Old Road West Surgery

Quality Report

30 Old Road West
Gravesend
Kent
DA11 0LL
Tel: 01474 352075
Website: www.oldroadwestsurgery.co.uk

Date of inspection visit: 5 February 2018
Date of publication: 15/03/2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Contents

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Old Road West Surgery on 15 August 2017. Overall the practice was rated as inadequate and was placed into special measures. Practices placed in special measures are inspected again within six months of publication of the last inspection report.

A breach of the legal requirements was found because care and treatment was not being provided to patients in a safe way and the practice had not assessed the risks to the health and safety of service users. Where risks had been identified these had not been mitigated.

Additionally, the practice did not have systems or processes established and operating effectively to assess, monitor and improve the quality and safety of the services provided.

As a result, the provider was not assessing, monitoring and improving the quality and safety of the services provided and mitigating the risks related to the health, safety and welfare of service users and others. Therefore, Warning Notices were served in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Key findings

- Regulation 12
- Regulation 17 Good Governance.

Following the comprehensive inspection, we discussed with the practice what they would do to meet the legal requirements in relation to the breach and how they would comply with the legal requirements, as set out in the Warning Notices.

We undertook this announced focused inspection on the 5 February 2018, to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 15 August 2017. The practice was not rated as a consequence of this inspection, as the practice is in special measures. It will be inspected again, with a view to assessing the practice's rating when the timescale for being placed into special measures has passed.

This report only covers our findings in relation to those requirements. The full comprehensive report on the August 2017 inspection can be found by selecting the 'all reports' link for Old Road West Surgery on our website at www.cqc.org.uk

Our key findings were as follows:

- The practice had improved its formal systems to underpin how significant events, incidents and concerns were monitored, reported and recorded. However, further improvements were still required.
- There were systems, processes and practices to minimise risks to patient safety. However, further improvements were still required in order to help ensure all risks identified were actioned.
- The system to keep all clinical staff up to date and check their understanding of current evidence based guidance and standards, had improved.
- The practice's disease registers had been established and now contained all the relevant patients presenting with the clinical condition. However, these were a work in progress and required further embedding.
- Improvements had been made to help ensure that staff had the skills and knowledge to deliver effective care and treatment.
- The practice had improved how they shared the information with the out of hours provider.
- Care and treatment was planned and delivered in a coordinated way.
- The practice had improved how they obtained consent from patient's consent for minor surgery.
- An assessment had been conducted of their appointment system to ensure it was meeting patients' needs.
- The practice had improved its system for handling complaints and concerns. However, further improvements were still required to help ensure complainants were responded to appropriately.

The practice had made improvements to its overarching governance framework. However, further improvements were still required in order to help ensure they were always effective.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure systems and processes to ensure good governance in accordance with the fundamental standards of care are effective.

In addition the provider should:

- Improve the daily checklist proforma for cleaning schedules.
- Improve policies in the locum induction pack to ensure they are up to date.
- Improve the way in which staff are involved with the development of practice specific policies.
- Improve staff development in order to ensure they are aware of their roles and responsibilities.
- Improve the management of complaints to help ensure they are processed effectively.

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

Old Road West Surgery

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, a second CQC inspector and a practice manager specialist adviser.

Background to Old Road West Surgery

Old Road West Surgery is located in Gravesend, Kent and has a practice population of approximately 10,210. They have a branch surgery located 2.1 miles and approximately 7 minutes away. The practice list is closed; therefore no new patients may be registered at the practice.

The practice is owned and managed by a single male GP, supported by locum GPs. There are two female locum GPs; one that works Tuesday's and Wednesdays and one that works Tuesday and Wednesday mornings, Thursday and Friday all day. The locums work across both practices. The GPs are supported by a female advanced nurse practitioner, a nurse prescriber and two practice nurses and a healthcare assistant (who is qualified as an assistant practitioner). They are supported by a reception/ administrative team which is overseen by the practice manager.

Old Road West Surgery is open daily Monday to Friday 8.30am to 6.30pm. Appointments are from 8.30am and 6pm with the nurses and the GPs from 9am to 6pm. The practice is open later, until 6.45pm on every second Thursday for the family planning clinic. The practice offers on the day appointments including telephone appointments. Routine appointments may be booked two weeks in advance with GPs via the reception team or online. Appointments may be booked six weeks in advance with members of the nursing team. Urgent appointments are also available for patients that needed them on the day at Old Road West Surgery.

