Priory Avenue Surgery

Quality Report

2 Priory Avenue
Caversham
Reading
RG4 7SF
Tel: 01189 472431
Website: www.prioryavesurgery.co.uk

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Priory Avenue Surgery, which is managed by One Medicare Limited, on 26 January 2017. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months.

On 2 June 2017 we carried out a focused inspection at Priory Avenue Surgery to determine whether the practice was meeting the conditions applied following the January inspection.

The outcome of this inspection was that three out of six conditions imposed were removed.

A further inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 10 October 2017. The practice was rated as requires improvement for safe, effective, caring and responsive services and inadequate for well-led services. Overall the practice was rated as requires improvement.

We carried out an unannounced focused inspection at Priory Avenue Surgery on 23 January 2018. This inspection was carried out in response to concerns

Summary of findings

received by CQC. We returned to the practice two days later on 25 January 2018 to review and corroborate evidence collected during our first visit. This inspection was undertaken in response to particular concerns. We have not re-rated the provider at this inspection.

The current conditions in place during this inspection were:

- The registered person must implement a sustainable system to ensure outstanding and future repeat prescription requests, medication reviews, clinical correspondence and paper medical records requiring summarisation are reviewed and actioned without delay, to ensure patients are protected from risk of harm, at Priory Avenue Surgery. The existing backlogs for repeat prescription requests, medication reviews, clinical correspondence must all be cleared by 1st March 2017.The summarisation of paper records must be completed by 15th March 2017.
- The registered provider must ensure adequate capability, resource and capacity of all staffing groups in order to deliver a safe service. This includes providing adequate clinical staffing and appointments at Priory Avenue Surgery at all times to protect the health and welfare of patients.
- Effective and sustainable clinical governance systems and process must be implemented by 15th March 2017 at Priory Avenue Surgery. This is to ensure that all patients are able to access timely, appropriate and safe care; the systems and processes implemented protect patient safety and enable compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Priory Avenue Surgery has ongoing enforcement actions, in the form of a warning notice, in place for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with a compliance date of 30 March 2018.

All reports from the inspections can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk. The practice has been managed by One Medicare Limited since September 2016 and they are registered to provide the services and this practice.

This service was placed in special measures following our inspection in January 2017. Insufficient improvements have been made such that there remains a rating of inadequate for provision of well-led services.

Overall the practice was rated as requires improvement following the October 2017 inspection..

Our key findings were as follows:

- We found the systems and arrangements in place had not ensured the risk of, and preventing, detecting and controlling the spread of infections were being assessed, monitored and mitigated effectively. The practice did not maintain appropriate standards of cleanliness and hygiene.
- Data returns provided to the Clinical Commissioning Group (CCG) and the inspection findings showed that the practice was not always dealing with receipt of clinical correspondence and pathology results in a timely manner.
- The system for allocating clinical correspondence did not mitigate the risk of correspondence being reallocated on numerous days without being viewed or actioned.
- There was an effective system in place to monitor the use of high risk medicines.
- Appropriate clinical supervision of locum Advanced Nurse Practitioners and Emergency Care Practitioners was not taking place. A locum practitioner told us they did not know where the practice policies were held and had not needed them so far.
- We were told by one member of staff that they had chaperoned, since our previous inspection in October 2017, without any training due to issues with capacity.
- We found clinicians knowledge of Mental Capacity Act during the 23 and 25 January inspection to be appropriate to their role.
- Clinical meetings and safeguarding meetings had taken place on a monthly basis to ensure learning and information was communicated within the practice.
- There was a lack of effective leadership to ensure risks to patient safety was mitigated. The systems and processes in place for reviewing and actioning clinical tasks, clinical correspondence and pathology results in a timely manner was not effective.

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

Summary of findings

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

This service was placed in special measures in January 2017. Insufficient improvements have been made such that there remains a rating of inadequate for well-led. Therefore the service will remain in special measures. The service will be kept under review and if needed could be escalated to urgent enforcement action. Another inspection will be conducted within six months of the publication of the 10 October 2017 inspection, and if there is not enough improvement we may move to close the service.

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

Priory Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector on both days of the inspection**.** On 23 January 2018 the team included a GP specialist adviser and a practice nurse specialist adviser. On 25 January 2018 the lead inspector was accompanied by a CQC Inspection Manager.

Background to Priory Avenue Surgery

Priory Avenue Surgery provides primary medical services to the Caversham area of Reading from a two-storey converted dwelling, which has undergone several extensions over the last 10 years.

There are no onsite parking facilities and the local roads have available parking for restricted times. There is one parking space adjacent to the practice for patients with limited mobility. The consultation and treatment rooms are on both the ground and first floors with three waiting areas. The first floor can only be reached by a staircase, with no lift facility currently in place.

