Dr Asha Sen

Quality Report

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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 Dr Asha Sen on 10 March 2016. Overall the practice was rated as inadequate and placed into special measures. Being placed into special measures represents a decision by the Care Quality Commission (CQC) that a practice has to improve within six months to avoid CQC taking steps to cancel the provider's registration. Because of the concerns we found during the inspection we served the provider with a notice to impose an urgent suspension of the provider's Regulated Activities for a period of six months from 18 March to 18 September, under Section 31 of the Health and Social Care Act 2008.

We undertook a focused inspection on 5 September 2016 to check whether the provider had made sufficient improvements to allow the suspension to end, and if any further enforcement action was necessary. The provider was not rated on this occasion, but we found that they had not made sufficient improvements to the service; therefore we have taken the decision to extend the provider's suspension by a further six months.

Summary of findings

This report only covers our findings in relation to our focused inspection. You can read about our findings from our last comprehensive inspection via our website: http://www.cqc.org.uk/location/1-572075752/reports.

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?

- There was a significant event recording form available to ensure that a log of significant events could be maintained, but none of the provider's significant events had been recorded or discussed.
- There was no evidence of chaperone training, or safeguarding training to the appropriate level, for several members of staff.
- The practice was clean and tidy but some actions to address infection control issues had not been completed in accordance with deadlines stated in their action plan.
- The security of prescription pads had been improved.
- The recruitment process was not robust.
- Risks to patients were not adequately assessed monitored or well managed.
- There was no emergency equipment available, and emergency medicines were available in limited quantities. This had not been risk assessed. We found several expired medicines on the premises.

Are services effective?

- There was no evidence to demonstrate a clinical audit plan.
- There was no formal system in place to identify the learning needs of staff.
- We requested but were not provided with evidence of training in basic life support, safeguarding children, information governance, infection control and mental capacity act for all staff. Fire safety training had not been completed by any staff.

Are services caring?

- Confidential patient information was stored securely

Are services responsive to people's needs?

- The provider had established a system for recording complaints, and a complaints policy; however, the complaints policy included outdated and inaccurate information.

Are services well-led?

- Steps had not been taken to ensure all staff were aware of their roles, such as for chaperoning.

Summary of findings

- Policies had been updated but some still required further modification. For example, the infection control and safeguarding adults policies did not state the named leads.
- The provider had not reviewed its performance in relation to the national GP patient survey.
- There was no evidence to suggest a clinical audit plan to monitor and improve outcomes for patients.
- The provider did not have adequate arrangements for identifying, monitoring and managing risks.
- The practice had not scheduled or held any documented governance or clinical meetings to discuss issues identified at our previous inspection, or to discuss a strategy for making the necessary improvements.
- Although some positive changes had been made, these changes were not sufficient or embedded well enough to ensure the safety of patients.

Dr Asha Sen

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a practice manager Specialist Adviser.

Background to Dr Asha Sen

The practice operates from one site in Plumstead. It is one of 42 GP practices in the Greenwich Clinical Commissioning Group (CCG) area. There are approximately 3,900 patients registered at the practice. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, and treatment of disease, disorder or injury.

The practice has a personal medical services (PMS) contract with the NHS and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These enhanced services include influenza and pneumococcal immunisations.

The practice has a higher than average population of female patients aged from birth to 59 years, and male patients aged from birth to 29 years and from 45 to 54 years. Income deprivation levels affecting children and adults registered at the practice are above the national average.

The clinical team includes a female GP and two female locum GPs. The GPs work a combined total of 15 sessions per week. There are four female salaried practice nurses. The clinical team is supported by a practice manager and six reception/administrative staff.

The practice is open between 8.00am and 6.30pm Monday to Friday and is closed on bank holidays and weekends. It offers extended hours from 6.30pm to 8.00pm on Thursdays. Appointments are available from 9.00am to 1.00pm and from 4.00pm to 6.30pm Monday to Friday. There are two consulting rooms and a treatment room on the ground floor. On the first floor there is a consulting room used by an external counsellor and an osteopath.