The branch surgery at Mackenzie Way is open from 8am to 12.30 Monday to Friday. Patients at the branch surgery were offered an appointment on the day or following day. Patients from Mackenzie Way were offered priority access to afternoon surgery at Old Road West Surgery on a Monday and Friday afternoon. Patients requiring urgent appointments are seen at Old Road West Surgery.

The practice does not provide an out of hours service. Patients are directed to the NHS 111 Service when the surgery is closed during the week, weekends and public holidays.

Services are provided from:

- Old Road West Surgery, 30 Old Road West, Gravesend, Kent DA11 0LL
- Mackenzie Way, 264 Mackenzie Way, Gravesend, Kent DA12 5TY

We inspected Old Road West Surgery during our inspection.

Why we carried out this inspection

We undertook a comprehensive inspection of Old Road West Surgery on 15 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on August 2017 can be found by selecting the 'all reports' link for 15 August 2017 on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Old Road West Surgery on 5 February 2018. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Are services safe?

Our findings

At our previous inspection on 15 August 2017, we rated the practice as inadequate for providing safe services because:

- There was no established and effective system to ensure the safe management of medicines.
- The premises and some clinical equipment required repair. The practice had not conducted an annual infection prevention control audit. There were no detailed cleaning schedules to demonstrate where, when and how items were cleaned.
- There were insufficient procedures in place for assessing, monitoring and managing risks to patient and staff safety.
- The practice had insufficient arrangements in place to respond to emergencies and major incidents. Best practice guidance had not been followed.

We issued a Warning Notice in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service on 5 February 2018.

Safe track record and learning

The practice had improved its formal systems to underpin how significant events, incidents and concerns were monitored, reported and recorded. Information about safety was being reviewed regularly and used to promote learning and some improvement. Discussions with staff and minutes of practice meetings confirmed this. We saw that the practice had good examples of clinical significant events investigated. Although actions had been taken they weren't always consistent. For example, we didn't see new protocols for vaccine management despite there having been four incidents in close succession. We also saw that following a significant event investigation, the practice had written in the investigation record that they had had a chat with the patient. Additionally, there were no records of administrative significant events, despite there being an incident where the practice was short of reception staff, which hadn't been investigated. We discussed this with the provider and practice manager, who agreed to extend the teaching of staff in significant events reporting to include administrative events.

Overview of safety systems and processes

The practice had systems, processes and practices to minimise risks to patient safety.

- The practice told us they followed up on children and vulnerable adults who failed to attend appointments with secondary care. There was documentary evidence where this had been done.

Infection prevention and control procedures had been improved. However, further improvements were still required.

- We found the premises were tidy. The practice had conducted an annual infection prevention control audit in September 2017. However, there were actions from the infection control audit which had not been dated or responded to. For example, the minor tears noted in examination couches. The hole in the wall of the downstairs patient toilet had been repaired. Rips to the seating of the patient waiting areas and rips exposing internal wadding of a treatment chair in a clinical room had been temporarily repaired. However, we were told that quotes had been obtained for the permanent repair of these items but not further action had been taken beyond this stage.
- We found that daily cleaning schedules had been implemented and checklists were completed with staff confirming cleaning had been undertaken. However, the daily checklist proforma did not have a comments box for recording any issues identified during cleaning. For example, tears/rips in examination couches.

The arrangements for managing medicines, including emergency medicines and vaccines had been improved. However, further improvements were still required.

- We reviewed the emergency medicines at Old Road West Surgery. Emergency medicines were stored and easily accessible to staff in a secure area of the ground floor and all staff knew of their location. Minor surgery procedures were conducted on the first floor and a set of emergency medicines were now available on this floor as well.
- Records were kept indicating the contents of the emergency medicines boxes had been checked. There was a list of what medicines were required to be available and the quantities present. Emergency medicines now contained medicines to enable them

manage a patient who experienced an epileptic fit should it occur. However, we found that there were no emergency medicines available for the treatment of croup (as per updated guidance) nor was there a risk assessment to show why this medicine was not available.