There are approximately 6,800 patients registered with the practice. The practice serves a population in an area of mainly average deprivation but with some pockets of low deprivation. The practice has a larger number of patients aged 30 to 49 than other practices nationally. The number of patients over the age of 65 is similar to the national average.

One Medicare Ltd registered as the provider of Priory Avenue Surgery in September 2016.

There are two whole time equivalent (WTE) GPs, 1 WTE advance nurse practitioner (ANP), 1 WTE practice nurse and 0.4 WTE health care assistant sessions every week. There were male and female GPs available. The practice has an Alternative Provider Medical Services (APMS) contract.

When the practice is closed, out-of-hours (OOH) GP cover is provided by the Westcall 111 service. Notices on the entrance door, in the patient leaflet and on the practice website clearly inform patients of how to contact the OOH service.

All services are provided from: 2 Priory Avenue, Caversham, Reading, Berkshire, RG4 7SF.

Why we carried out this inspection

We undertook a comprehensive inspection at Priory Avenue Surgery in January 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, effective, responsive and well led services and was placed into special measures for a period of six months.

The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Priory Avenue Surgery on our website at www.cqc.org.uk.

We also imposed urgent conditions upon the provider's registration. We undertook a follow up inspection on 1 June 2017 to check that action had been taken to comply with legal requirements.

We undertook a further announced comprehensive inspection of Priory Avenue Surgery on 10 October 2017. This inspection was carried out following the period of special measures to check improvements had been made

Detailed findings

and to assess whether the practice could come out of special measures. The practice was rated was requires improvement overall with a rating of inadequate for providing well-led services and remained in special measures.

This inspection on 23 and 25 January 2018 was undertaken in response to specific concerns.

Are services safe?

Our findings

At our previous inspection in January 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of procedures and equipment for dealing with emergencies, processing or repeat prescriptions in a timely manner and

staffing levels were not adequate.

At our last inspection on 10 October 2017, we rated the practice as requires improvement for providing safe services as the arrangements in respect of cleanliness and infection control were not adequate.

The arrangements in respect of cleanliness and infection control had deteriorated when we undertook a follow up inspection on 23 and 25 January 2018.

Safety systems and processes

During our inspection in October 2017 we found the systems and arrangements in place had not ensured the risk of, and preventing, detecting and controlling the spread of infections were being assessed, monitored and mitigated effectively. The CQC inspection team found the practice did not maintain appropriate standards of cleanliness and hygiene.

- In October 2017 we observed some areas of the premises to be dirty. Specifically the treatment room and downstairs consulting rooms and the non-clinical areas had a thick layer of dust. We saw dust on the spill kit and the anaphylaxis kit (to treat allergic reactions) was dusty and sticky.
- The lead practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

During the inspection on 23 January 2018 we found:

The patient toilet had;

- yellow stains with 'furry' growths, which appeared to be mould' on the walls
- The toilet smelled 'musty'
- The sink in this room had black marks inside the bowl.
- The toilet was taken out of use following the inspection and our feedback of these concerns to the provider.

Consulting rooms and treatment rooms had thick layers of visible black dust on high and low surfaces, including on top of cupboards, on top of the curtain rail and on the treatment couch. If the dust became dislodged during a procedure, such as minor surgical procedures and insertion of contraceptive coils, there was a risk of infection to patients.

We told the provider of our concerns regarding the cleanliness and infection control at the end of the day on 23 January 2018. However, when we returned on 25 January 2018 the treatment room, consulting rooms and patient toilet were still dirty as described above.

Risks to patients

Following the comprehensive inspection carried out on 10 October 2017 the provider had provided activity data returns to the local Clinical Commissioning Group (CCG). These data returns were made available to CQC and showed that the practice was not always dealing with receipt of clinical correspondence and pathology results in a timely manner.

For example:

- From 01 November 2017 to 17 November 2017 there were between 20 and 71 Docman correspondence records not reviewed within five days of receipt.
- On 20, 22 and 24 November there were seven, eight and seven pathology results not reviewed within five days of receipt.
- On 03 November 2017 there were 62 abnormal/urgent pathology results that had not been reviewed within 24 hours and on 27 November 2017 there were 13 abnormal/urgent pathology results that had not been reviewed within 24 hours.
- From 27 December 2017 and 05 January 2018 there were between five and 19 referrals outstanding to be processed each day. The provider informed us that this backlog was exacerbated by the bank holidays over this period reducing staff capacity to complete such tasks.

During our inspection on 23 January 2018, we therefore reviewed in detail how the practice was dealing with pathology results and clinical letters.

Are services safe?

