SKHealth (Knowsley) Ltd

St. Laurence's Medical Centre

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 31 October 2017 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.

Background

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 service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

CQC have not previously inspected this service.

St. Laurence's Medical Centre (SKHealth Knowsley Ltd) provides minor surgery and Ear, Nose and Throat (ENT) consultations and procedures. They offer diagnosis, treatment and support for people aged 16 years old and over within the Knowsley area of Liverpool.

The hours of operation are: Monday, Wednesday and Thursdays 1pm – 3.30pm. The service is run by three doctors and a business manager, and is supported by two nurses, one healthcare assistant and administrative staff.

One of the doctors is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards which were overall very positive about the standard of care received. Comments included; staff treated them with compassion, dignity and respect, staff provided them with good information on treatments, staff allayed anxieties and were professional.

Summary of findings

Our key findings were:

- There were systems in place to report, analyse and learn from significant events, incidents and near misses.
- Recruitment procedures required improvement in order to ensure staff were employed appropriately.
- Systems and practices for the prevention and control of infection required improvement to ensure risks of infection were minimised.
- There were policies and procedures in place for safeguarding patients from the risk of abuse. Most staff had received training in safeguarding, however not all had at an appropriate level to their role.
- Patients' needs were assessed and treatment was planned and delivered following best practice guidance.
- Staff felt supported. They had access to training and development opportunities.
- Patients commented that they were treated with compassion, dignity and respect. Patients were given good verbal information regarding their treatment; however written information was not available.
- Access to the service was monitored to ensure it met the needs of patients. Contract monitoring meetings with the Clinical Commissioning Group (CCG) were evident.
- There was a system in place to manage complaints.
- There were systems in place to monitor and improve quality and identify risk.
- Patient satisfaction views were obtained at the time of treatment. However no further satisfaction surveys or follow up feedback was obtained.

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

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure care and treatment is provided in a safe way to patients. For example, infection risks to patients, public and staff are minimised by assessment and implementation of appropriate prevention and control measures.

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

There were areas where the provider could make improvements and should:

- Review staff training and development and implement a plan to include identification and monitoring of staff training needs. Include safeguarding training for all staff employed and at an appropriate level for their role.
- Review the availability of written information regarding treatments given and post-operative care.
- Review systems to proactively gain patient feedback at intervals following treatment.
- Review governance/staff meetings to include documenting agendas and discussions.

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.

We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

Systems were in place to ensure that equipment was safe to use and that the premises were maintained.

Staff were aware of procedures and there were policies in place for safeguarding patients from the risk of abuse. Some staff had not received safeguarding training at a level appropriate to their role.

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

Appropriate recruitment procedures were not implemented or followed and not all required pre-employment checks had been carried out to ensure staff suitability.

Infection control practices were not suitable in order to minimise and prevent risks occurring.

The practice had adequate arrangements to respond to emergencies and major incident.

Are services effective?

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

The provider assessed and delivered treatments in line with relevant and current evidence based guidance, standards, best practice and current legislation.

Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared.

Staff had the skills and knowledge to deliver effective care and treatment.

Staff had access to training and development opportunities and most staff had received training appropriate to their roles.

Are services caring?

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

Patients' comments indicated they were positive about the care they received from the service. They commented that they were treated with respect and dignity and that staff were caring, compassionate and supportive.

There was good verbal information given to patients regarding treatments, however there was no written information available. There was written information for patients regarding the complaints process which was accessible.

Staff displayed caring, kindness and respectful behaviours.

Patient and information confidentiality was maintained.

Are services responsive to people's needs?

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

Summary of findings

The practice understood its population profile and used this understanding to meet the needs of its population. It liaised with its commissioners to provide suitable services in the area for patients of Knowsley CCG.

The practice had good facilities and was well equipped to treat patients and meet their individual needs. Facilities were accessible to those with limited mobility and translation services were available.

Appointments were available on different days and at different locations across the area.

Information about how to complain was available. A complaints process was in place. The service had not received any complaints.

Are services well-led?

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

We found areas where improvements should be made. This was because:

- The provider requested patient satisfaction feedback at the time of treatment only. There was no mechanism for reviewing satisfaction at intervals following on from treatment and at periods of time post operatively.
- Staff/governance meetings were held informally and not documented.