- < >he healthcare assistant/assistant practitioner was trained to administer vaccines and medicines in accordance with patient specific prescriptions or directions (PSD's). However, we found that signed PSDs were not always scanned in a timely manner in order to ensure they were maintained appropriately on the patients medical records. {cke_protected_1} Systems had been implemented to ensure the safe handling of repeat prescriptions which included the review of high risk medicines. We found repeat prescriptions for high risk medicines had been issued with the patient having received appropriate monitoring. We spoke with staff who told us that these medicines were now being routinely checked and patients were being advised when their monitoring appointments were due to occur. Additionally, we were told that there was now a system for tracking patients receiving monitoring from secondary care providers.
- The practice had conducted medicines' audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Immunisations/vaccines were stored appropriately and were within their expiry date. However, one fridge had a tracking sheet for the purpose of monitoring how many vials were stored within it but there was no tracking sheet for the other two fridges on site.
- Blank prescriptions were not always being stored and monitored appropriately. We saw that weekly monitoring of records maintained were being undertaken but not all blank prescriptions were removed from printers when rooms were left vacant.
- The practice managed Medicines and Health Regulatory products Agency (MHRA) alerts and patient safety alerts. The principal GP told us the practice manager received the alerts. We spoke with the practice manager who told us they conducted a search of patients' records in response to any alert received, in order to identify patients who may be adversely affected. Any results were shared with the clinical team for actioning. We found that historic alerts had been reviewed and all patients at risk had been contacted and informed of the associated risks or of current advice. All of the staff we spoke with told us that they were aware of alerts received and what actions were being taken and by whom. Minutes of practice meetings confirmed this.

Monitoring risks to patients

The procedures for assessing, monitoring and managing risks to patient and staff safety had been improved. However, further improvements were still required.

- The practice had now had risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella and actions from the Legionella assessment for both surgeries had been partially conducted. For example, the running of water to dead pipes had been implemented but there were other actions which had not been completed.
- There was a health and safety policy available dated August 2017 which stated there was a requirement to conduct an annual assessment. The practice confirmed an assessment had now been conducted. We saw a monthly checklist had been implemented. However, it was unclear as to what the checklist was trying to identify. Additionally, we found that the cupboard housing the practices electrical fuse box was not secure and was accessible to patients. This had not been identified nor had it been risk assessed.
- The practice had a fire risk assessment dated June 2017. An action plan supported the report and required the practice to install emergency lighting. This had been actioned. We reviewed correspondence relating the an assessment from July 2016 which found smoke detectors within common circulation areas were out of date and required replacing. This had now been completed. Records confirmed that fire evacuation plans had been updated and now identified how staff could support patients with mobility problems to vacate the premises. We were told that weekly fire alarm tests were being conducted. Records viewed confirmed this.
- We saw that control of substances hazardous to health (COSHH) products were inappropriately stored in the downstairs staff toilet which was accessible to patients. Additionally, not all rooms were named and one room,

Are services safe?

accessible to patients, was being used as a store room that contained sterile clinical implements and equipment. There was no risk assessment for this room or lock on the door.

Arrangements to deal with emergencies and major incidents

The practice had improved the arrangements to respond to emergencies and major incidents. However, further improvements were still required.

- The practice had a defibrillator available at Old Road West Surgery and at the branch surgery at Mackenzie Way. However, we found that routine checks of the defibrillator at Old Road West Surgery had not been conducted since July 2017 and the adult pads had expired in December 2017. We were told that the lead responsibilities for these had changed between staff members but this had not been discussed with the practice manager. Therefore checks had not been completed as a result. Children's pads were now available for use with both defibrillators.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 15 August 2017, we rated the practice as requires improvement for providing effective services because:

- There was no system in place to ensure staff knew and adhered to current evidence based guidance.
- We found some of the practice's disease registers had not been validated. Therefore, the Quality and Outcome Framework data was not representative of the care and treatment provided to some of the practice's patients.
- The practice did not provide evidence of clinical audits having been conducted to inform quality improvement.
- There was no induction pack for locum GPs defining roles and responsibilities, signposting policies and procedures and referral pathways.
- There were inconsistencies in the quality of the care plans.
- The practice had not shared patient records including end of life care plans with their out of hours provider.
- Some clinical staff had not received annual appraisals.

We issued a Warning Notice in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service on 5 February 2018.

Effective needs assessment

The practice had improved its system to keep all clinical staff up to date and check their understanding of current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. All of the staff we spoke with told us that they were aware of NICE guidelines and how to access them. Minutes of practice meetings and audits confirmed that NICE guidelines were routinely monitored and discussed with staff.

