was no incident reporting policy or procedure (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).
- The practice told us that they had recorded two events as significant in the previous 13 months. One event related to two different diagnoses that had been made by the hospital for a patient. One of these diagnoses was entered onto a patient care plan. The patient disagreed with the diagnosis and the surgery changed it on the care plan. The patient was informed of the change and was given a written apology. We were told that the second significant event regarded a needle stick injury sustained by an outside contractor when collecting clinical waste from a child health clinic at the practice. The practice was unable to show us any documentation relating to this incident but we were told that a clinical meeting was held to discuss the event.

The practice held monthly meetings and told us that safety records, incident reports and patient safety alerts were discussed as needed. They did not constitute a regular agenda item. We saw evidence of a meeting to discuss the significant event regarding the patient disagreement with diagnosis.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children from abuse. These arrangements reflected relevant legislation and local requirements. We were told that the practice did not have a policy for safeguarding vulnerable adults, however, we were given the policy on the day after inspection and told that it had been held in paper form in a safeguarding folder. We noted that there was no practice safeguarding lead named in the policy. The safeguarding children policy was accessible to all staff on the practice computer system and contained the name of the practice safeguarding lead which was the registered provider. However, it did not contain details of who to contact outside the practice for further guidance if staff had concerns about a patient's welfare. Further contact details were available in printed form in a separate safeguarding folder. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. The practice had not had formal meetings to discuss vulnerable patients and we were told that discussions were held with community staff when appropriate. Staff demonstrated they understood their responsibilities and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. The practice protocol allowed for trained, non-clinical staff to act as chaperones without receiving a Disclosure and Barring Service (DBS) check (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). However, we were told that only clinical staff members acted as chaperones and the practice policy would be changed to reflect this.
- The practice maintained appropriate standards of cleanliness and hygiene and we saw cleaning records. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and a non-clinical member of staff assisted in these duties. There was an infection control protocol in place and staff had received up to date training. The non-clinical infection control assistant carried out an audit of infection control every two months and we were told that action was taken to address any improvements identified as a result. However, there was no documentation of this in any of the audits. We noted that there was no soap next to the basin in the nurse's

room. There was also no cleaning schedule for the ear irrigation machine and not all of the disposable curtains were dated so that it was clear when they should be renewed.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were mostly sufficient to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There were two refrigerators in the practice for storing medications. The Practice had not arranged for calibration of the temperature recorders in the refrigerators since 2010.
- Arrangements to monitor the safety of clinical supplies in the practice were not well managed. We found many clinical items in the practice that were out of date. They included three cervical smear testing kits, three speculums, a pack of dressing scissors, a pack of blood bottles, glucose testing strips, two syringe needles and a dressing pack. Dates on these items varied from 2013 to 2015. We also found ten opened dressing packs for named patients which were out of date and ranged in date from 2011 to 2015.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The Clinical Commissioning Group (CCG) pharmacist carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found appropriate recruitment checks had not been undertaken prior to employment. The practice had a new staff member checklist that detailed the appropriate documents that were needed. This included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). However, we saw very little evidence of these documents in the files. For example none of the files contained references, including for the newest staff member who had been employed for five months. None of the staff had had DBS checks or been risk assessed, including the practice nurse.

Monitoring risks to patients

Risks to patients in relation to the surgery premises were assessed and generally well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office although it did not identify local health and safety representatives. The practice had up to date fire risk assessments, tested fire alarms weekly and documented these tests and also carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, we saw that there were no risk assessments in relation to cords on blinds at surgery windows. There were two large windows in the patient waiting area with floor to ceiling blinds and the cords had not been secured or risk assessed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents but these were not always safe.

- There were panic buttons in the consultation and treatment rooms which alerted staff to any emergency and further buttons in reception and clinical rooms that communicated directly with the police. Staff told us that they would telephone clinicians for support in an emergency situation in reception. However, staff we spoke to had not received training in some emergency situations. For example, staff were unclear on when to advise patients to ring 999 in an emergency.
- Non-clinical staff had not received the recommended basic life support training in a timely manner.
- There were emergency medicines available in the treatment room and these were all in date. However, supplies included a syringe with an expiry date of 2009 and two out of date needles dated 2013 and 2014. The emergency medications were also kept in a locked safe in the nurse's room which was also locked when no nurse was in the practice. This meant that they were not easily accessible in an emergency.

