

Care Quality Commission

Inspection Evidence Table

Dashwood Medical Centre

(1-2710506334)

Inspection Date: 16 May 2023

Date of data download: 10 May 2023

Overall rating: Inspected but not rated

This inspection was carried out on 16 May 2023 to check the progress against the requirements of the Warning Notices issued on 3 January 2023, for breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities Regulations 2014: Safe Care and Treatment and Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

The rating of Inadequate following our comprehensive inspection on 23 November 2022 remains unchanged. A further full inspection of the service will take place within 6 months of the original report being published and their rating reviewed.

Safe

Rating: Inspected but not rated

At our previous inspection on 23 November 2022, we rated the practice as Inadequate for providing safe services because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were not always met.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff had some information they needed to deliver safe care and treatment. However, improvements were required.
- The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, improvements were needed.
- The practice did not have a robust system to learn and make improvements when things went wrong.

At this inspection in May 2023, we did not rate the practice for providing safe services because we only checked the progress made against the requirements of the Warning Notices issued on 3 January 2023.

We found:

- Improvements to the practice's systems, practices and processes were insufficient and did not always keep people safe and safeguarded from abuse.
- The provider had made some improvements to systems and processes to help maintain appropriate standards of cleanliness and hygiene. However, some infection prevention and control (IPC) issues were ongoing and had not been managed in a timely manner.
- Improvements to the assessment, monitoring and management of risks to patients, staff and visitors had been made but further improvements were still needed.
- Staff did not always have access to the information they needed to deliver safe care and treatment.
- Improvements to the arrangements for managing medicines were insufficient and placed patients at continued risk of harm.
- The provider had made improvements to the management of significant events. However, systems for dealing with safety alerts were not effective.

Safety systems and processes

Improvements to the practice's systems, practices and processes were insufficient and did not always keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	No
Disclosure and Barring Service (DBS) checks were undertaken where required.	No
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 November 2022:</p> <ul style="list-style-type: none"> • The practice's computer system alerted staff of children who were on the risk register, however the system did not alert staff to family and other household members of these children. • We were not provided with the practice's safeguarding children and vulnerable adults policies. • Not all staff had received safeguarding training at a level appropriate to their role. • We were not provided with evidence to show staff members who acted as chaperones had received training for this. • We were not provided with any Disclosure and Barring Service (DBS) checks for staff (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). We had been provided with a risk assessment that demonstrated a DBS check was not required for a member of non-clinical staff. We were told the staff member acted as a chaperone; however, this information was not included as part of the risk assessment. Therefore, we could not be sure the appropriate checks had been completed. <p>At this inspection on 16 May 2023:</p> <ul style="list-style-type: none"> • We looked at a sample of 5 records of children subject to safeguarding at the time of our inspection. We found there had not been an alert placed on family and other household members for 3 of these children. This could result in a clinician seeing a relative of a vulnerable child and be unaware of the whole family 	

circumstance in which the consultation was being conducted. We also found the computer system had not shown that an adult was assigned to 1 child.

- We saw the practice had a comprehensive safeguarding adults and children policy which was accessible to all staff. The policy outlined who to contact for further guidance if staff had concerns about a patient's welfare. We also saw the provider had created a standard operating procedure for staff that outlined activities they should take in accordance with guidance.
- We asked to see evidence to demonstrate the 2 members of clinical staff identified at our previous inspection, had received safeguarding training at a level appropriate to their role. We were not provided with evidence to show 1 member of staff was up to date with safeguarding vulnerable adults training. After the inspection, the provider told us this member of staff had completed this training on 24 May 2023. However, we were not provided with evidence to support this.
- Records showed the other staff member was up to date with safeguarding vulnerable adults training. However, we were not provided with any evidence to show they were up to date with safeguarding children training at a level appropriate to their role. The provider told us this staff member was currently completing their training for this. However, we were not provided with any evidence to support this.
- We also looked at the training records of an additional 2 staff members (1 clinical and 1 non-clinical). Records showed the non-clinical staff member was up to date with safeguarding vulnerable adults training and safeguarding children training at a level appropriate to their role. However, we looked but could not find evidence to show that the clinical staff member was up to date with any safeguarding training.
- We looked at the records of 3 members of staff who acted as chaperones and saw all had received training for this. We asked to see evidence that DBS checks had been completed for these members of staff. Staff told us DBS checks had not been completed for these members of staff. They also told us applications had been submitted for DBS checks for all relevant staff members. However, we were not provided with any evidence to support this.
- We asked to see evidence to show a DBS check or relevant risk assessment had been carried out for the staff member identified at our previous inspection as being a chaperone. At this inspection, staff told us this staff member no longer acted as a chaperone.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 November 2022:</p> <ul style="list-style-type: none"> • The provider was unable to demonstrate recruitment checks had been carried out in accordance with regulations for all staff. • The provider had incomplete immunisation records for some staff. <p>At this inspection on 16 May 2023:</p> <ul style="list-style-type: none"> • We looked at the recruitment files of the same 4 members of staff whose files we reviewed at the previous inspection. Records showed recruitment checks had been carried out in accordance with regulations for 2 of these members of staff. • For the other 2 clinical members of staff, we looked but could not find evidence of: a signed contract; pre-employment references; DBS checks; proof of qualifications, evidence of registration with professional organisations (where required); completed induction checklists or a signed confidentiality policy. 	

