# Cross Keys Practice

## Quality Report

Cross Keys Practice
60 High Street
Princes Risborough
Buckinghamshire
HP27 0AX
Tel: 01844 344488
Website: http://www.crosskeyspractice.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.

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services responsive to people's needs? | Requires improvement |
| Are services well-led? | Requires improvement |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

In December 2014 we found concerns related to the recruitment of staff, identification of staff training needs and systems to monitor risk during a comprehensive inspection of Cross Keys Practice in Princes Risborough, Buckinghamshire. Following the inspection the provider sent us an action plan detailing how they would improve the areas of concern.

We carried out a follow up inspection of Cross Keys Practice on 3 February 2016 to ensure these changes had been implemented and that the service was meeting the requirements of the regulations. Our previous inspection in December 2014 had found four breaches of the regulations relating to the safe, effective and responsive delivery of services. We also found a regulation breach in services being well-led.

This follow up inspection was undertaken more than six months after the original inspection and as a result our follow up methodology would not support a re-rating. However the practice were offered the opportunity of a full comprehensive inspection which would have included a change in ratings.

The ratings for the practice have not been updated to reflect our findings however following the improvements made since our last inspection on 4 December 2014; the practice was now meeting the regulations that had previously been breached.

Specifically the practice was:

- Operating safe systems in relation to the recruitment of staff. Background, recruitment and health checks were completed for staff. This included health checks such as Hepatitis B immunity status for all clinical staff and Disclosure and Baring Service (DBS) checks for all clinical staff and other staff undertaking chaperone duties.
- Providing staff with appropriate training to their roles and had an effective system to identify when staff when required a training update. Specifically, staff had an appropriate understanding of the Mental Capacity Act 2005 ensuring patients were able to provide consent and have their rights protected.
- Effectively monitoring the quality of service which included identification, assessment and management of potential risks to patients, staff and visitors. This included risk assessments in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded as to the risk to staff and patients.
- Awaiting further adaptions to ensure the design and layout of the premises were suitable. Several steps inhibiting the access for people with mobility problems and patients with pushchairs and prams. Whilst awaiting the adaptions the step hazard has been risk assessed, a system now flags patients who

# Summary of findings

require a treatment room located away from the steps and we saw the practice is ready to finalise architect adaptions and process for planning permission.

The practice had also taken full heed of our report following the December 2014 inspection with regards tackling inequity and promoting equality, for example, implementing a telephone translation service. We also saw members of the nursing team were now involved in discussions about how to run and develop the practice.

We have not changed the rating for this practice to reflect these changes, although the practice was now meeting the regulations that had previously been breached.

**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?**

Requires improvement

The practice was rated as requires improvement for providing safe services in December 2014 and was not re-rated as part of this inspection.

Our last inspection in December 2014 identified several concerns relating to safety systems and processes. During the inspection in February 2016 we saw all the concerns had been addressed:

- Incidents were investigated robustly in line with the practice's significant event policy and learning outcomes were shared with staff to improve safety.
- The practice was operating safe systems in relation to the recruitment of staff. Background, recruitment and health checks were completed for staff. This included health checks such as Hepatitis B immunity status for all clinical staff and Disclosure and Baring Service (DBS) checks for all clinical staff and other staff undertaking chaperone duties.

We saw the practice was effectively monitoring the quality of service which included identification, assessment and management of potential risks to patients, staff and visitors. This included risk assessments in relation to the control of substances hazardous to health (COSHH).

**Are services effective?**

Requires improvement

The practice was rated as requires improvement for providing effective services in December 2014 and was not re-rated as part of this inspection.

Our last inspection in December 2014 identified several concerns relating to how effective the practice was with specific concerns about staff training. During the inspection in February 2016 we saw all the concerns had been addressed:

- All staff had received training appropriate to their roles and there was a system to identify when staff had training and when it would need to be refreshed.
- All staff demonstrated an appropriate understanding of the Mental Capacity Act 2005 to ensure that patients were able to provide consent and have their rights protected.