Inadequate

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult masks. There were no child masks for use with the oxygen and no paediatric pads for the defibrillator. The practice resuscitation equipment contained a box with an airway inside that was out of its packaging and therefore was not dated, an out of date adult mask (expiry date 2014) and an airway dated September 1994. The practice also carried two nebulisers for use in an emergency (a nebuliser allows a patient with breathing difficulties to breathe more easily), however, there were no oxygen masks or tubing contained in the boxes. A first aid kit and accident book were available.
- All staff knew of the location of the emergency medicines. All the medicines we checked were in date however, we saw that the schedule for checking these medicines had not been completed for over three months. There was also no documented checking schedule for emergency equipment.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff told us that the practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had not developed its own clinical protocols from these guidelines and we saw no evidence that changes in guidelines were discussed in meetings. We noted that there were printed guidelines for the management of asthma in the nurse's room that were dated 2004 although there was no evidence that they were being used.

The practice had systems in place to keep clinical staff up to date. Staff had access to guidelines from NICE online and used this information to deliver care and treatment that met patients' needs. However, the CCG pharmacist had identified that some patients with atrial fibrillation (a heart condition) were not being treated with appropriate medication according to NICE guidelines. The staff had been told of this and the pharmacist was conducting medication reviews with those patients to rectify the situation.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.4% of the total number of points available with 6.1% exception reporting (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice was 5.2% below the CCG average exception reporting rate and was significantly below for exception reporting for atrial fibrillation, heart failure and cancer clinical domains where no patients were excepted at all. However, the prevalence of patients with a long term condition was considerably below local and national averages for all chronic diseases (prevalence relates to the number of patients with a particular condition).

The practice had acknowledged that it was not identifying all patients with chronic disease and was working on this. We reviewed five patient medical records and found evidence that indicated that patient diagnoses were not being coded correctly. For example, we saw evidence of one patient who had been seen at the practice several times with a cough and wheeze and was on regular medication for this but had not been diagnosed as suffering from asthma or added to the register of asthmatic patients. We also saw details of a patient who had been seen at the practice many times with the same symptoms and had been given a confirmed diagnosis by the hospital of left ventricular failure (failure of the left side of the heart) but this had not been coded correctly in the patient record. There was also evidence of diagnostic reasoning not adequately recorded and minimal recording of patient history and examination. We saw evidence of the patient presenting complaint recorded as the problem without any working diagnosis.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was better than the clinical commissioning group (CCG) and national averages. For example blood measurements for diabetic patients showed that 85% of patients had well controlled blood sugar levels compared with the CCG average of 83% and national average of 78%. Figures for those patients whose last blood pressure reading was well controlled (140/80 mmHg or less) were 89% compared to the CCG average of 84% and the national average of 78%.
- Performance for some mental health related indicators was better than CCG and national averages. For example, 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented in their record compared to the CCG average of 93% and the national average of 88%.
- However, only 71% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months which was worse than the CCG average of 85% and national average of 84%.

There was little evidence of quality improvement including clinical audit. There had been two clinical audits completed in the last year and neither of these were completed two cycle audits where improvements were implemented and monitored.

Inadequate

Are services effective?

(for example, treatment is effective)

There was no evidence that information about patients' outcomes was used to make improvements.

The CCG pharmacist carried out medication audits and used these to make improvements to practice prescribing.

Effective staffing

Staff did not always have the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. We also saw evidence of GP training in understanding the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- Staff had not received an annual appraisal. Staff told us that learning needs were identified through an open door policy that allowed staff to request training when necessary. Staff had access to and made use of online training to meet their learning needs and to cover the scope of their work and training was also addressed in house. We were told that staff were reluctant to access external training. One member of staff reported a lack of training to support the role.
- Staff received training that included: safeguarding, fire safety awareness and information governance. Non-clinical staff had not received training in basic life support in a timely way to recommended guidelines. We were shown communication that indicated that training was to be supplied to staff the week following inspection.
- Practice staffing was not sufficient to meet patients' needs. There was a rota system in place for non-clinical staff but at the time of the inspection there was no practice nurse available at the practice. We were told that the practice nurse generally took three months off every year for annual leave and that the practice always obtained relief cover for this absence. However, at the time of the inspection, the nurse had taken extended leave of four months and the practice had been unable to find cover for any part of the absence. We were told that the nurse workload was managed to allow for annual reviews for patients with long term conditions to take place at times that the nurse was available. The practice said that in the nurse's absence GPs covered all aspects of the nursing role as well as their usual surgeries. We saw that GP appointments were still readily available but we did see evidence that clinical care was affected. For example, we saw that a newly diagnosed diabetic patient had been given an annual review date and had not been asked to attend for more regular monitoring. The practice also postponed all routine health screening for new and existing patients until the nurse returned to practice.