- We also looked at the recruitment files for an additional 2 clinical members of staff. Records showed recruitment checks had been carried out in accordance with regulation for 1 of these members of staff.
- For the other member of staff, we looked but could not find evidence of proof of identity, signed contract, pre-employment references; a DBS check; evidence of registration with professional organisations; a completed induction checklist or a signed confidentiality policy.
- We looked at the personnel records of the same 4 staff members whose personnel records we reviewed at our previous inspection. Records showed the vaccination status for 2 of these staff members were maintained in line with current guidance.
- There was no evidence to show the vaccination statuses for the other 2 clinical members of staff, were maintained in line with current guidance.
- We also looked at the personnel records for an additional 2 clinical members of staff and found the vaccination statuses of both were maintained in line with current guidance.

Safety systems and records		Y/N/Partial
Date of fire risk assessment: None		
Actions from fire risk assessment were identified and completed.		No
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 November 2022:</p> <ul style="list-style-type: none"> • A fire risk assessment had not been completed. The provider said they had contacted a specialist company to complete undertake one. • We did not see evidence that relevant staff members had received fire marshal training. • Emergency lighting tests had not been completed as per the practice's policy. <p>During our inspection on 16 May 2023:</p> <ul style="list-style-type: none"> • Staff told us a specialist company conducted a fire risk assessment in January 2023. However, due to the provider not completing a purchase order, the fire risk assessment report was not provided. We saw evidence to show the specialist company had been contracted to carry out another fire risk assessment on 22 May 2023. • Staff told us 6 members of staff who worked at Dashwood Medical Centre were designated fire marshals. However, there was no evidence to show any of these members of staff had completed fire marshal training. Staff told us they were in the process of scheduling fire marshal training for these members of staff. However, we were not provided with any evidence to confirm this. • Records showed the emergency lights had been tested monthly from December 2022 to May 2023 in line with the practice's policy. 		

Infection prevention and control

The provider had made improvements to systems and processes to help maintain appropriate standards of cleanliness and hygiene. However, some infection prevention and control (IPC) issues were ongoing and had not been managed in a timely manner.

	Y/N/Partial
Date of last infection prevention and control audit: 6 October 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
Explanation of any answers and additional evidence: At our inspection on 23 November 2022, we found: <ul style="list-style-type: none">• There was a clinical waste bin that was not locked.• There was no infection prevention and control (IPC) action plan to demonstrate actions had been completed or that there was a timeline for completion. During this inspection on 16 May 2023, we found: <ul style="list-style-type: none">• All clinical waste bins were stored securely and kept locked when not in use.• The provider had developed and implemented an action plan to address the issues identified by the IPC audit. For example, the need to repair a rip in a couch in one of the clinical rooms and the need to replace fabric chairs in a consultation room. During the inspection, we saw these actions had been completed. However, there was no planned review or completion date for 1 of the actions identified (regarding carpeted floors in some clinical areas of the practice). Records showed the provider had contacted relevant parties around November 2022 to enquire about replacing the carpet in clinical areas with coverings that were easier to keep clean. However, staff told us they were still waiting for a response.	