- On 23 January 2018 we found 47 abnormal pathology results that had not been reviewed by GPs within 24 hours of receipt. The oldest was from 17 January 2018.
- On 25 January 2018 we reviewed these results with a clinician and found they were not significantly out of target range and posed minimal risk to patient care and treatment.
- However, the failure to review abnormal pathology results and take appropriate action, in a timely manner, placed patients at risk if the result required urgent follow up action by the GPs, referral to another service or consideration of admission to hospital.
- The provider was not able to assure themselves that the risks to patients of pathology results not being reviewed and actioned in a timely manner were mitigated.

There was a system in place for GPs to review records and correspondence about patients received from other services. However, the system was not operated effectively because there was a backlog of correspondence that was not reviewed by GPs in a timely manner. Docman correspondence was allocated daily to clinicians working at the practice. If they were not actioned by the end of the day the clinician handed them back and they were reallocated the following day. We saw evidence of correspondence being allocated and sent back for five consecutive days without being viewed or actioned by a clinician.

- On 23 January 2018 we found 32 letters in Docman awaiting processing. The oldest was from 16 January 2018 and eight of these were from 17 January 2018.
- On 25 January 2018 all of the correspondence had been allocated out to the clinicians for the day. We do not know how many of these were actioned by the end of the day or if they were put back in the system for reallocation.
- The failure of the practice to deal with incoming clinical correspondence in a timely manner placed patients at risk. Incoming correspondence could contain information that required urgent action by GPs or clinicians such as requests to undertake further tests, change patients medicines or see the patient for an early review of their care and treatment.
- The provider was not able to assure themselves that the risks to patients of correspondence not being reviewed in a timely manner were mitigated.

Safe and appropriate use of medicines

On 23 and 25 January we reviewed the process in place for monitoring high risk medicines because we noted that pathology test results were not always dealt with in a timely manner. We found there was an effective system in place to monitor the use of high risk medicines.

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 in January 2017, we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, no overarching governance structure and no clear leadership arrangements.

At our last inspection on 10 October 2017, we continued to rate the practice as inadequate for providing well-led services due to a lack of governance structures.

We issued a warning notice in respect of these issues. We found a lack of improvement in some areas when we undertook a follow up inspection of the service on 23 and 25 January 2018. The practice is remains inadequate for being well-led.

Governance arrangements

Following our inspection in October 2017 we found the systems for supervision of clinical staff did not ensure that new team members were supported in their role and appropriately supervised.

- Staff reported there was a lack of onsite clinical supervision and clear guidance on what duties they were expected to perform. Three staff members told us had not had clinical supervision or a review of the standard of their work since commencing employment.
- Appropriate clinical supervision of locum Advanced Nurse Practitioners and Emergency Care Practitioners was not taking place.
- The clinical lead told us that they operated an open door policy and that staff would and have spoken to them when they have questions or concerns.
- There was no system in place to review the work of the locum practitioners to highlight any unconscious lack of knowledge. The process did not allow practitioners to highlight examples of good practice and areas which they could improve to ensure effective care is provided to patients. They told us they did not know if they had audits of their work undertaken and that they felt they did not need them as they were only a locum.
- A locum practitioner told us they did not know where the practice policies were held and had not needed them so far.
- A requirement in place for the provider to submit data returns to CQC showed large gaps in activity data reporting. For example, there was no data reported between 12 December 2017 and 22 December 2017. The practice told us this was due to the member of staff reviewing and collating the data was not working. The practice told us they did not have alternative arrangements to report the data when this member of staff was not working.

Managing risks, issues and performance

- At the inspection in October 2017 we found staff had undertaken chaperone duties without training. We were told on 23 January 2018 by one member of staff that they had since chaperoned without any training due to issues with availability of chaperones.
- At the inspection in October 2017 we found two clinical members of staff did not have the appropriate knowledge regarding their responsibility to adhere to the Mental Capacity Act 2005. We did not find any concerns relating to staff competence and knowledge of Mental Capacity Act during the 23 and 25 January inspection.
- At the inspection in October 2017 we were told clinical meetings were not held on a regular and planned basis. We found that when meetings were held these were not documented to enable the practice to demonstrate what had been discussed to demonstrate learning needed and monitoring of services provided.
- Following the inspection on 23 and 25 January the provider sent us minutes of practice clinical meetings that had been undertaken since October 2017. Clinical meetings and safeguarding meetings had taken place on a monthly basis to ensure learning and information was communicated within the practice. However, findings from the previous CQC inspections had not been effectively used to ensure learning and actions were implemented appropriately to mitigate risks to patients.
- There was a lack of effective leadership to ensure risks to patient safety was mitigated. The systems and processes in place for reviewing and actioning clinical tasks, clinical correspondence and pathology results in a timely manner were not effective.