Dr Dineshwar Prasad

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the practice on 20 January 2015, when we found breaches of legal requirements.

After the comprehensive inspection, the practice wrote to us to say what actions would be taken to meet the legal requirements in relation to the breaches of regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to person-centred care and good governance.

We undertook this focussed inspection on 8 December 2015 to check that the planned actions had been implemented and to confirm that the practice now met the legal requirements. This report covers our findings in relation to those requirements.

We found that the practice had taken appropriate action to meet the requirements of the regulations.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Dr Dineshwar Prasad on our website at www.cqc.org.uk.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had taken appropriate action and introduced procedural changes to address the issues found at our comprehensive inspection in January 2015.

- Significant events were investigated appropriately and learning passed on to staff.
- The practice had a comprehensive safeguarding policy and identified leads for safeguarding issues.
- Staff had received chaperoning training and patients' records were completed when chaperones were offered and used.
- A legionella risk assessment had been carried out and its recommendations had been implemented.
- The practice's recruitment policy had been updated to ensure that all appropriate pre-employment checks were carried out.
- The practice's procedure for dealing with test results had been revised to ensure that results were seen by the duty doctor and actioned appropriately and in a timely manner.
- The practice had obtained an automated external defibrillator for use in patient emergencies.
- A risk assessment had been carried out relating to emergency medicines.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice had taken appropriate action and introduced procedural changes to address the issues found at our comprehensive inspection in January 2015.

- The provider had conducted the practice nurse's annual clinical appraisal.
- The practice had revised its protocol for dealing with incoming correspondence and test results in a timely manner
- Evidence of consent to treatment was appropriately recorded on patients' notes and staff had received training relating to the Mental Capacity Act and consent.
- Care plans for patients aged over-75 years included details of their health goals, future treatments and of their specific care needs.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had taken appropriate action and introduced procedural changes to address the issues found at our comprehensive inspection in January 2015.

- Learning from significant events and complaints investigations was passed on to all staff to help drive improvements to the service and patient outcomes.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice is rated as good for the care of older people.

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Good

People with long term conditions
The practice is rated as good for the care of people with long term conditions.

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Good

Families, children and young people
The practice is rated as good for the care of families, children and young people.

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Good

Working age people (including those recently retired and students)
The practice is rated as good for the care of working age people (including those recently retired and students).

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Good

People whose circumstances may make them vulnerable
The practice is rated as good for the care of people whose circumstances may make them vulnerable.

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Good

People experiencing poor mental health (including people with dementia)
The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good

Summary of findings

As the practice was now found to be providing good for safe, effective and well-led services this affected the ratings for the population groups we inspect against.

Dr Dineshwar Prasad

Detailed findings

Why we carried out this inspection

We had previously carried out a comprehensive inspection of the practice on 20 January 2015 and found that it was not meeting some of the legal requirements associated with the Health and Social Care Act 2008 and regulations made under that act. From April 2015, all health care providers were required to meet certain Fundamental Standards, which are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 relates to the Fundamental Standard of person-centred care and regulation 17 to the Fundamental Standard of good governance.

At the comprehensive inspection, we had found that the practice was failing to meet the requirements of regulations 9 and 17 and served two notices requiring the provider to take action, as follows -

1. The provider must ensure the care and treatment of service users is appropriate and meets their needs. The provider must ensure a clear and effective system is in place for the processing of patients' test results.
2. The provider must establish and operate effective systems or processes to enable them to assess, monitor and improve the quality and safety of the services, identify and mitigate risks relating to the health, safety and welfare of service users and evaluate and improve practice in respect of these processes. Shortcomings in a number of systems were identified including staff awareness of safeguarding processes; staffing (chaperone training, practice nurse annual appraisal, working knowledge of the Mental Capacity Act 2005, pre-employment checks); and risk assessments (emergency medicines, Legionella).

Following our comprehensive inspection the practice sent us a plan of the actions it intended to take to meet the legal requirements. This follow up inspection was carried out to check that the actions had been implemented and improvements made.

We inspected the practice against three of the questions we ask about services: Is the service safe? Is the service effective? And Is the service well-led? In addition, we inspected the practice against all six of the population groups: older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia). This was because any changes in the rating for safe, effective and well-led would affect the rating given previously for all the population groups we inspect against.

How we carried out this inspection

We carried out an announced inspection on 8 December 2015. Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a second CQC inspector. During the inspection we -

- Spoke with the provider, Dr Prasad, and with the practice manager.
- Reviewed the personal care or treatment records of patients.
- Reviewed policies and procedures relating to the clinical and general governance of the service.

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

At our comprehensive inspection in January 2015, we saw that incidents and significant events had been recorded and learning had been identified from them. We were told by staff that these were discussed in practice meetings, but meeting minutes did not reflect this. At our follow up inspection in December, we saw that significant events monitoring had been made a standing item on meeting agendas. There had been one significant event, which had occurred in early December and the investigation was ongoing. The provider and practice manager confirmed that once the investigation was complete the incident would be reviewed with staff for all to benefit from appropriate learning.

Reliable safety systems and processes including safeguarding

At our comprehensive inspection in January 2015, we found that although clinical staff said they would pass on any concerns, they were less clear on who was the allocated lead for the practice and what was the formal reporting procedure. At our following up inspection, we were shown the practice's comprehensive safeguarding policy which identified the lead staff member for safeguarding issues and set out the procedure for raising concerns and reporting them to the relevant agency. Copies of the policy were available in all consulting rooms and the practice's computer system for staff to access.