Risks to patients

Improvements to the assessment, monitoring and management of risks to patients, staff and visitors had been made. However, some improvements were still ongoing.

	Y/N/Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Explanation of any answers and additional evidence: At our inspection on 23 November 2022, we found: <ul style="list-style-type: none">• The provider did not have all emergency equipment that was required to be kept.• Not all staff members had completed basic life support training.• A keypad lock for access to the third floor was not in use which could have meant “staff only” areas were accessible to patients and visitors. Staff had told us the lock did not work. During this inspection on 16 May 2023, we found:	

- All emergency equipment that was required to be kept was available to staff for use in a medical emergency.
- We looked at the training records of the 2 non-clinical members of staff whose training records we reviewed at our previous inspection.
- Records showed that 1 of these members of staff was now up to date with basic life support training.
- Staff told us the other member of staff was also up to date with basic life support training. However, we were not provided with evidence to confirm this.
- We also looked at training records of 2 additional members of staff (1 non-clinical and 1 clinical). We found they were both up to date with basic life support training.
- The keypad lock restricting access to the third floor was in use. Patients and visitors were no longer able to gain unauthorised access to this area.
- We saw the keypad lock for access to the staff only area of the reception was not in use. Patients and visitors were therefore able to gain unauthorised access to this area. However, staff told us the lock was faulty and had been reported to management for repair.

Information to deliver safe care and treatment

Staff did not always have access to the information they needed to deliver safe care and treatment.

	Y/N/Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection on 23 November 2022, we found:</p> <ul style="list-style-type: none"> • There were 344 laboratory results dated from October to November 2022 which had not been viewed or acted upon. • The practice's system showed there were also other outstanding documents dating from June 2020 to November 2022. • There were 916 tasks showing in the practice's system dating from June 2021 to November 2022. <p>During this inspection on 16 May 2023, we found:</p> <ul style="list-style-type: none"> • The provider had reviewed the laboratory results from the previous inspection and had taken appropriate action. We saw results were managed in a timely manner. • The provider had reviewed the outstanding documents found at the previous inspection. We saw documents were now being managed in a timely manner. • The practice's system showed there were 989 tasks from July 2021 to May 2023. • The practice's system showed there were 6,665 test requests that had been requested and were awaiting samples. After our inspection the provider told us they had contacted the computer software provider who advised them there was an information technology (IT) error in that the system did not delete a test request when a clinician completed the test review during a patient's consultation. The provider told us they had started to review and action these requests. They told us as of 5 June 2023, there were 2,045 remaining test requests to review. However, we were not provided with any evidence to confirm nor were we provided with details of when the remaining test requested would be reviewed by. The provider told us 	

this would be discussed during clinical meetings. However, we were also not provided with evidence to confirm this.

Appropriate and safe use of medicines

Improvements to the arrangements for managing medicines were insufficient and placed patients at continued risk of harm.

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our inspection on 23 November 2022, we found:</p> <ul style="list-style-type: none">• Improvements were required for some reviews of patients who had been prescribed angiotensin-converting-enzyme (ACE) inhibitors or Angiotensin II receptor blockers (ARBs) (medicines used to lower blood pressure).• The provider did not have all emergency medicines that were required to be kept. <p>During this inspection on 16 May 2023:</p> <p>We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>We looked at the records of patients who had been prescribed ACE inhibitors or ARB medicines. We found there were 1,086 patients who had been prescribed these medicines. The search identified 104 patients who potentially may not have had the required monitoring in the last 18 months.</p> <p>We reviewed the 5 patients who had been identified at our previous inspection as not having had the required monitoring tests. We found;</p> <ul style="list-style-type: none">• One of these patients had received monitoring tests in line with best practice guidance for the management of this medicine.• One of these patients had not received monitoring tests in line with best practice guidance for the management of this medicine. We saw their last blood test was in September 2010 and last blood pressure check was in September 2019. The provider told us due to the COVID-19 pandemic restrictions and the patient's personal circumstances; it had been difficult to conduct the monitoring tests. The provider also said they have made numerous attempts to contact the patient to arrange an appointment and that further attempts would be made. However, we saw the provider last prescribed the medicine in February 2023 with no evidence of monitoring being completed. The risk of prescribing this medicine without monitoring tests could result in adverse effects for the patient and was not in line with best practice guidance for the management of this medicine.• One of these patients had received monitoring tests in line with best practice guidance for the management of this medicine. However, the recent blood test indicated kidney function had decreased.	