There is wheelchair access and baby changing facilities. There is car parking available in the surrounding streets, and limited parking on the premises.

The practice directs patients needing care outside of normal hours to call the NHS non-emergency number 111.

Why we carried out this inspection

We undertook a focused announced inspection of Dr Asha Sen's practice on 5 September 2016. This was carried-out because at our previous inspection on 10 March 2016 the service was identified as being in breach of legal requirements and regulations associated with the Health & Social Care Act 2008. Specifically, the provider was in breach of Regulation 12 Safe care and treatment; Regulation 13 Safeguarding service users from abuse and improper treatment; Regulation 17 Good Governance; and Regulation 19 Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified the following areas where the provider had to make improvements:

- Take action to address identified concerns with medicine prescribing and management, infection prevention and control, health and safety and fire safety processes.

Detailed findings

- Ensure there are sufficient quantities of emergency medicines, and oxygen is available and all staff know how to use it.
- Ensure there are effective systems in place for safeguarding patients from abuse.
- Ensure all staff receive mandatory training at appropriate intervals.
- Ensure recruitment arrangements include all necessary checks for all staff.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Securely maintain records in respect of service users at all times.
- Ensure staff have appropriate policies, guidance, competence and experience to carry out their roles in a safe and effective manner.
- Assess, monitor and improve the quality of services provided and establish systems for seeking feedback from patients and managing complaints.

Our concerns led us to impose a suspension of the provider's registration for a period of six months from 18 March 2016 under the powers granted to us by section 31 of the Health and Social Care Act 2008.

Our recent inspection on 5 September 2016 was carried out to check whether the provider had made sufficient improvements to allow the suspension to end, or if further enforcement action was necessary.

How we carried out this inspection

Before visiting, we reviewed the issues we found at our previous inspection on 10 March 2016 and asked other organisations to share what they knew. We also reviewed an action plan submitted by the provider that detailed what actions they would take to make the necessary improvements. We carried out an announced visit on 5 September 2016.

During our visit we:

- Spoke with the lead GP and the practice manager.
- Reviewed documents and inspected the premises.

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?

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

During our previous inspection on 10 March 2016 we found that there were inadequate systems in place for recording, sharing and learning from significant events. There was no central log of significant events that had occurred, and no evidence to demonstrate that they had been discussed to share learning from them. Staff we spoke with were not clear on the process to follow for reporting significant events. A serious incident had not been recorded or discussed to prevent a similar situation from happening again.

During our recent inspection on 5 September 2016 we found that there was a significant event reporting form available. No significant events had been recorded or discussed.

Overview of safety systems and processes

During our previous inspection on 10 March 2016 we found the following:

- Arrangements in place to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Although staff told us they liaised on a case-to-case basis with the relevant health and care professionals, a non-clinical member of staff was not clear on that would constitute a safeguarding concern and there was no formalised system to identify service users at risk of abuse. The use of alerts to flag vulnerable children on computer records was inconsistent, there was no protocol in place for safeguarding vulnerable adults and not all staff were clear on who the practice's safeguarding lead was. Training certificates we reviewed showed that some staff had not received safeguarding training at appropriate intervals, and we were not provided with evidence of child or adult safeguarding training for the locum GPs and a nurse when requested.
- Staff who acted as chaperones were not clear on the procedure and they told us they had not received training for the role. None had received a Disclosure and Barring Service (DBS) check. (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).
- The practice did not maintain appropriate standards of cleanliness and hygiene. Carpets in consulting rooms were visibly very dirty and had not been regularly cleaned. Cleaning equipment had not been stored appropriately. Cleaning was carried out only twice a week and there were no cleaning schedules in place for the general areas to demonstrate that cleaning tasks had been completed. Cleaning schedules for medical equipment were in place but were not used. There was visible dust behind computers and in the creases of consulting/treatment room chairs. There was no hand tissue dispenser in a consulting room. In a toilet, the toilet roll dispenser was broken, the light pull cord was visibly very soiled and broken, and toilet rolls had been left on the window ledge.