Coordinating patient care and information sharing

Patient information was available to relevant staff through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice told us that regular meetings with community services had been difficult because of staff changes in those services. A meeting with other services to discuss patients who were in receipt of palliative care had recently taken place and we were told that this was to be continued on a regular basis every three months. We were told that meetings took place with other health care professionals on an individual patient basis when needed and these meetings were not minuted.

The practice did not have an appropriate system for dealing with communication received. Non-clinical staff removed some items of post before sending it to the GPs for consideration. These items included some attendances at local walk-in services.

Inadequate

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking, alcohol cessation and patients who had drug and alcohol dependency. Patients were signposted to the relevant service. The practice also supported patients with drug dependency to limit prescribing for those patients and introduce a medication-reducing program.

The practice's uptake for the cervical screening programme was 66%, which was worse than the CCG average of 71% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice was aware that figures for patient attendance at national programmes for bowel and breast cancer screening were low when compared to local and national averages but had not addressed this. For example, patients screened for breast cancer in the last 36 months were 51% compared to the CCG average of 66% and national average of 73% and figures for patients attending screening for bowel cancer in the last 30 months were 49% compared with the CCG average of 53% and national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 100% and five year olds from 81% to 100%.

Patients had limited access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. These checks were routinely only available when the practice nurse was in practice. Health checks for new patients were carried out by the GP when the nurse was absent if necessary to inform treatment but not as routine.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the nine Care Quality Commission patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One of the patients commented on a GP's attitude and one mentioned long waits in reception before appointments. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients generally felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs. For example:

- 77% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 81% of patients said the GP gave them enough time compared to the CCG and the

national averages of 87%.

- 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national averages of 95%.
- 67% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

However, survey results relating to other staff showed higher levels of patient satisfaction. For example:

- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%.
- 94% of patients said the last nurse they saw or spoke to was good at listening to them (CCG average 92%, national average 91%).
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

We were told that the practice was aware of the survey results relating to staff attitude and had discussed it. The practice had considered that the results were in line with the complaints that it had received that year and that they were working on improving the service offered to patients.

Care planning and involvement in decisions about care and treatment

The practice used care planning for vulnerable patients to facilitate their care and treatment and we saw that these care plans were personalised.

Results from the national GP patient survey showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment when they saw or spoke to a GP. For example:

- 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national averages of 86%.
- 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.

When responding to questions about similar decisions when they saw or spoke to a nurse, results were in line with CCG and national averages. For example:

- 94% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 90%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

We were told that the practice had discussed these results and were aware of the negative figures. Staff said that patients were always offered choice when referral to further services was needed.

Requires improvement

Are services caring?

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- There were leaflets available in the practice offering advice about patient choice and detailing other services available.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. The Citizens Advice Bureau visited the practice twice a week and offered advice to patients in the local area. Practice patients and other patients in neighbouring practices were able to book appointments for this.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 57 patients as carers (2.4% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice was part of a local neighbourhood group that met monthly to discuss new services for patients in the area.

- There were longer appointments available for patients with a learning disability and for those with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately and were referred to other clinics for some vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- All of the clinical rooms for patients were on the ground floor.

Access to the service

The main Grange Park Health Centre practice was open between 8.30am and 6pm Monday to Friday except on a Wednesday when it closed at 3.30pm. The branch surgery at Staining was open from 9am to 1.30pm and 2.30pm to 6.30pm Monday to Friday. There were also emergency appointments available at Staining between 6.30pm and 7pm although these were not advertised to patients. Appointments with a GP were from 9.30am every morning and until 5.30pm (except Wednesdays) at Grange Park and until 6.30pm at Staining. The emergency appointments were at 6.40pm and 6.50pm daily at Staining if needed and were booked by the practice. In addition to pre-bookable appointments that could be booked at least six weeks in advance, urgent appointments and telephone appointments were also available for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than national averages.

- 90% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 88% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Comment cards collected on the day of inspection also said that patients were able to get appointments when they needed them. We saw evidence that the next available pre-bookable appointment was on the following working day.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system and a leaflet was available for patients on reception.

The practice told us that they had had only two written complaints in the previous 12 months. Both complaints related to staff attitude. We looked at one of these complaints and found that it was handled satisfactorily and responded to in a timely way. Apologies were offered and the practice reflected on lessons learnt. The patient complaint we saw had been recorded by the practice on the significant event reporting form to allow for reflection and analysis of events. However, staff told us of incidents when patients had complained verbally and there was no documentation of these events.

The practice did not have a patient participation group (PPG). We were told that efforts had been made in the past to recruit patients but there had been no success with this. The practice had made no further efforts to engage with patients save for an audit of patient satisfaction with access

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

in March 2015. Results from this survey were very positive however, the number of patients completing the survey was not documented. We asked for this figure and were told that it was very low, approximately ten patients.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice told us that they always aimed to deliver high quality care and promote good outcomes for patients. However, there was no written strategy or succession planning for the future of the practice.