We looked but could not find evidence to show there was a documented plan for the next blood test recorded in the patient's notes.

- One of these patients had received monitoring tests in line with national guidance. Their last blood pressure monitoring was on 23 December 2022. The result of the blood pressure reading indicated another blood pressure check would be required. After the inspection, the provider told us the patient had received a blood pressure review as part of their annual diabetes review and that the reading was within the recommended range as per national guidance. However, we looked but could not find evidence of this documented in the patient's notes. Also, the provider did not send us evidence to confirm that the patient had received a blood pressure review as part of their annual diabetes review.
- One of these patients had received monitoring tests in line with national guidance. However, their last blood pressure check (taken on 5 August 2022) indicated it was above the target range of 150/90. Further, the patient had a blood test on 28 April 2023 which suggested there had been a slight decrease in kidney function. We looked but could not find evidence to show there was a documented plan for the next blood test and blood pressure check in the patient's records. The provider told us they would discuss this in the next clinical meeting to help ensure clinicians followed protocol detailed in the medicines management policy when reviewing medicines with regards to setting the next review date.

We found all emergency medicines that were required to be kept was available to staff for use in a medical emergency.

Track record on safety and lessons learned and improvements made

The provider had made improvements to the management of significant events. However, systems for dealing with safety alerts were not effective.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded since our last inspection in November 2022	20
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection on 23 November 2022, we looked at the significant event log and saw it lacked detail of the events, the action taken and evidence of shared learning with non-clinical staff.</p> <p>During this inspection on 16 May 2023, we saw the significant event log contained detail about the events being reported and the action taken. The log also noted how learning from the events was disseminated to staff members. We looked at 3 significant events that had been recorded since our last inspection in November 2022. We saw details of the events had been investigated, escalated to the relevant staff members, discussed in meetings and action taken. We looked at clinical meeting minutes; we saw discussion and the sharing of learning from significant events were a standing agenda.</p>	

We also looked at staff meeting minutes and saw there had been discussions and learning shared about 2 significant events regarding verbal abuse towards staff.

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
There was a delay in processing a patient's laboratory results.	Appropriate investigation of this significant event took place. The patient was contacted and relevant follow up work was completed. We saw that staff were informed of this and measures had been put in place to help prevent reoccurrence. For example, a review of how the practice processes results to help ensure they are reviewed in a timely fashion.
Ensuring staff cover - due to a computer issue at the pathology laboratory, results had been delayed and were delivered in a large batch.	We saw there had been a discussion with relevant staff and systems were put in place to help manage the high workload. For example, a rota was implemented to ensure there was enough staff to review the results and ensure no duplication of work. The meeting minutes also showed discussion took place regarding when the best time was to contact patients about their results. We also saw analysis of ways to efficiently manage a high volume of tasks.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts and acted on these alerts.	No
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2022, we found improvements were required regarding actioning Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts.</p> <p>At this inspection in May 2023, during our clinical searches, we reviewed 2 safety alerts and found relevant action had not been taken in response to either of them.</p> <p>We looked at the records of patients who had been prescribed the medicine citalopram 40mg (an anti-depressant). The alert explained the need to review patients over 65 years who had been prescribed citalopram because they should not be prescribed more than 20mg. It also explained it was contraindicated to prescribe citalopram together with some other medicines.</p> <p>Our search identified 8 patients who had been prescribed this medicine. We reviewed the records of the same 3 patients whose records we reviewed at our previous inspection.</p> <p>We found:</p> <ul style="list-style-type: none"> One patient had been informed of the risks associated with this medicine and their dosage had been reduced. However, monitoring tests (blood test and blood pressure check) and a medication review were overdue. The provider told us an appointment would be arranged for this patient, but we were not provided with evidence to confirm this or informed when this appointment would take place. One patient's dosage had been reduced in line with the MHRA alert. However, there was no evidence to show that a discussion took place with this patient to inform them of the risks associated with this medicine. There was also no evidence to show an assessment had been made of the patient's symptoms 	

or that they had been informed about the plan to reduce the dose of the medicine. The provider told us an appointment would be arranged for this patient. But we were not provided with evidence to confirm this or informed when this appointment would take place.