The practice had a statement of purpose. Staff could articulate the service's values and ethos to provide treatment for its patients working within local and national governance, guidelines and regulations.

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

The practice had a number of policies and procedures to govern activity. However the recruitment policy was ineffective and needed updating and implementing to reflect relevant employment legislation and guidance. Infection control policies were not localised and specific to the service.

St. Laurence's Medical Centre

Detailed findings

Background to this inspection

We undertook a comprehensive inspection of St. Laurence's Medical Centre on 31 October 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection team was led by a CQC lead inspector and included a GP specialist advisor and a second CQC inspector. The service had branch surgeries which were situated in medical practices in other areas of the Clinical Commissioning Group (CCG). We saw evidence that these premises were properly maintained. Staff employed by the provider worked across the service and we reviewed their records.

Before visiting, we reviewed a range of information we hold about the practice and asked them to send us some pre inspection information which we reviewed. During our visit we:

- Spoke with a range of staff from the service (doctors, business manager and administration staff).
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients had shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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. If unexpected or unintended safety incidents occurred the provider told us they would give affected people reasonable support, truthful information and a verbal and written apology. The service had systems in place for knowing about notifiable safety incidents.

There was a system in place for reporting, recording and investigating significant events. The practice had a significant event management policy and a significant event recording form which was accessible to all staff. Staff spoken with knew how to identify and report a significant event. There had been no recorded significant events in the two years they had been operating this service. The business manager described how events and incidents would be analysed and how themes and trends would be identified and learnt from if issues arose.

There was a system in place for the management of patient safety alerts. These were received and disseminated to relevant staff. There was documented evidence of action having been taken where relevant.

Reliable safety systems and processes (including safeguarding)

Policies and procedures for safeguarding children and vulnerable adults were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who had received appropriate training at level three. However some of the nursing staff had not received training to a suitable level. The provider told us that following the inspection provision had been made for these staff to complete an appropriate level of training within one month.

Disclosure and Barring Service (DBS) checks had been undertaken on all staff. These 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. Staff whose role included chaperoning had received appropriate training.

Medical emergencies

Staff had received basic life support training. The practice had a defibrillator and oxygen available on the premises which were checked to ensure they were safe for use. There were emergency medicines available which were all in date, regularly checked and held securely.

Staffing

Disclosure and Barring Service (DBS) checks had been undertaken for all staff. The service had a recruitment policy and procedures (last reviewed in August 2017). We reviewed four personnel files including the most recently employed staff members and found that the recruitment policy had not been followed and was ineffective. There were no application forms, employment histories, professional references or interview records held. We were told these staff had been employed and deemed suitable for employment as the doctors had previous knowledge and had worked with them in similar roles. They told us they had confirmed verbally the staff had the suitable skills, knowledge and experience to undertake the role, however there was no documented evidence to this effect.

Some staff did not have relevant proof of identity including a recent photograph. The provider told us following the inspection that photographic evidence was being sought and would be held for all staff.

The business manager told us they carried out periodic checks of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to ensure the professional registration of staff; however this was not fully documented. We saw that clinical staff were up to date with their professional body revalidation and had medical indemnity insurance.

Following the inspection, the provider told us they would rectify these issues and would ensure appropriate information was obtained for staff and a suitable, effective recruitment policy was operated.

Monitoring health & safety and responding to risks

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a

health and safety policy available. There was a fire risk assessment and the service carried out regular fire safety equipment tests. Electrical equipment was checked to ensure the equipment was safe to use. An up to date electrical wiring certificate and gas safety certificate for the building was available.

The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and Legionella risk assessment.

Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place to ensure that enough staff were on duty

Infection control

The service used consulting rooms, patient waiting and reception areas and had a minor operations room. The areas appeared clean and tidy and were free from clutter. The minor operations room work surfaces did not have sealed splashbacks in order to prevent damage and allow effective cleaning. The flooring seams against the walls were partially sealed and did not allow for effective cleaning. The provider told us that this would be rectified following the inspection.

There were cleaning schedules in place and we were told the business manager also checked on these standards. However there were no specific instructions for cleaning the minor operations room and no documented evidence that cleaning of this specific area was monitored. We were sent cleaning instructions specific to the minor operations room that had been developed following the inspection. There was no evidence that the room was regularly deep-cleaned in keeping with best practice.