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**Are services responsive to people's needs?**

**Requires improvement**

The practice was rated as requires improvement for providing responsive services in December 2014 and was not re-rated as part of this inspection.

Our last inspection in December 2014 identified several concerns in how responsive the practice was to people's needs. During the inspection in February 2016 we saw all the concerns had been addressed:

- The practice was now offering access to translators via a telephone translation service. This service was clearly displayed in the waiting areas of the practice. There was a computerised system which highlighted patients who required translators to ensure timely access to care and treatment.

The practice was working with an architect to remove the step hazard within the practice. This hazard had been risk assessed and a system was in place ensuring patients with mobility difficulties would be seen in consultation and treatment rooms away from the steps.

**Are services well-led?**

**Requires improvement**

The practice was rated as requires improvement for providing well-led services in December 2014 and was not re-rated as part of this inspection.

Our last inspection in December 2014 identified several concerns in how the practice was managed. During the inspection in February 2016 we saw all the concerns had been addressed:

- The practice had a clear vision including what its objectives were in meeting patients' needs.
- There was a strategy as to how the practice planned to maintain the service and meet demands such as increases to the patient population.
- Members of the nursing team were now involved and contributed to clinical leadership and influenced the running of the practice. For example, attendance at practice meetings and nurse led clinical audits.

There were systems in place to monitor and improve quality and identify risk, this included risks which not identified at the December 2014 inspection, for example COSHH risks and risks associated to the design and layout of the premises.

# Cross Keys Practice

**Detailed findings**

## Why we carried out this inspection

We inspected this service as a focused inspection to follow up on concerns identified at the comprehensive inspection undertaken in December 2014. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting.

The focused inspection of this service was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection is planned to check whether the provider has made the necessary improvements and is meeting the legal requirements in relation to the regulations associated with the Health and Social Care Act 2008.

We have followed up to make sure the necessary changes have been made and found the provider is now meeting the regulations associated with the Health and Social Care Act 2008 included within this report.

This report should be read in conjunction with the full inspection report.

## How we carried out this inspection

Before visiting on 3 February 2016 the practice confirmed they had taken the actions detailed in their action plan.

We met with the practice manager and the Senior GP Partner. We reviewed information given to us by the practice, including records of staff training, recruitment checks and a recruitment policy. We also reviewed documents relevant to the management of the service including risk assessments and significant event analyses. During our visit we undertook observations of the environment.

All were relevant to demonstrate the practice had addressed the breaches of regulation identified at the inspection of December 2014.

Requires improvement

# Are services safe?

## Our findings

**Learning and improvement from safety incidents**

When we visited on 4 December 2014 we looked at the system the practice used for reporting, recording and monitoring significant events, incidents and accidents. We saw there was an inconsistent approach in how learning outcomes and findings were disseminating to practice staff.

During the inspection in February 2016, we saw the practice was now using a range of systems to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and could show evidence of a safe track record.

**Reliable safety systems and processes including safeguarding and recruitment**

In December 2014, we found chaperone training was not completed by all staff who performed the role, including reception 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). Therefore staff were not prepared to undertake their full responsibilities when acting as chaperones.

During the inspection in February 2016, we saw all staff that carried out chaperone duties had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

At the inspection in December 2014, we looked at records containing evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, and full employment histories were in place. However, there were no references or other evidence of conduct during employment in previous health and social care settings for nurses or GPs. Some DBS certificate checks were not available for nurses.

Also, the practice did not check that staff had up to date Hepatitis B inoculations to protect them and patients from infection.

Following the last inspection we received an action plan from the provider informing us of the action they had taken. The practice confirmed that they had taken appropriate action to ensure that all staff were subject to suitable checks prior to commencing employment and these checks had been undertaken for all staff.

During the February 2016 inspection we saw a revised recruitment policy and confirmation of DBS checks for all the nurses' and Hepatitis B immunity status for all clinicians who work at the practice.

This action had ensured that patients received care and treatment and support from staff who had been subject to appropriate health and recruitment checks. The provider was now ensuring that requirements relating to recruitment of staff were now being met.