- One patient's dosage had been adjusted and we saw a discussion with this patient had taken place. However, a medication review was overdue. Records also showed this patient had been prescribed phenytoin. However, blood test monitoring for this medicine was also overdue.

We also reviewed the records for an additional 2 patients who had been prescribed this medicine:

- We looked but could not find evidence to show a discussion about the risks had taken place with 1 of these patients. After the inspection, the provider told us this patient had received a review with a GP and a clinical decision was made to keep the patient on the current dose. However, we were not provided with evidence to support this. We also saw there was an alert on this patient's record telling staff the patient required a blood pressure check. However, there was no evidence to show this had been actioned.
- Records of the second patient showed a prescription for citalopram had been issued on 10 May 2023. There was no evidence to show this patient had been informed they would need an assessment before the medicine is due to be prescribed next. Records also indicated this medicine had been stopped by a GP on 13 May 2023 without informing the patient. There was no evidence to show an assessment had been made. The provider told us this patient recently turned 65 years of age and would have been reviewed when they completed their 6 monthly MHRA reviews. The provider told us that as a result of this inspection, they would arrange an appointment for the patient, but we were not provided with evidence to confirm this or informed when this appointment would take place.

We also looked at the records of patients who had been prescribed the medicines simvastatin (used to lower cholesterol) and amlodipine (used to treat blood pressure). The alert explained the need to prescribe an alternative statin but if simvastatin was the only option, then the maximum dose should be 20mg if prescribed with amlodipine.

Our search identified 3 patients who had been prescribed these medicines.

We found:

- One of these patient's dosage had been reduced in line with the MHRA alert. However, we looked but could not find evidence to show this had been discussed with the patient. We also looked but could not find evidence to show a blood test had been carried out prior to lowering the dosage. Records also showed a relevant blood test was overdue as the patient had been prescribed a disease modifying antirheumatic drug.
- We looked at the records of the second patient but could not find evidence to show they had been informed of the risks associated with these medicines. Records showed this patient was last issued these medicines on 11 May 2023.
- We looked at the records of the third patient but could not find evidence to show they had been informed of the risks associated with these medicines. Records showed this patient was last issued these medicines on 26 April 2023. Records also showed amlodipine was stopped on 12 May 2023. However, we could not find evidence to show the reason for this. Records also showed monitoring tests for simvastatin had been overdue; the last blood test to check cholesterol levels was in August 2021.

The provider told us they complete searches on the computer system for historic safety alerts every 6 months as per their action plan from the previous inspection (conducted in November 2022). They said they would discuss this in their next clinical meeting to help ensure all clinicians were aware of this MHRA alert.

Effective

Rating: Inspected but not rated

At our previous inspection on 23 November 2022, we rated the practice as Requires Improvement for providing effective services because:

- Patients’ needs had not always been assessed, and care and treatment had not always been delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- The practice always obtained consent to care and treatment. However, DNACPR decisions were not always made in line with legislation and guidance.

At this inspection in May 2023, we did not rate the practice for providing effective services because we only checked the progress made against the requirements of the Warning Notices issued on 3 January 2023.

We found:

- Some patients’ needs were still not always assessed and care and treatment was not always delivered in line with current legislation and standards.
- All staff were still not up to date with essential training and did not have access to regular appraisals.
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were still not being completed in line with legislation and guidance.

Effective needs assessment, care and treatment

Patients’ needs were still not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients’ treatment was regularly reviewed and updated.	No
Explanation of any answers and additional evidence: At our inspection on 23 November 2022, we found improvements were required for some reviews of patients who had been prescribed 12 or more Short-Acting Beta Agonist (SABA) inhalers in the previous 12 months and for patients who had hypothyroidism who had not had appropriate monitoring in the previous 18 months. During this inspection on 16 May 2023, we saw there were 26 patients who had been prescribed 12 or more SABA inhalers in the last 12 months. We looked at the records of the same 4 patients whose records we reviewed at our previous inspection. We found:	

- All 4 of these patients had received an asthma review regarding the overuse of SABA inhalers since our last inspection. However, we found 3 of these patients were overdue a medicines review.
- Records showed 1 of these patients had an appointment for a medication review but did not attend their appointment. The provider told us these patients would be reviewed by the clinical pharmacist. However, we were not provided with any evidence to confirm this nor informed when the reviews would take place.