We found specimens in an unsecured basket on the ground next to a clinical waste bin outside at the rear of the premises and none of the staff were aware of why they had been placed there. There was one post box on an exterior wall of the premises which was used to collect clinical samples and post, which presented a risk of cross-contamination. It was not secure as the interior of the box was easily accessible by hand via a lid, which posed a risk of cross-contamination or infection to any members of the public or patients that were able to gain access to any unsecured infected samples.

Staff were not clear who the infection control lead was, or whether there was one in place, and the infection control policy did not state any named lead. We requested, but were not provided with, evidence that the practice liaised with the local infection prevention teams to keep up to date with best practice. Policies for infection control and sharps management were for a different practice and had not been adapted to be specific to Dr Asha Sen's practice.

We requested, but were not provided with, evidence that all staff had received up to date infection control training, and two members of staff we spoke with were not aware of the spill kit for the management of bodily fluids. Annual infection control audits were not undertaken – the last audit was conducted in 2014 and we noted from discussions with the practice manager that although some actions had been completed or were in progress, they had not been documented to create an audit trail, and action had not been taken to address several other areas for improvement identified.

Are services safe?

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice were not sufficiently effective to keep patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had not followed advice given by Greenwich Clinical Commissioning Group's (CCG) medicines management team in September 2015 that certain medicines were not suitable for prescribing in primary care according to guidance from the South London Area Prescribing Committee and the South London Healthcare Trust. There was no evidence that the serious risks (of foetal deformity or foetal death) of one medicine had been discussed with a patient of childbearing age that it had been prescribed to. The lead GP told us that a locum GP had used her computer login details to carry out the consultation.
- Prescription pads were not securely stored in two consulting rooms and there were no systems in place to monitor their use to ensure they could not be misappropriated or misused. Medicines used in the treatment of anaphylaxis had been left unsecured on a shelf in a consulting room, and recalled vaccines had been unsecured on a desk in the reception area for three days. Staff we spoke with, except the practice manager, did not know why the vaccines had been recalled. Vaccine fridge temperatures had not been checked on 17 dates (excluding weekends and public holidays when the practice was closed) to ensure they remained within acceptable limits for safe storage. There was no second thermometer independent of the mains electricity supply to ensure temperatures recorded were accurate, and there was no system in place to ensure there was an uninterrupted electrical supply to the fridge. Guidance on the management of refrigerated vaccines was outdated (the last version was due to be updated in 2013).
- We reviewed personnel files and found appropriate recruitment checks had not always been undertaken prior to employment. For example, there were no records of proof of identification, references, qualifications, registration with the appropriate professional bodies, or DBS checks for the locum GPs and the medical summariser. There were no written references in place for the receptionist due to commence employment at the practice in April 2016. We were not provided with evidence of registration with the appropriate professional body for the practice nurse.

During our recent inspection on 5 September 2016 we found the following:

- There was still no evidence of safeguarding children and adults training to the appropriate level for the locum GPs and a nurse; the practice's action plan stated that this training would be completed for all staff by 31 August 2016. The practice manager informed us that all non-clinical staff had completed safeguarding training but we were not provided with evidence of this for two receptionists when requested. This posed a risk because the provider could not demonstrate that all staff were updated on their responsibilities and guidance in relation to safeguarding vulnerable service users.

The provider had created a policy for safeguarding adults but the policy did not state the name of the practice's lead for safeguarding adults. This posed a risk because the provider could not demonstrate that staff would have clear guidance on the appropriate person to direct concerns about vulnerable adults to.