Management, monitoring and improving outcomes for people

We found the practice's disease registers had been established and now contained all the relevant patients presenting with the clinical condition. However, these were a work in progress and required further embedding to ensure that Quality and Outcome Frameworks targets would be achieved. (QOF is a system intended to improve the quality of general practice and reward good practice). Unverified data provided by the practice showed they were achieving 384 points out of the available 559 for the period of 2017/18.

The practice manager was the lead for QOF management and was supported by the principal GP and two administrative staff. Since our previous inspection the practice had reviewed their clinical data system that patients were correctly assigned to the appropriate register.

Patients who were prescribed inhalers were now on the appropriate disease registers and were being offered appropriate care. For example, patients with asthma were being offered an annual review that included an assessment of their asthma control. We found that of the 501 patients on the asthma register 301 had been reviewed. Similarly, of the 35 patients on the learning disability register 14 had been reviewed.

Effective staffing

The practice had made improvements to ensure that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had improved and formalised its induction of locum GPs. We saw that there was an induction pack for locum staff defining roles and responsibilities, signposting to policies and procedures and referral pathways. However, we found that some policies in the induction pack were not as up to date as those maintained on the practices computer system.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Previously, we found there was no employment agreement in place for a GP to cover in the principal GP's planned or unplanned absence. As a consequence the principal GP had not taken leave since our last inspection. A new GP partner has been appointed and will commence in their role in April 2018.
- Staff appraisals had been commenced and we saw records to confirm this. Where staff had not been appraised; we saw that dates for these to be completed

Are services effective?

(for example, treatment is effective)

were scheduled within the next two weeks. All clinical staff had been appraised. The staff who were scheduled for an appraisal knew the appraisal system and who would be their appraiser.

- Staff training was now being monitored and tracked. We saw that all staff had received basic life support training and members of the clinical team had received practical training.

Coordinating patient care and information sharing

The practice had improved how they shared the information with the out of hour's provider and had implemented the use of Share My Care (a system which allows instant, secure access to patients' electronic health and social care records for professionals involved in their care). Staff we spoke with knew how to use the system and told us that it was effective.

There was an established system to help ensure care and treatment was planned and delivered in a coordinated way. The practice had held multidisciplinary meetings since our previous inspection. Care plans had been updated and communication between health and social care professionals to understand and meet the range of patient needs had improved.

Administrative staff were no longer reviewing and prioritising clinical information for clinicians. Minutes of meetings showed that managing correspondence had been discussed at practice meetings and a system for processing correspondence had been implemented. All correspondence received from external parties (hospital discharge information, consultant letters and test results) were reviewed and prioritised by the duty doctor. Staff we spoke with were clear about how to manage clinical correspondence.

The practice had implemented a failsafe system for the management of histology results for patients who had received minor surgery procedures. Records showed that the system was being monitored routinely.

We found there was now a system to monitor the timeliness and appropriateness of clinical referrals, particularly those made by locum GPs. Records viewed confirmed this.

Consent to care and treatment

The practice had improved how they obtained consent from patient's consent for minor surgery. We saw that consent was now being obtained in accordance with the General Medical Council guidance on Consent: Patient and doctors making decisions together (2008). We found patient now consented to the treatment only at the time of the procedure.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 15 August 2017, we rated the practice as requires improvement for providing responsive services because;

- The practice did not demonstrate an understanding of their population profile and had not conducted an assessment of their appointment system and whether it was meeting their patients' needs.
- Information about how to complain was available. Complaints were investigated and responded to appropriately. However, we found no evidence of learning or sharing of outcomes with staff and other stakeholders.

We issued a Warning Notice in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service on 5 February 2018.

Access to the service

The practice had conducted an assessment of their appointment system to ensure it was meeting their patient needs. As a consequence the appointment system had been reviewed and changes had been made. Appointments were now available on the day and up to two weeks in advance. Staff told us that verbal feedback from patients about the changes had been positive. The practice had conducted a patient survey which had been carried out by the patient participation group (PPG). The practice was in the process of reviewing the results at the time of our visit.

Listening and learning from concerns and complaints

The practice had improved its system for handling complaints and concerns. However, further improvements were still required.