One of the doctors was the infection prevention and control (IPC) clinical lead. They had received training in infection control. There was an overarching infection prevention and control policy in place. The practice used the local community infection control team's policies such as hand hygiene, safer use of sharps and clinical waste management, however these were not localised or specific to the service.

An IPC audit had been undertaken recently (June 2017) in conjunction with the community infection control team which the service had passed.

The service had a Legionella risk assessment in place. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The risk assessment identified control measures including water temperature checking. There was no documented evidence that this had been undertaken.

On the day of inspection we found the clinical waste bins were not stored securely. The bins were locked but stored, unsecured, in the car park of the building. During discussions it emerged the waste company had instructed the service to position them there; they immediately secured the bins to an internal location whilst awaiting collection.

On the day of inspection we found some sterile instruments that had past their sterility expiry date. They were situated in the cupboard alongside sterile instruments. We were told that these items were not used as sterile instruments but as clean instruments. The provider removed the items from use and disposed of them.

Hepatitis B immunisation status was not known or documented for all but one of eligible staff. The provider told us following the inspection that arrangements had been made to check their status and document it.

Premises and equipment

The premises were situated in a purpose built medical centre. Appropriate checks were maintained such as on the fire alarm system, electrical systems and emergency lighting. Clinical equipment was checked to ensure it was working properly, regularly serviced and calibrated where needed. There was a business continuity plan in place that was available to all staff and contained all the relevant contact details and procedures.

Safe and effective use of medicines

The arrangements for managing medicines, including emergency drugs and local anaesthetics, in the service overall kept patients safe. There was a medicines management policy in place. The service did not prescribe or dispense any medicines. Local anaesthetics requiring cold storage were stored safely in appropriate fridges that were serviced, maintained and the cold chain was monitored and maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The provider assessed and delivered treatments in line with relevant and current evidence based guidance, standards, best practice and current legislation. This included National Institute for Health and Care Excellence (NICE) guidelines for minor surgery in primary care.

Clinical staff attended training and educational events and where appropriate had clinical supervision to keep up to date with best practice in their field. Doctors we spoke with were familiar with and used national standards for the referral of patients, for example patients with suspected cancers.

Patients were seen at consultation and assessed. Information regarding the surgery/treatment was given verbally and informed consent recorded.

The service undertook audits of clinical practice including infections, complications, referrals and histology. Contract monitoring took place with the CCG who commissioned the service. These reviews also monitored the quality of service.

Staff training and experience

The doctors and supporting staff had a varied skill mix to support effective treatment of their patients. These included GPs with special interests (GPWSI) and doctors with knowledge and skills in the specific field for the services provided. Clinical staff kept up to date in their specialist areas with training and supervision.

The practice had an induction programme for all newly appointed staff. This covered training, confidentiality and a familiarisation programme. Newly employed staff worked alongside experienced to staff to gain knowledge and experience.

Staff told us they felt well supported and had access to training. The service held a record of staff training; however there was no formal training and development plan to identify learning needs of staff.

A new member of staff had not undertaken some core training required. We were told following the inspection that arrangements had been made for them to undertake safeguarding training and any other relevant training appropriate to the role. This would be completed within one month.

Working with other services

The information needed to plan and deliver care and treatment was available to staff through the practice's patient record system and their intranet system which linked in to the NHS GP record systems. This included medical history, assessments, treatment plans and test results.

There were systems in place to ensure relevant information was shared with other services in a timely way, for example when people were referred to other services and receipt and information exchange of results. There were failsafe procedures in place to ensure histology reports were received and reviewed.

Patients' own GPs were routinely informed of the treatments and procedures carried out and histology results.

Consent to care and treatment

We spoke with clinical staff about patients' consent to care and treatment and found this was sought in line with legislation and guidance.

They understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, and had received training in this.

When providing care and treatment for children and young people clinical staff told us assessments of capacity to consent were also carried out in line with relevant guidance.

Before treatment, the provider informed the patients of the main elements of the treatment proposed (including investigations and tests) and any further treatment or follow up. Written consent was obtained and included discussion around benefits, risks and any possible complications. Consent to communicate with the patient's own GP was obtained and documented.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that staff were courteous, respectful and helpful. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations and assessments.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards which were all very positive about the standard of care received. Comments referred to the caring, kind and respectful nature, helpfulness and professionalism of all staff. Comments also indicated that clinical staff listened to their concerns and treated them with compassion and empathy.