We also looked at the records for an additional 3 patients who had been prescribed 12 or more SABA inhalers in the last 12 months and found:

- Of the 3 patients; 2 had received a full asthma review in line with national guidance.
- One of these patients had not received a medicine review since March 2020. After the inspection, the provider told us this patient was not prescribed any medicine other than inhalers and therefore a medication review was not required. However, we were not provided with any evidence to support this.
- Another of these patients had not received a medicines review since December 2018.
- For the third of these patients, the provider told us there was no respiratory diagnosis yet and they were awaiting lung function tests from secondary care. However, we found this patient had not received a medicine review since July 2021.

During our clinical searches, we also looked the records of patients who had been diagnosed with hypothyroidism. We saw there were 8 patients who had potentially not received the required blood test in the last 18 months.

We looked at the records of the same 5 patients whose records we reviewed at our previous inspection. We found:

- Two of these patients had received monitoring tests in line with national guidance.
- One of these patients had a recent blood test result in their records (April 2023). The result indicated follow up by the practice was required. However, we looked but could not find evidence to show the patient had been informed of the result or the need for follow up. After the inspection, the provider told us a follow up appointment had been booked for this patient for 23 May 2023. However, we were not provided with evidence to confirm this.
- One of these patients was overdue monitoring tests. We saw the last blood test result in their records was December 2018 and the result indicated follow up by the practice was required. Records showed the provider had sent a letter to the patient asking them to book an appointment for relevant follow up. The provider told us there had been multiple attempts (via telephone and text messages) asking the patient to book an appointment for follow up, but they had been unsuccessful. However, we were not provided with any evidence to confirm this. Records showed this patient had been prescribed thyroxine on 9 May 2023. We looked but could not find evidence to show that relevant monitoring had been completed prior to issuing this prescription.
- One of these patients had a recent blood test result in their records (February 2023) but this indicated follow up by the practice was required to review whether an adjustment in medication was needed. We saw the provider had identified the need for review; a clinical decision was made to repeat the blood test. The provider told us the patient had cancelled their appointment for a repeat blood test and had rescheduled it. Records showed this patient had been prescribed thyroxine on 23 April 2023. However, we looked but could not find evidence to show the prescriber had checked or was aware that the patient had not had their second blood test.

Effective staffing

All staff were still not up to date with essential training and did not have access to regular appraisals.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	No
There was an induction programme for new staff.	No
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No
Explanation of any answers and additional evidence: At our inspection on 23 November 2022, we found: <ul style="list-style-type: none">• Not all relevant staff were up to date with safeguarding training, basic life support training, chaperone training and fire marshal training.• We could not be sure staff had access to regular appraisals.• We could not be sure that all staff had received an induction appropriate to their role. At this inspection on 16 May 2023: <ul style="list-style-type: none">• We looked at chaperone training records for 3 members of staff and found all had received this training.• We looked at the safeguarding training records for 4 members of staff. We looked but could not find evidence to show 1 clinical member of staff was up to date with safeguarding vulnerable adults training nor that another member of clinical staff was up to date with safeguarding children training to the level appropriate for their roles. We also looked but could not find evidence to show another clinical member of staff was up to date with safeguarding vulnerable adults training and safeguarding children training.• We looked at the basic life support training records for 4 members of staff. Of the 4, we looked but could not find evidence to show that 1 member of staff was up to date with this training.• We asked to see evidence to show that staff with fire warden responsibilities had been trained for the role. The provider confirmed there were 6 staff members who were designated fire wardens. However, the provider told us they had not received fire warden training but that they were in the process of scheduling training for staff. However, we were not provided with evidence to confirm this.• We looked at the personnel records of 6 members of staff. We looked but could not find evidence to show that 3 of these members of staff had received a recent appraisal. The provider told us 1 of these members of staff had received an appraisal in September 2022. However, we were not provided with evidence to confirm this.• We looked at the personnel records of 5 members of staff. We could not find evidence to show 3 of these members of staff had an induction checklist or a signed a statement of understanding document.	