- We found that there was still no evidence that chaperones had been trained for their role; the provider's action plan stated that chaperones would receive chaperone training for their role by 31 August 2016. This posed a risk because the practice could not demonstrate that chaperones were updated on the correct procedure to follow to ensure that patients were kept safe during examinations.
- Cleaning schedules for general areas of the practice were in place, the toilet roll dispenser had been replaced and was in use, and the premises was clean and tidy. Cleaning equipment was stored appropriately, and policies had been created for the management of infection prevention and control. However, there were areas of concern; staff were still not clear who the infection control lead was; the lead GP and the practice manager gave us conflicting information about who had been assigned the role of infection control lead, and the infection control policy had not been updated with this information. This posed a risk because other staff members would have been unclear about who to approach with any infection control related issues. Infection control training had not been booked for, or received by, any members of staff; the provider's action plan stated that this training would be booked and completed by 31 August 2016.

Are services safe?

The practice had redecorated the premises but had still not installed hand tissue dispensers in clinical rooms; they told us there was an informal agreement for their builder to install them after our inspection.

Although the practice had completed further outstanding actions from the infection control audit conducted in 2014 (such as the removal of carpets from consulting rooms), they had still not documented them. The provider had still not conducted any further infection control audits as advised from the previous audit, and the infection control policy did not make any reference to how often infection control audits should be conducted. This posed a risk because the provider did not demonstrate that there were effective systems in place to monitor past risks and identify any new risks related to infection control.

The provider had still not removed the post/specimen box; their action plan stated that it would be removed by 31 August 2016. They had not taken any steps to clearly display that patients should no longer deposit their samples in the existing post box. They also told us in their action plan that specimens would be stored in a new fridge, but this had not been written into the specimen handling protocol and there was no new fridge available.

There was no evidence to show that staff had been updated on the use of the spill kit. The provider's infection control policy referred to using granules to clean spillages of blood and other bodily fluids but they only had spill kits available for blood and not for any other bodily fluids such as vomit or urine. This posed a risk of infection as there was no clear guidance on how to safely clean other bodily fluids.

- Although the lead GP had attended an update on medicines management, there was no evidence of any discussions between Dr Sen and the locum GPs regarding inappropriate prescribing of these medicines. This posed a risk because the provider had no systems in place to ensure that learning from the incident where a pregnant woman was presctibed a medicine without being warned of the potential risks to the foetus, was shared with the locum GPs to prevent it from happening again. We found this to be particularly concerning because the lead GP insisted that the prescriptions were not made by her, but by the locums using her computer login details. The lead GP told us she planned for the locums to resume work at her practice following resumption of services. The lead GP had sought assistance from the CCG's medicines management team but this request had been declined.
- The practice had installed a lockable cupboard to securely store prescription pads that were not in use and they kept a record of prescription paper batch numbers to ensure their use could be monitored.
- We found the hazardous chemical sodium hypochlorite (commonly known as bleach) unsecured in the disabled toilet. We raised this with the practice manager at the beginning of the inspection but no action was taken to store it more securely. This posed a risk to patients that were still using the services of the counsellor on the premises, five of whom attended the practice during our inspection.
- Guidelines on the management of vaccines that we reviewed in the nurse's room had not been updated since our previous inspection on 10 March 2016. This posed a risk as the provider could not ensure that staff would have been aware of any recent changes and recommendations.

The practice had not installed in the vaccines fridge a second thermometer that was independent of the mains electricity supply to ensure temperatures recorded were accurate; their action plan stated that this would be in place by 30 July 2016 but we found during our recent inspection on 5 September 2016 that this had not been implemented.

There were no unsecured medicines on the premises.

The practice had created a 'do not unplug' label to prevent power supply to the vaccine fridge from being interrupted but they had not applied the sticker to the fridge plug.

- The practice had created a new recruitment policy but there was still no evidence of background checks, references, photographic identification, registration with the relevant bodies, or indemnity insurance for locum GPs (whom the lead GP informed us would resume work at the practice after the removal of the suspension), with the exception of a driving license, registrations and indemnity insurance for one locum GP. The provider was unable to assure itself of the true identity of the locums, that they were suitably experienced and qualified, and that they were of suitable character to perform their

roles in the practice. Documents demonstrating registration of two practice nurses with the Nursing and Midwifery Council (NMC) had expired in April 2016 (in the UK, nurses must be registered with the NMC to be able to work legally). There was no evidence to demonstrate that these registrations had been renewed.

