Don Hezseltine

Beacon Medical Services

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 11 October 2017 at Beacon Medical Services to ask the service the following key questions; are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the services it provides.

Beacon Medical Services is an independent provider of GP services and offers a range of services to patients to both adults and children. The practice has a patient population of 500 patients.

The practice offers general medical services for their population and is based on the outskirts of Doncaster town centre.

The provider, Don Hezseltine, is registered with the Care Quality Commission to provide services at Beacon Medical Services, 3 Heather Court, Shaw Wood Way, Doncaster, DN2 5YL. The property is rented by the provider and consists of a patient waiting room, an administration office and a consulting room in a single storey building. There are car parking spaces outside the practice for patients, including a disabled parking space.

The practice holds a list of registered patients who reside in England who require services.

As part of our inspection we reviewed 48 Care Quality Commission comment cards where patients and

Summary of findings

members of the public shared their views and experiences of the service. All of the 48 comment cards we received were extremely positive about the service experienced. Patients reported the practice offered an excellent service and staff were caring, understanding, professional and supportive and treated them with much dignity and respect. They also told us that the environment was clean and hygienic. Patients told us they received information to help them make informed decisions about their care and treatment.

The practice is open from 8am until 6pm Monday to Friday. An out-of-hour's service is provided at the request of the patient and accessed via the dedicated telephone number.

Our key findings were:

- There was an effective system in place for reporting and recording significant events.
- Information about services and how to complain was available and easy to understand.
- Most risks to patients were assessed and managed with the exception of infection prevention and control and medicines management.
- The practice held a register of policies and procedures which were in place to govern activity.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We identified regulations that were not being met and the provider must:

- Ensure care and treatment is provided in a safe way to patients.

In addition the provider should:

- Implement a business continuity plan.

You can see full details of the regulation not being met at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

- There were systems in place for unintended or unexpected safety incidents, to support patients, provide truthful information and a verbal and written apology. They would be told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- There were effective recruitment processes in place and all members of staff had received a Disclosure and Barring Service check (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).
- All staff who acted as a chaperone were trained to carry out this role and had a DBS check in place. However, the practice did not have a chaperone procedure and staff were not trained in medical chaperoning.
- Systems and processes for repeat prescribing, including high risk medicines, kept patients safe. Arrangements for the management of medicines and infection prevention and control required review.
- There were some risk assessments in place which included a fire risk assessment. However the provider did not have sight of a risk assessment for the control of Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and an infection prevention and control audit had not been completed.
- The practice held evidence of Hepatitis B status and other immunisation records for clinical staff members.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- All members of staff were suitably trained to carry out their roles. There was evidence of appraisals, induction processes and personal development plans for all staff.
- The practice ensured sharing of information with NHS GP services and general NHS hospital services when necessary and with the consent of the patient. For example, the practice sent information of consultations to the patients NHS GP.
- The practice had evidence of quality improvement through clinical audits that were relevant to their population. This included an audit of medicines that treat the heart and blood vessels.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Patients reported they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- There was evidence of the caring nature of staff from the comments documented on the comment cards.
- Patients reported staff treated them with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- Patients reported good access to appointments with the GP and that there was continuity of care. They could also text the GP to request a prescription or an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand. No recent complaints had been received.
- Interpretation services were available for patients whose first language was not English. This ensured patients understood their treatment options. The practice also utilised face to face interpretation for any patients who were deaf.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. However this required review for infection prevention and control and medicines management.
- The provider was aware of and complied with the requirements of the Duty of Candour. The practice encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients which it acted on.

Beacon Medical Services

Detailed findings

Background to this inspection

The inspection was carried out on 11 October 2017. The inspection was led by a CQC inspector and included a second inspector and a GP specialist adviser.

Prior to the inspection we had asked for information from the provider regarding the service they provide. We carried out an announced, comprehensive inspection on 11 October 2017 to ask the service the following key questions; are services safe, effective, caring, responsive and well-led?

During our visit we:

- Spoke with the GP and the practice manager.
- Reviewed 48 comment cards where patients and members of the public shared their views and experiences of the service.

We informed the local clinical commissioning group that we were inspecting the service; however, we did not receive any information from them.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about and managing notifiable safety incidents and alerts.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal explanation and would write a written apology.
- They kept written records of verbal interactions as well as written correspondence.
- There was an effective system in place for the receiving, actioning and sharing of patient safety alerts. There was a log of these and patient records reflected any actions taken in response to the alerts.