The practice had recorded 26 complaints since April 2017. We looked at the complaints and found they had acknowledged receipt of the complaints, investigated the concerns and responded appropriately. However, response letters did not make reference to the parliamentary health service ombudsmen if complainants were not satisfied with the practice response. We saw that whilst Duty of Candour had improved, it had not been applied consistently to all complaints. Therefore complaints processed had not always been completed effectively.

Identified learning from complaints were shared with the practice staff team. Practice meeting minutes and staff we spoke with confirmed this. The practice were conducting an analysis of trends and what action was taken to as a result to improve the quality of care.

Are services well-led?

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

Our findings

At our previous inspection on 15 August 2017, we rated the practice as inadequate for providing well-led services because:

- Changes to personnel had left roles vacant and the risks associated with this had not been addressed. For example, the practice had failed to validate their disease registers to ensure the integrity of their clinical data assessed as part of the Quality and Outcome Framework.
- Policies were incomplete, not adhered to and recommendations not followed.
- We found only one staff meeting had been held in July 2017.
- We found no identification or evidence of quality improvements.
- There was no induction pack for locum GPs; members of the clinical team had not received annual appraisals.
- The lead GP told us they encouraged a culture of openness and honesty. However we found the practice did not have an established or effective system for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice reviewed feedback from staff and patients. We found formal mechanisms to inform patients about changes were limited. For example, the reduced opening hours at the branch surgery.

We issued a Warning Notice in respect of these issues and found arrangements had improved when we undertook a follow up inspection of the service on 5 February 2018.

Governance arrangements

The practice had made improvements to its overarching governance framework which supported the delivery of the strategy and good quality care.

A comprehensive understanding of the performance of the practice was now being provided to staff by the GPs. Staff we spoke with were aware of performance issues and patient satisfaction data. These had been acknowledged by the practice and an improvement plan that was ongoing and under review on a consistent basis, had been implemented. All staff were aware of the plan and actions/ tasks they were allocated in order to support improvements.

Practice specific policies were implemented, or were being developed and were available to all staff on the practice computer system. However, staff told us they would like to be more involved in the development of these.

The practice had some risk assessments to monitor safety of the premises. For example, control of substances hazardous to health and legionella. We saw that actions from the Legionella assessment for both surgeries had been partially conducted.

The systems and processes to underpin the services provided had been improved. For example; significant events, complaints, infection control audits, checks of equipment, staff training/appraisal, MHRA and patient safety alerts, policies and procedures. However, further improvements were required where risks which had not been actioned. For example, infection prevention and control, fire safety and legionella recommendations.

Leadership and culture

Staff told us they felt valued and supported and were being kept informed about developments within the practice. We saw documentary evidence to support this. They were aware of significant events, complaints and safety issues and they were encouraged to raise concerns or identify areas for improvement to the services provided.

Practice meetings had been held on a monthly basis. Records of meetings viewed and staff we spoke with confirmed this. There was now a programme of audit and understanding of the benefits of employing such an approach to identifying, addressing and reducing risks and improving patient outcomes.

There have been many staff changes and new staff recruited. However, roles needed to be further developed to ensure staff have clear roles and responsibilities.

The practice had established and ensured systems were in place to comply 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). We found consistent recording and investigation of significant events

Are services well-led?

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

and that learning from these had been recorded. We reviewed minutes from monthly practice meetings and found reference to complaints or significant events had been made, as well as learning being shared.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider was failing to ensure that care and treatment was being provided to patients in a safe way. The emergency medicines available did not reflect professional guidance in that there was medicine to treat service users presenting with croup. The practice had not ensured the proper and safe management of blank prescriptions. The practice had not ensured signed PSDs were scanned in a timely manner. The practice had not ensured the proper and safe management of medicines, in particular the monitoring of vaccines and immunisations stored at the practice. The practice had not taken all actions from the assessed risk of, and preventing, detecting and controlling the spread of infections. There was out of date emergency equipment and a failure to routinely check emergency equipment. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The provider was failing to ensure that they were operating effective systems and processes established in order to assess, monitor and improve the quality and safety of the services provided. For example, there were no records of administrative significant events which had occurred.

The practice failed to assess, monitor and mitigate risks to the health, safety and welfare of service users. For example, unaddressed risks such as infection prevention and control, fire safety, legionella and health and safety recommendations. Control of substances hazardous to health (COSHH) products were inappropriately stored.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.