The practice's new recruitment policy stated that application forms would be used to assess candidates on the basis of comparable information, but when we asked to see the application forms we were informed that there were none in place, and that the provider would only ask to see curriculum vitaes and would not use application forms. This was concerning because the provider informed us they intended to recruit a new practice nurse and a new practice manager and there was no clear understanding of the provider's recruitment process.

Monitoring risks to patients

During our previous inspection on 10 March 2015 we found that risks to patients were not adequately assessed, monitored or well managed.

- The practice had not conducted risk assessments for fire safety, asbestos, control of substances hazardous to health (COSHH), health & safety, or for blinds in the waiting area which had cords that were within easy reach of young children. Actions from the legionella risk assessment conducted in 2013 had not been implemented, including some which had been classed as medium and high risk. In addition, the legionella risk assessment had not been updated as recommended in 2015. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Blinds in the waiting area with cords that were within easy reach of young children had not been risk assessed.
- There was no evidence of the communicable disease Hepatitis B status of clinical staff, or of non-clinical staff who informed us they disposed of clinical waste bags when the cleaner was not present.
- Annual fire drills were not being carried out to ensure staff were updated on the fire evacuation procedure. Smoke alarms were tested every six months instead of weekly (as stipulated in their fire policy) to ensure the alarms were in good working order. There was no information displayed in the public areas regarding action to take in the event of a fire. We requested but were not provided with evidence of annual fire safety training for all staff, with the exception of a nurse. A weighing scale in a consulting room failed a calibration test in 2013 but had not been replaced or repaired.
- Non-clinical staff had been asked to perform tasks, such as medicine changes, which they had not received training for and did not feel competent doing.

During our recent inspection on 5 September 2016 we found:

- The provider had still not conducted risk assessments for fire safety, asbestos, health and safety, or COSHH. Their action plan stated that they would conduct a risk assessment for COSHH by 31 August 2016, and that other risk assessments would be completed by 30 September 2016 but the lead GP told us they would not complete any risk assessments until they had been given a date on which the practice could re-open, due to the cost implications of paying for the risk assessments. Medium and high risks from the Legionella risk assessment conducted in 2013 had not been addressed and the Legionella risk assessment had not been updated as recommended. This posed a risk because the provider had not implemented any effective systems in place to identify or monitor any related risks. Although the blinds in the waiting area had not been risk assessed, the cords had been placed further up the wall to make them inaccessible to young children.
- The provider told us in their action plan that they would obtain records of the immunisation status of all clinical staff by 31 August 2016 but we found during our inspection that this was still not in place for a locum GP and a practice nurse. The provider could not assure itself that all clinical members of staff (who were likely to have regular clinical contact with, and carry out exposure prone procedures such as injections on, patients as part of their roles as doctors and nurses) had been immunised against communicable blood-borne viruses. This posed a risk of harm to patients who may have undergone an exposure prone procedure from any clinical member of staff who may have been infected with blood-borne viruses as a result of a lack of immunisation. It also posed a risk of harm to any clinical member of staff who would not have been protected from any exposure to these viruses from infected patients via, for example, needle stick injuries, without prior immunisation.

Are services safe?