Consent to care and treatment

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were still not being completed in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	No
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	No
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection previous on 23 November 2022, we found 3 DNACPR decision forms did not contain review dates and 2 of these did not include reasons why Cardiopulmonary Resuscitation (CPR) would be inappropriate.</p> <p>At this inspection on 16 May 2023, we found 3 DNACPR decision forms did not contain review dates.</p>	

At our previous inspection on 23 November 2022, we rated the practice as Requires Improvement for providing responsive services because:

- Complaints were not used to improve the quality of care.

At this inspection in May 2023, we did not rate the practice for providing responsive services because we only checked the progress made against the requirements of the Warning Notices issued on 3 January 2023.

We found:

- Although complaints were now being investigated, there was no evidence to show learning from complaints was being shared with relevant staff.

Listening and learning from concerns and complaints
Although complaints were now being investigated, we could not find evidence to show learning from complaints was being shared with relevant staff.

Complaints	
Number of complaints received since our last inspection in November 2022	7
Number of complaints we examined.	7
Number of complaints we examined that were satisfactorily handled in a timely way.	7

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence: At our previous inspection on 23 November 2022, we did not see that complaints had been investigated to identify learning points to be shared with all staff. At our inspection on 16 May 2023, records demonstrated complaints were recorded, investigated and the complainants received a response in a timely manner. We saw from clinical meeting minutes that complaints were a standing agenda. However, we did not see evidence to show that complaints and any learning were shared with non-clinical staff. During the inspection, the provider told us they had recently implemented a new system whereby complaints and any learning would now be discussed during monthly staff meetings. We reviewed a complaint the provider had received from a patient explaining the difficulties they had experienced in obtaining a GP appointment. We saw the provider had acknowledged the complaint in writing, investigated it, and a written response had been sent to the complainant. However, we did not see evidence to show learning from this complaint had been shared with all staff.	

We also reviewed another complaint about a patient not receiving a follow up appointment and difficulties in obtaining a medical certificate. We saw the provider had investigated this, telephoned the patient to discuss the complaint and offered an apology. We also saw that a follow up letter was sent to the patient where the provider explained the misunderstanding regarding the medical certificate and informed the patient, they would share feedback with staff to help prevent this from occurring again. However, we could not find evidence to show this had been shared with all staff.

Well-led

Rating: Inspected but not rated

At our previous inspection on 23 November 2022, we rated the practice as Inadequate for providing well-led services because:

- Improvements were needed to ensure the delivery of high-quality sustainable care.
- The provider was unable to demonstrate they had an effective complaints procedure.
- Improvements were needed to systems of accountability for the management of backlogs of activity.
- The practice did not have clear and effective processes for managing risks, issues, and performance.
- There was little evidence of systems and processes for learning, continuous improvement, and innovation.

At this inspection in May 2023, we did not rate the practice for providing well-led services because we only checked the progress made against the requirements of the Warning Notices issued on 3 January 2023.

We found:

- Leaders had not taken sufficient action on all required improvements to quality, safety and performance which placed patients at continued risk of harm.
- The provider had made improvements and was now able to demonstrate compliance with the duty of candour.
- Improvements had been made to the management of backlogs of laboratory results and outstanding documents that required action. However, management of tasks on the practice’s computer system as well as management of test requests was insufficient.
- Improvements to processes for managing risks, issues and performance were insufficient.
- Learning from complaints was not being shared with all relevant staff.

Leadership capacity and capability
Leaders had not taken sufficient action on all required improvements to quality, safety and performance which placed patients at continued risk of harm.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Explanation of any answers and additional evidence:	

At our previous inspection on 23 November 2022, we found:

- The provider did not have a clinical governance policy and there was no evidence of the arrangements for clinical governance within the policies we had reviewed at that time.
- Improvements to quality, safety and performance were required.

At our inspection on 16 May 2023, we found improvements to the quality, safety and performance were insufficient. We saw the practice had a clinical governance policy which was accessible to all staff.

Culture

The provider had made improvements and was now able to demonstrate compliance with the duty of candour.