Governance arrangements

The practice had no overarching governance framework to support the delivery of strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, no provision had been made for clinical cover for the only practice nurse to take extended leave.
- Some practice specific policies were implemented and were available to all staff although some had not been put onto the practice intranet. Some protocols were out of date and needed review and the practice did not always follow the procedures documented in its policies. There were no practice specific clinical protocols.
- The practice had some understanding of its performance, however, there was no evidence of any actions taken to address deficiencies in service provision. We asked for examples of improvements in quality of care in the last year but staff were unable to give us any.
- A programme of continuous clinical and internal audit was not present to monitor quality and to make improvements. Infection control audits were undertaken but there was no documentation of any actions taken.
- The practice did not maintain patient information securely. We found a notepad in an unlocked desk drawer in an empty treatment room with personal computer login details and passwords and other patient confidential information in unlocked drawers. We also found lists of patients with full details of names and addresses in a bag under the desk in that room and further patient-identifiable details in a tray near the emergency drug safe.
- There were poor arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. There was no governance framework in place to ensure that the practice was meeting its responsibilities for ensuring the safety of its patients.

Leadership and culture

The GP told us they prioritised safe, high quality and compassionate care. Staff told us the GPs were approachable and always took the time to listen to all members of staff.

The GP was aware of and had systems in place to ensure compliance with the requirements of 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). The practice encouraged a culture of openness and honesty. Although the practice had systems in place to ensure that when things went wrong with care and treatment the practice gave affected people reasonable support, truthful information and a verbal and written apology, these systems were not comprehensive. There was no evidence that the practice recorded verbal complaints. Staff were unclear about how to report an incident but said that if they were concerned they would speak to the practice manager.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. These meetings were mostly monthly and all staff were encouraged to attend. GPs did not always come to these meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team social events were held twice a year.
- Staff told us that there was a high staff turnover at the practice and we saw that this was the case. We were told that the reasons given for leaving were mainly financial.
- Staff said they felt respected and supported in the practice and were involved in identifying opportunities to improve the service delivered by the practice. However, a member of staff also reported a lack of training to support the role. There was no system in

Are services well-led?

Inadequate

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

place to assess the need for staff training or to monitor and manage its use. We saw that one member of staff had undertaken online training that was not relevant to GP practice.

Seeking and acting on feedback from patients, the public and staff

The practice told us that they encouraged and valued feedback from patients however, evidence of this was limited.

- The practice told us that they had attempted to form a patient participation group (PPG) but that they had been unsuccessful. The only evidence of the practice proactively seeking patient feedback that we saw was a patient survey conducted in March 2015 with a very small number of patients.
- The practice had gathered feedback from staff during staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. However, staff had had no appraisals in the last year.

This section is primarily information for the provider

Enforcement actions

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not receive timely basic life support training in line with recommended guidelines and not all staff had received training relevant to their role. Emergency medicines were not easily accessible to staff in an emergency. The practice did not always provide care and treatment in line with best practice guidelines and had not produced clinical guidelines specific to the practice. Patient information was not always accurately recorded on the patient record. There was no provision of cover for clinical staff extended absence. Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no overview of significant events and complaints or summary of actions taken, lessons learnt and ongoing monitoring. Staff were not clear about reporting incidents, near misses and concerns. The practice did not have a programme of regular audit or quality improvement to assess, monitor and improve the quality and safety of the service. Actions taken were not recorded in infection control audits. Not all communication with the practice by external services was seen by clinical staff in the practice.

This section is primarily information for the provider

Enforcement actions

Poor outcomes of treatment and low satisfaction scores in the national patient survey were not acted on. The practice had no PPG and the quality of the experience of service users in receiving services was not regularly assessed.

Not all practice policies and procedures were easily available to all staff and were not all up to date or comprehensive

The practice did not have sound systems in place to assess, monitor and mitigate risks to the health and safety of service users. These included:

• Lack of systems in place to identify and address learning and development needs of staff.

• Lack of systems for maintaining the safety of clinical supplies, emergency medicines and equipment .

Some patient confidential information was not held securely.

There were no formal regular meetings with staff from other services to discuss safeguarding concerns or care for vulnerable patients.

The practice was not recording verbal complaints.

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed
Maternity and midwifery services	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

The provider had not undertaken all the necessary recruitment checks prior to employment to ensure fit and proper persons were employed. Information missing included disclosure and barring service (DBS) checks for clinical staff and references.

Regulation 19 (1)(2)(3) and schedule 3