During the inspection in December 2016, we found the practice did not always have systems and policies in place to monitor and manage risks to patients, staff and visitors to the practice. For example, we reviewed the risk assessment for the control of substances hazardous to health (COSHH). The COSHH risk assessment did not list what chemicals were stored in the building and what the individual risks associated with each of them was.

At the February 2016 inspection, we saw comprehensive risk assessments in relation to COSHH. Each type of substance used at the practice that had a potential risk was recorded and graded as to the risk to staff and patients.

These actions were now ensuring that requirements relating to the identification, assessment and management all risks related to health, welfare and safety were now being met.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective staffing**

During the inspection on 4 December 2014, we found an inconsistent approach to how the training needs of staff was recorded and managed. For example, there was no training log to identify whether staff had training or when they would require it again. Staff we spoke with were unsure when they had last undertaken some training such as safeguarding or hygiene and infection control.

- In February 2016, we reviewed a revised system the practice used to log training needs. This new system was clear and effectively highlighted future learning for all members of staff. This system and staff files including certificates indicated all staff were up to date with their mandatory training.

This action had ensured that staff were appropriately supported by receiving training to enable them to undertake their responsibilities safely and to an appropriate standard. The provider was now ensuring that requirements relating to supporting staff were now being met.

**Consent to care and treatment**

When we visited on 4 December 2014 we found that not all staff were aware of the Mental Capacity Act (MCA) 2005. The GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. However nursing staff lacked understanding of who was able to provide consent on behalf of patients who may lack mental capacity.

We also saw training on the MCA 2005 was not formalised and there were no means of testing or ensuring their staff members awareness.

Following the last inspection we received an action plan from the provider informing us of the action they had taken. The practice confirmed that they had taken appropriate action to ensure that all staff had received formal MCA 2005 training. This included e-learning and classroom training sessions facilitated by one of the GPs.

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

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

This action had enabled staff to obtain consent, protect patients' rights and protect them from potential abuse.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Tackle inequity and promote equality**

When we visited on 4 December 2014 we saw the practice had recognised the needs of different groups in the planning of its services. However, the practice was not always responsive to the needs of ethnic minority groups who may not speak English by ensuring that a translation service was offered to them.

During the inspection on 3 February 2016 we saw the practice had access to translators via a telephone translation service. We saw a recent example of an arranged telephone translator however staff told us there was little call for the service as most patients were able to speak English.

At the December 2014 inspection, we observed adaptations have been made to ensure the practice is accessible.

Adaptations made included:

- Automatic double doors and level access had been installed.
- A phone for contacting reception and check-in screen were available for wheelchair users.
- A wheelchair friendly consultation rooms on the ground floor.
- Accessible toilet facilities were available for all patients.

However, patients with mobility problems, prams or pushchairs, who needed to access the old part of the building for their appointments, were restricted by steps in the reception area.

Cross Keys Practice is located in a converted listed building. Further adaptions including replacing steps required planning permission and detailed plans from an architect with experience of designing in healthcare. The practice risk assessed the step hazard and is about to apply for planning permission to make further adaptions, this was evidenced in various forms of correspondence between the practice and architect.

Nurse treatment rooms were in the easily accessible part of the premises, until these adaptions and removal of the steps have been completed, a system identifies patients who may require an easy access room. This system is regular updated by GPs, nurses and administrative staff.

These actions had ensured that patient's needs were considered ensuring they can access services provided by the practice safely and where possible independently.

# Are services well-led?

Requires improvement

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

## Our findings

**Vision, governance arrangements and leadership**

The practice had a clear vision that had improvement of service quality and safety as its top priority. The practice fully embraced the need to change, high standards were promoted and there was good evidence of team working.

In December 2014 the practice was inspected by the Care Quality Commission. An inspection report followed which highlighted four regulatory breaches relating to safety and suitability of premises, assessing and monitoring the quality of service providers, supporting staff and requirements relating to workers.

We received an action plan from the practice which outlined the corrective action they would take. We found all the actions had been completed at the inspection on the 3 February 2016. The practice had paid full heed to the report compiled by the commission, where action was required.

For example operating safe systems in relation to the recruitment of staff.