Involvement in decisions about care and treatment

Written, informed consent was obtained and recorded in the patients notes. Consent forms detailed the procedure to be undertaken with risks and benefits explained.

Verbal information regarding the procedure/treatment and post-operative instructions was given, however there were no written information leaflets available for patients to take away with them. Comments from patients indicated that verbal information given was good and informative.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The provider worked with the local Clinical Commissioning Group (CCG) and was supported by local NHS specialist services to provide services for patients in the area.

Services were planned and delivered to take into account the needs of patients referred for treatment within the area/CCG. Patients were seen at a pre-operative assessment clinic and options discussed to achieve the most appropriate course of treatment.

Tackling inequity and promoting equality

The premises and facilities at the service were appropriate for the services delivered.

The service was located in a purpose built medical building which was accessible to people with impaired mobility. Translation services (Language Line) were available for people whose first language was not English. The premises had a hearing loop.

Access to the service

Appointments were available on different days and at different locations/branches throughout the area.

Monitoring took place of the service provision by the provider and the commissioning CCG. Data showed that timely access to assessments and treatments was achieved.

Referrals to secondary care (where applicable) were made in line with national guidelines (such as suspected cancer referrals). Histology and test results were followed up.

Concerns & complaints

The service had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and there was a designated responsible person who handled all complaints at the service.

Information signposting patients' to the complaint procedure and a complaints information leaflet was available. This included the details of who the patient should contact if they were unhappy with the outcome of their complaint.

The practice would keep a record of written complaints, however there had been no complaints received regarding the service. Staff told us of the procedure that would be undertaken in the event of receiving a complaint. This discussion indicated that all complaints, verbal and written, would be logged and addressed in a timely manner and that complaints would be reviewed to identify and learn from them and any themes or trends arising.

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 service had a clinical governance policy in place to support the delivery of good quality care and treatments.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. Doctors took lead roles in governance.

The service had policies and procedures in place that were reviewed regularly and were available to all staff. However we found that the recruitment policy was not effective and was not followed and infection control policies were not local or specific to the service.

A comprehensive understanding of the performance of the service was maintained. Contract monitoring meetings were held with the CCG. Data reports were analysed.

Clinical audit was used to monitor quality and to make improvements.

There were appropriate arrangements for identifying, recording and managing risks.

Staff meetings were held however these were not formal or documented.

Leadership, openness and transparency

Staff told us that the leaders and management were supportive and approachable. The culture of the service encourages candour, openness and honesty. There were policies and procedures in place for reporting and staff were aware of their responsibilities.

The service had a whistleblowing policy in place that was available to all staff. Staff we spoke to said they felt supported and confident in raising any issues with the leadership team.

Learning and improvement

Staff felt able to contribute to the development of the service, however this was informal and staff meetings were not documented.

Audits were undertaken and shared with staff and commissioners where any improvements identified would be acted upon.

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

The service undertakes a patient satisfaction survey quarterly. This is carried out at the time of treatment and no further survey or feedback is sought following treatment or at further intervals of their care. We looked at the satisfaction survey for June 2017. Nine questionnaires were returned (approximately 10% of patients treated in that month), 100% were positive about the treatment/service received with patients saying the service was either good or very good. Comments on the survey forms included patients saying the service was excellent, professional and friendly.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment, staff and the public. In particular: There were not adequate systems and processes in place to minimise and control the risks of infections. Infection control policies and procedures were not localised to the service. Legionella control measures were incomplete and not documented Staff immunisation status against Hepatitis B was not known or documented. Flooring and walling in the minor operations room were not appropriate to maintain good standards of hygiene. This was in breach of Regulation 12 (1)

Regulated activity	Regulation
Surgical procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person's recruitment procedures did not ensure that only persons of good character were employed. Effective recruitment procedures had not been established and operated. In particular: The provider did not carry out full checks to ensure that persons employed were of good character, had the competence, skills and experience necessary and were able by reasons of their health to perform the role.

This section is primarily information for the provider

Requirement notices

The provider did not have available information on persons employed such as proof of identity including a recent photograph, satisfactory evidence of conduct in previous employment, a full employment history, together with satisfactory explanation of any gaps and satisfactory information about any physical or mental health conditions which are relevant to the person's ability to undertake the role.

This was in breach of Regulation 19 (1), (2),