	Y/N/Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection on 23 November 2022, we had not been provided with examples of responses to patient complaints therefore we could not be sure of compliance with the duty of candour or that people received an apology when they were affected by things that went wrong.</p> <p>At our inspection on 16 May 2023, we reviewed 7 complaints; we saw they had been recorded, investigated and complainants received a timely response via telephone and/or letter. We saw evidence patients were given an apology and action had been taken by the provider where appropriate. We saw the provider had been open as well as transparent with the complainants and was complying with the duty of candour.</p>	

Governance arrangements

Improvements had been made to the management of backlogs of laboratory results and outstanding documents that required action. However, management of tasks on the practice computer system as well as management of test requests was insufficient.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	No
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 November 2022, we found:</p> <ul style="list-style-type: none"> • There were 916 tasks on the practice's computer system, dating from June 2021 to November 2022. • There were 314 laboratory results that had not been viewed, dating from October to November 2022. • There were outstanding documents requiring action for one of the GPs dating from June 2020 to November 2022. 	

- We had not been provided with policies for safeguarding adults and children or clinical governance.

After the inspection in November 2022, the provider told us the backlog of 916 tasks had been cleared, they had begun reviewing the backlog of laboratory results and staff were receiving support with the practice's computer system including; training for clinical and administrative staff to support the management of documents and results.

At our inspection on 16 May 2023, we found:

- There were 989 tasks on the practice's computer system, dating from July 2021 to May 2023.
- The provider had taken appropriate action regarding the laboratory results that had not been viewed and the outstanding documents requiring action found at our last inspection.
- We saw the practice had a comprehensive safeguarding adults and children policy and a clinical governance policy which was accessible to all staff.
- The practice's computer system showed there were 6,665 test requests that were awaiting sample, dating from October 2022 to May 2023.

After the inspection, the provider told us they had contacted the computer software company and were told there was an information technology (IT) error in that the system did not delete a test request when a clinician completed the test review during a patient's consultation. The provider told us they had started to review and action these requests. They told us as of 5 June 2023, there were 2,045 remaining test requests to review. However, we were not provided with any evidence to confirm this, nor were we provided with details of when the remaining test requested would be reviewed by. The provider also told us this would be discussed during clinical meetings. However, we were also not provided with any evidence to confirm this.

Managing risks, issues and performance

Improvements to processes for managing risks, issues and performance were insufficient.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Explanation of any answers and additional evidence:	
At our previous inspection on 23 November 2022, we found the provider was unable to demonstrate their systems and process were effective in the management of risks from:	
<ul style="list-style-type: none"> • The practice's computer system not alerting staff of family and other household members of children that were on the risk register. • Fire safety, infection prevention and control and health and safety risks. • The lack of some emergency equipment and emergency medicines that were required to be kept. • The lack of appropriate management of the prescribing of some high-risk medicines. • The management of safety alerts. • The management of documents and test results. • The continued review of patients with long-term conditions, in line with current best practice guidance. • The management of significant events. • The management of complaints. • The management of palliative care records, including record keeping for DNACPR orders. 	

- Staff recruitment, training and vaccination records not being in line with regulatory requirements.

At our inspection on 16 May 2023, we found systems and processes were still not effective in the management of risks from:

- The practice's computer system not alerting staff of family and other household members of children that were on the risk register.
- Fire safety.
- The lack of appropriate management of the prescribing of some high-risk medicines.
- The management of safety alerts.
- The management of tasks and test results.
- The continued review of patients with long-term conditions, in line with current best practice guidance.
- The sharing of learning from complaints.
- Record keeping for DNACPR decisions.
- Staff recruitment, training and vaccination records not being in line with regulatory requirements.
- DBS checks not completed on all staff, for example staff who had been assigned as chaperones.

Continuous improvement and innovation

Learning from complaints was not being shared with all relevant staff.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection on 23 November 2022, we saw there had been some discussion of complaints during clinical staff meetings. However, we did not see evidence that significant events and complaints had been used to make improvements nor was there evidence that learning had been shared with relevant staff.</p> <p>At our inspection on 16 May 2023, we saw evidence that learning from significant events had been shared with all staff. However, we did not see evidence that complaints and learning from these were shared with non-clinical staff.</p>	