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the GP of any incidents or significant events and there was a recording form available on the provider's computer system.
- Staff told us significant events were discussed in provider meetings.
- We saw evidence of a serious incident reporting policy.
- The provider held a record of significant events which included details of investigations and actions taken as a result of the significant event.
- The provider carried out a thorough analysis of the significant events.

During our inspection we looked at one significant event and discussed this with the GP. We reviewed safety records and incident reports. We saw where significant events were discussed and action plans agreed to ensure safety was improved . For example, processes relating to the review of palliative care patients were reviewed and updated following a look back exercise. The GP now contacted these patients on a weekly basis to review their needs.

Reliable safety systems and processes (including safeguarding)

The provider had some systems, processes and providers in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was responsible for safeguarding. Staff we spoke with demonstrated they understood their responsibilities for safeguarding children and adults. The GP was trained to child safeguarding level three. However, the practice manager had not attended a safeguarding update within the last three years as recommended in the Safeguarding children and young people Intercollegiate Document 2015.
- We saw evidence that staff understood the Mental Capacity Act (MCA) 2005.
- Information sent to patients when they joined the practice informed them chaperones were available if required. The GP also informed patients they could bring their own chaperone along to appointments. We did not see a notice to inform patients of the chaperone procedure with in the premises.
- Staff who acted as a chaperone had received a Disclosure and Barring Service check (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). Whilst staff had undertaken chaperone training in another role outside of healthcare they were not trained in medical chaperoning. The provider did not have a chaperone policy.

We reviewed one personnel file for a member of staff recruited prior to the provider's registration with CQC. We found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications and the appropriate checks through the Disclosure and Barring Service.

Medical emergencies

The provider had adequate arrangements in place to respond to emergencies and major incidents.

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available. Emergency medicines were easily accessible to staff in a secure area of the provider and all staff knew of their location. All the medicines we checked were in date and fit for use. However, the provider did not have a stock of water ampoules for injection on the day of inspection that would be used to reconstitute an antibiotic powder. The ampoules previously stocked were found to be out of date prior to the inspection and had been discarded but had not been replaced. The provider did not keep a stock of Atropine (a medicine used to help the heart to beat normally) and intra uterine devices (coils) were fitted to females. The practice offered coil fitting to females.
- The provider had a defibrillator available on the premises. We saw evidence that this equipment was checked quarterly to ensure it was fit for purpose, rather than weekly, as recommended by the Resuscitation Council (UK). A first aid kit and an accident book were available.
- The provider did not have a documented comprehensive business continuity plan in place for major incidents such as power failure or building damage. However,staff we spoke with could tell us what the contingencies were including arrangements to be taken in the event of major disruptions to the service in the event of adverse weather conditions.

Staffing

There was adequate staffing levels in place to meet the demands of the service, staff we spoke with told us that levels of cover were adequate.

All members of staff had received a Disclosure and Barring Service check (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).

The learning needs of staff were identified through a system of appraisals, meetings and reviews of development needs. We were told during the inspection that safeguarding training and chaperone training would be arranged for the practice manager.

The GP was registered with the Independent Doctors Federation and had undertaken revalidation. Staff had received an appraisal within the last 12 months. The practice offered coil fitting to females. The GP was trained in obstetrics and gynaecology, however did not have a Letter of Competence in Intrauterine Techniques as recommended by the Faculty of Sexual and Reproductive Healthcare Service Standards.

We saw evidence of medical indemnity insurance for the GP and evidence of the General Medical Council (GMC) registration with a licence to practice.

Monitoring health & safety and responding to risks

Risks to patients and staff were always assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy in place which was accessible to all members of staff electronically and in paper format.
- The provider had adequate fire safety equipment in place and all equipment had been serviced on a regular basis and a fire risk assessment undertaken on November 2016. A fire action plan was on display informing patients and staff what to do in the event of a fire, staff had received fire safety training and regular fire drills and fire alarm tests were carried out by the landlord.
- All electrical equipment was checked quarterly to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw that all electrical items had been checked and all clinical items had been calibrated in October 2017.
- The provider held a risk register which contained risk assessments such as health and safety and environmental factors.

Infection control

The provider had an infection control policy in place but staff had not completed any recent training. An infection prevention and control audit had not been undertaken. The provider told us this would be arranged at the earliest opportunity. We noted some shortfalls with infection prevention and control. There was one hand washing sink in the administrative office but there were no hand washing facilities in the GP consultation room. Hand sanitising gel was not available. There were no spill kits available to clean up body fluids.

Are services safe?