At our comprehensive inspection it was unclear how consistently the chaperoning process was used by clinical staff. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). When a chaperone was offered, it was not recorded in the patients' records. At our follow up inspection we saw evidence that all staff had received training on chaperoning and that when chaperones were offered it was appropriately recorded on the patients' records.

Cleanliness and infection control

At our comprehensive inspection, we noted that a risk assessment had been carried out relating to legionella, but it was unclear whether water temperature was regularly tested by the practice. At our follow up inspection were shown the record of a further risk assessment undertaken in December 2015. It was recognised that the risk from legionella was minimal, as the practice had no stored hot water, it being heated directly from the mains at the outlets. The practice had fitted thermostatic taps which shut off the supply when the water temperature was outside the appropriate range.

Staffing and recruitment

In January, we saw that the practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, not all staff records contained references and although we could see that references had been requested, those that had not been received had not been followed up. At our follow up inspection we saw that the practice recruitment policy had been updated to stipulate that references be obtained prior to an unconditional job offer being made. However, there had been no new staff recruited since the original inspection, so evidence of the new procedure being followed was not available. We discussed the revised policy with the practice manager who agreed that a further amendment would be made ensuring that photographic proof of identification would also be checked before new staff members are appointed.

Monitoring safety and responding to risk

At our comprehensive inspection, we found that a number of test results were marked on the patient record system as 'not viewed' or 'not actioned'. The GP responsible for reviewing all test results only worked three sessions a week. They told us it was sometimes unclear if incoming results received in their absence had been checked. Following the inspection, the practice sent us a new protocol that had been introduced outlining the procedure for dealing with test results. This included the use of a duty doctor to check all incoming results in the absence referring GP and the patients' registered GP. At our follow up inspection, we saw from a number of patients' records that the new procedure had been appropriately implemented.

In January we noted that the practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency), as it shared one

Good

Are services safe?

with a nearby practice. We were told that one was to be obtained. At our follow up inspection we saw that the practice now had an AED and that all staff had been trained in its use.

At our comprehensive inspection in January, we were told that the practice did not routinely hold stocks of medicines for the treatment of hypoglycaemia or epileptic seizure. The practice protocol was to offer a sweet drink for hypoglycaemia and to call an ambulance in the case of an epileptic seizure. The practice nurse, who was responsible for emergency medicines, said this had been discussed with the GPs, but there was no formal risk assessment in place. At our follow up visit, we were shown that a suitable risk assessment relating to emergency medicines had been undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

At our comprehensive inspection in January, we were told that the practice manager carried out the appraisal for the practice nurse. The practice manager recognised that they were not qualified to appraise the clinical aspects of the nurse's work. At our follow up visit we saw that the provider had conducted the practice nurse's appraisal on the 18 November 2015.

Working with colleagues and other services

At our comprehensive inspection, we saw that the practice had a protocol outlining the responsibilities of all relevant staff in the administration and actioning of all correspondence, reports and test results relating to patient care. However, there were no time scales identified for the completion of these tasks and not all results had been actioned in a timely manner. At our follow up inspection, we saw the revised protocol now stipulated timescales for dealing with incoming correspondence and test results and we looked at a number of healthcare records which confirmed the protocol was being followed.

Consent to care and treatment

In January, at our comprehensive inspection, the provider had not been to show us any patient record where they had sought or been given patient consent. At our follow up visit we saw evidence on patients' records that, where appropriate, consent was sought and given. We also saw evidence that staff had been provided with Mental Capacity Act training in July 2015, which covered obtaining suitable consent to treatment.

Health promotion and prevention

At our comprehensive inspection we had looked at a number of healthcare records of patients aged over 75 years. The practice used a standard care plan template and had included basic information about the patients' medical history and current medication. Although there was some limited information on the patients' current situation there was no information on their health goals, future treatments or their specific care needs. During our follow up visit, we again inspected a number of records for over-75 year old patients. We saw that their care plan template had been fully completed, with details of their health goals, future treatments and their specific care needs.

Are services well-led?

Good

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

Our findings

Management lead through learning and improvement

At our comprehensive inspection in January, we saw that the practice had a number of policies and procedures to govern activity and clinical issues and that these were discussed at ad hoc meetings. Although significant events were recorded the practice was unable to demonstrate that appropriate learning had been shared and discussed with all staff. At our follow up visit, we saw that significant events monitoring had been made a standard agenda item for clinical meetings. However, only one significant event had been recorded since our January inspection and was still undergoing investigation. Accordingly, it had not yet been reviewed and discussed with staff for learning purposes.

But we were assured by the provider and practice manager that once the investigation had been completed the matter would be appropriately reviewed and any learning passed on to improve practice.

Seeking and acting on feedback from patients, public and staff

At our comprehensive inspection in January 2015, we found no evidence to show that complaints were reviewed and discussed at practice meetings.

At our follow inspection in December, we were told that only one formal complaint had been submitted since January. We saw that it related to a hospital referral and had been dealt with appropriately. We were shown a copy of meeting minutes which confirmed the complaint had been reviewed and discussed with staff. Together with significant events monitoring, complaints had been made a standing item on meeting agendas.