- The practice manager told us that there was no designated fire marshal and smoke alarms were not tested; the fire safety policy stated that they should be tested weekly. The policy also stated that the fire meeting point was in the car park, but fire action signs the provider had created for patients stated the meeting point was at a store beside the practice. This posed a risk because the provider could not assure themselves that the alarms were in good working order, or that there was clear guidance on actions to take in the event of a fire. The weighing scale that had failed calibration testing was still in place, and a new one had not been ordered.
- Although the provider informed us the responsibility for performing medicine changes had been removed from non-clinical staff and would be assigned to GPs. The provider's action plan stated that they would create a policy with clear guidelines on the protocol for medicine changes, and a risk assessment on the storage of smartcards, by 31 August 2016 but we found that there were no written policies in relation to this to keep staff informed of the changes, and no such risk assessment.
- The practice's action plan stated that daily or weekly checks of medicines would be in place by 31 August 2016; however, several medicines/equipment on the premises had expired and there was no clear protocol outlining who was responsible for the management of medicines. The expired medicines/equipment included eleven boxes of vaccines, a box of the emergency medicine adrenaline, a box of the emergency medicine salbutamol, three boxes of the emergency medicine ipratropium bromide, three boxes of blood glucose testing strips, a box of hydrocobalamin solution, three syringes for the administration of vaccines and a box of medical disinfection swabs. This posed a risk because expired medicines can be less effective or risky due to a change in chemical composition or a decrease in strength.

Arrangements to deal with emergencies and major incidents

During our previous inspection on 10 March 2016 we found that the practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- We requested but were not provided with evidence of annual basic life support training for all staff. Basic life support training for two nurses had not been updated annually, in line with current guidelines, since 2013 and 2014.
- Emergency equipment, such as a defibrillator (for use on patients who may have suffered sudden cardiac arrest) or oxygen (for use on acutely ill patients and those who may have suffered respiratory failure requiring emergency medical assistance), was not available and there was no protocol in place for managing medical emergencies. A risk assessment had not been conducted to determine the risk of not having these available. The provider did not have benzyl penicillin for the treatment of viral meningitis in children, diazepam for the treatment of epilepsy, diclofenac for the treatment of pain and inflammation, hydrocortisone for the treatment of acute severe asthma or severe or recurrent anaphylaxis, or Glucagon/ Glucagel for the emergency treatment of episodes of diabetic hypoglycaemia in a medical emergency, and no risk assessment had been carried out in relation to this.
- There was no safety pull cord in the wheelchair-accessible toilet to alert staff to an emergency from disabled patients using the toilet. A first aid kit and accident book were available.
- There was no business continuity plan in place to inform staff of the course of action to take or which external organisations to contact for assistance during non-medical emergencies such as power failure.

During our recent inspection on 5 September we found:

- There was evidence of updated basic life support training for the nurses. There was no evidence of this training for a locum GP.
- The provider had not conducted any risk assessments in relation to the absence of emergency equipment and medicines, and they had not purchased any additional emergency equipment or medicines. This posed a risk of harm to patients who may have suffered from the conditions listed above as some can be fatal if left untreated, or if they are not treated within a reasonable time. The provider had still not conducted any risk assessments in relation to this.

Are services safe?

- A safety pull cord and new light pull cord had been installed in the wheelchair-accessible toilet.
- The provider was in the process of completing a business continuity plan; it needed to be updated with the contact numbers of practice staff and external contacts.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

During our previous inspection we found that there was no evidence of a continuous cycle of audits that led to quality improvements. There had been a completed two-cycle clinical audit conducted in the previous two years but it was not clear if any improvements had been made as a result.

During our recent inspection on 5 September 2016 we found that there was no evidence to demonstrate a clinical audit plan. The lead GP told us they were thinking about conducting a diabetes audit once they started seeing patients again.

Effective staffing

During our previous inspection we found that there was no formal system in place to identify the learning needs of staff, and staff members did not always have access to appropriate training to meet their learning needs and to cover the scope of their work. We requested but were not provided with evidence of training for safeguarding, fire safety, infection control and information governance for all members of staff.

During our recent inspection on 5 September 2016 we found that infection control, fire safety, and safeguarding adults training had not been completed by any staff, except a nurse who had completed safeguarding adults training in 2014, and a receptionist that had completed information governance training. There was no evidence of safeguarding children training to the appropriate level for the locum GPs, a nurse and two receptionists. There was no evidence of basic life support training for a locum GP. The provider's action plan stated that a training needs assessment would be devised and implemented, and all staff would complete information governance training by 31 August 2016, but we found that neither of these actions had been completed.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our previous inspection we found that patient identifiable information awaiting shredding was stored in an unlocked box, in an unlocked room which was easily accessible by unsupervised patients in the waiting area on the first floor. This presented a risk of a breach of patients' confidentiality. We raised this with the practice manager who locked the room immediately.