The provider did not have sight of the landlords legionella risk assessment and associated remedial action plan for the building. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We therefore could not be assured all appropriate actions to minimise risk had been completed.

Suitable processes were in place for the storage, handling and collection of clinical waste.

The provider held evidence of Hepatitis B status and other immunisation records for clinical staff members who had direct contact with patients' blood, for example, through use of sharps.

The provider had a safe and effective system in place for the collection of pathology samples such as blood and urine.

Premises and equipment

Appropriate standards of cleanliness and hygiene were maintained. During our inspection we conducted a tour of the premises which included consulting rooms and patient areas. We observed the premises to be visibly clean and tidy. There was a process in place to ensure a cleaning and monitoring checklist was completed and signed on a weekly basis for each area of the premises which included all consulting rooms and patient areas. Staff took responsibility to ensure the provider was kept clean throughout the day.

Safe and effective use of medicines

During our inspection we looked at the systems in place for managing medicines. Medicines were stored appropriately. The processes in place to monitor medicines were safe to administer and supply to patients required review.

- Blank prescription pads were securely stored and there were systems to monitor their use. However, the provider did not keep a central log of prescription numbers and would refer to the numbers documented in the patient notes to monitor use. We observed safe procedures relating to security of reception areas and clinical rooms.
- During our inspection we observed that all medicines and vaccines were stored appropriately. Stock checks of medicines were carried out quarterly. We found 10 flu vaccinations that had expired in May 2017 in the medicine fridge.
- The medicine fridge temperatures were continually monitored by a data logger. These were downloaded every one to two weeks. We were told the data logger would alarm should the temperature fall below two degrees celsius or go above eight degrees celsius. We checked the temperature recordings for the last two weeks prior to our inspection and they were within range. The fridge temperature was not checked daily as recommended by Public Health England's Protocol for ordering, storing and handling vaccines.
- We saw evidence of a repeat prescribing policy. The GP could prescribe medicines and issue repeat prescriptions.

There were small number of patients prescribed high risk medicines. The provider was able to identify each patient on a high risk medicine, such as warfarin. They demonstrated safe monitoring and management of these patients and liaison with other care providers involved in the monitoring of the patient

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The GP 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. They had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs and would document relevant links to the guidance in the patient's medical records.

The practice held a register of all clinical audits carried out which included timescales for further re-audit. During our inspection we saw evidence that two clinical audits had been completed and re-audited which showed quality improvement. For example, the practice had reviewed and updated treatment plans for patients taking medicines that treat the heart and blood vessels. The results were compared with the same audit completed in a NHS GP practice to evaluate the findings which concluded NICE guidance was followed for all patients.

Staff training and experience

The practice had not recruited any staff in the last three years. There was an induction programme for all newly appointed staff which included fire safety, health and safety and confidentiality. Training records showed that staff had received all training deemed mandatory by the practice. Staff told us they valued the training provided to them.

The learning needs of staff were identified through a system of appraisals; we saw evidence that all staff had received an appraisal within the last 12 months by the GP. All staff had a continual professional development record held on their personnel file which recorded details of all training undertaken such as basic life support, fire safety, and health and safety training.

Working with other services

The information needed to plan and deliver care and treatment was available to the GP in a timely and accessible way through the practice's paper patient record system. This included care assessments, medical records, investigations and test results.

The GP liaised with the other care providers to meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. The practice made referrals to other independent or private sector services and could refer to NHS services. The practice also communicated with the patients registered GP to inform them of care provided and medicines prescribed.

If a patient was admitted to hospital, the GP would contact the patient to see if there was anything they could do to help, including arranging referral to other care providers if needed.

Consent to care and treatment

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

- Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Where a patient's mental capacity to consent to care or treatment was unclear the GP told us they would assess the patient's capacity and, recorded the outcome of the assessment

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments on the CQC comment cards reported staff were courteous and very helpful to patients and treated them with dignity and respect.

- The treatment area in the consulting room was obscured behind a half wall to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors could be closed during consultations; conversations taking place in these rooms could not be overheard.
- Staff we spoke with understood the importance of confidentiality and the need for speaking with patients in private when discussing services they required.
- Staff regularly followed up patients that had not been seen by the provider annually by contacting them and offering a medical review.
- The provider took into account the needs of patients. We saw specific examples of staff going above and beyond normal care to ensure patient's needs and wishes were met. For example, communicating with patients via text message and arranging appointments with other care providers.