During our recent inspection we found that documents awaiting shredding were stored securely.

Care planning and involvement in decisions about care and treatment

Staff told us that translation services were available for patients who did not have English as a first language; however, we did not see any notices in the reception area informing patients this service was available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Listening and learning from concerns and complaints

During our previous inspection on 10 March 2016 we found that the practice did not have an effective system in place for handling complaints and concerns. The practice informed us they did not respond to complaints in writing but they called patients and invited them in to discuss their complaints; these discussions were not documented. There was no information available to inform patients about the practice's complaints protocol.

During our recent inspection on 5 September 2016 we found that the provider had created a new complaints protocol but it contained the details of external organisations, that patients could seek assistance from, that no longer exist such as NHS Direct which closed in 2014. The policy also stated that the practice's complaints and comments patient information leaflet and the practice website would be the prime source of information for implementing the complaints policy but the practice did not have any such leaflets or a website.

Are services well-led?

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

Our findings

Governance arrangements

During our previous inspection on 10 March 2016 we found:

- Non-clinical staff were not aware of their own roles and responsibilities in relation to chaperoning and carrying out medicine changes to patients' records without prior training. Staff carrying out medicine changes informed us that they did not feel competent in carrying out this role.
- Several policies including those relating to infection control and safeguarding adults were not in place. Several of the policies and guidelines available had not been reviewed or updated.
- A comprehensive understanding of the performance of the practice was not maintained. For example, the practice had not reviewed the results of the national GP patient survey and had no formal mechanisms to gain, monitor or document feedback from its patients.
- There was no evidence of a programme of continuous clinical and internal audit to monitor quality and to make improvements. A clinical audit had been completed but it was not clear what improvements had been made to patient outcomes.
- There were inadequate arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. This was in relation to the management of significant events, infection control processes, recruitment arrangements, mandatory training, medicines management and prescribing procedures, fire safety, risk assessments, business continuity and the absence of emergency equipment and medicines.

During our recent inspection on 5 September 2016 we found:

- Steps had not been taken to ensure staff were familiar with the chaperone procedure. There was a new policy that only GPs would perform medicine changes but this had not been documented to provide guidance for staff about the changes.
- Policies had been reviewed and updated but some contained information that did not align with what staff told us; for example, the fire action notice contained a different meeting point to the fire safety policy. The infection control and safeguarding adults policies did not contain the names of the relevant leads.
- The provider had not reviewed the results of the national GP patient survey by 31 August 2016 as stated in their action plan. There were complaints forms available for patients to use.
- There was no evidence to suggest a clinical audit plan. The lead GP told us they had thought about conducting a diabetes audit once they were able to start seeing patients again.
- The provider did not have adequate arrangements for identifying, monitoring and managing risks. Outstanding risk assessments had not been completed by scheduled dates, and emergency equipment and additional emergency medicines had not been installed.

Leadership and culture

During our previous inspection on 10 March 2016 we found that governance and leadership arrangements were not effective enough to ensure safe and high quality care. We requested but were not provided with records of unexpected or unintended safety incidents, documented complaints or written records of verbal interactions with patients and written correspondence. The provider was not able to demonstrate compliance with requirements of the Duty of Candour. There were no formal governance, multi-disciplinary team, or clinical meetings. Some staff said they did not always feel supported when they raised concerns and that they did not feel involved, respected or valued.

During our recent inspection on 5 September 2016 we found that although some positive changes had been made, these changes were not sufficient or embedded well enough to ensure the safety of patients. The practice had not held any documented governance or clinical meetings to discuss issues identified at our previous inspection, or to discuss a strategy for making the necessary improvements. The lead GP had met with a local practice to discuss a possible merger, and the practice had created a system for recording complaints and safety incidents. Staff we spoke with told us they still did not feel supported.