Involvement in decisions about care and treatment

Patient feedback on the 48 comment cards we received told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. A common theme reported was patients were provided with appropriate information to assist them in their decision making.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- There was good access to the premises with all facilities at street level. Accessible patient toilet facilities were available.
- There was a separate waiting area and the reception desk was located in the administration office. All incoming telephone calls were to a mobile telephone to ensure privacy and confidentiality for patients as the staff member could move to an appropriate area to answer the call.
- All of the patient population were English speaking, however, the provider had details of telephone interpretation services if required. Arrangements could be made for face to face interpretation for any deaf patients.
- There was a comprehensive practice information guide which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also the treatment options and services available.
- Health promotion information could be printed off for patients requesting further information or links to health information websites.

Tackling inequity and promoting equality

The provider offered appointments to both adults and children who had registered for the service. People contacted the service initially by email or telephone. There were disabled facilities and interpretation services available upon request.

Access to the service

The provider was open from 8am until 6pm Monday to Friday. An out-of-hour's service was provided at the request of the patient and accessed via the dedicated telephone number. Patients could ring or text the mobile telephone number to speak to the GP or request an appointment.

The provider also noted any appointments made for patients at hospital and contacted them the day before to remind them.

Concerns & complaints

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

- The provider had a complaints policy.
- The practice manager was the designated responsible person who handled all complaints received by the provider.
- The provider had a system in place to record all complaints received, including verbal complaints, which included a record of all actions taken as a result of complaints received.
- A complaints form was available to help patients understand the complaints system. There was information on how to complain in the patient guide, patient waiting area and on the provider website.

The provider had not received any complaints in the last 36 months.

Are services well-led?

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

Our findings

Governance arrangements

The practice had an overarching governance framework which mostly supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- The practice held details of the GP's professional General Medical Council (GMC) registration and included details of medical indemnity insurance, renewal dates and dates training was completed.
- Practice specific policies were implemented and were available to all staff. The practice held a central register of policies and procedures. During our inspection we looked at policies which included confidentiality, safeguarding and health and safety. All policies and procedures were available in an electronic file which all members of staff had access to. Key policies were also available in reception as a paper copy, as well as the minutes of recent meetings.
- A comprehensive understanding of the performance of the practice was maintained.
- There were some arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. However arrangements for medicines management and infection prevention and control required further review.

Leadership, openness and transparency

The GP had the experience, capacity and capability to run the practice and ensure high quality care. Staff prioritised safe, high quality and compassionate care. Staff told us there was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held quarterly meetings and we saw meeting minutes as evidence of this.
- 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 in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported. Staff were involved in discussions about how to run and develop the practice and to identify opportunities to improve the services delivered by the practice.

Learning and improvement

The practice values were clearly embedded within the practice team. Staff encouraged feedback and offered patients the opportunity to reflect on their experiences.

The practice held a register of all clinical audits carried out which included timescales for further re-audit.

Provider seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

The practice had gathered feedback from patients through surveys and comments received. The practice collated this information and carried out an action plan which included replacing the hand dryer in the patient toilet.

The practice had also gathered feedback from staff through meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users.** **How the regulation was not being met** **The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • The practice leaflet informed patients they could bring their own chaperone along to appointments. We did not see a notice to inform patients of the chaperone procedure with in the premises. Staff were not trained in medical chaperoning. The provider did not have a chaperone policy. **There was no proper and safe management of medicines. In particular:** • The provider did not have a stock of water ampoules for injection on the day of inspection that would be used to reconstitute an antibiotic powder. The ampoules previously stocked were found to be out of date prior to the inspection and had been discarded. The provider did not keep a stock of Atropine (a medicine used to help the heart to beat normally) and intra uterine devices (coils) were fitted to females on the premises. • We found 10 flu vaccinations that had expired in May 2017 the medicine fridge. • The medicine fridge temperatures were continually monitored by a data logger. These were downloaded every one to two weeks. We were told the data logger would alarm should the temperature fall below two degrees celcuis or go above eight degrees celcuis. We checked the temperature recordings for the last two weeks prior to our inspection and they were within range. The fridge temperature was not checked daily as recommended by Public Health England guidelines.

This section is primarily information for the provider

Requirement notices

- Emergency equipment checked quarterly rather than weekly.
- The provider did not keep a central log of prescription numbers.

There was no assessment of the risk of, preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:

- An infection prevention and control audit had not been completed. We noted some shortfalls with infection prevention control. There was one hand washing sink in the administrative office and no hand washing facilities in the GP consultation room. Hand sanitising gel was not available. There were no spill kits available to clean up body fluids.
- The provider did not have sight of a legionella risk assessment.