Care Quality Commission

Inspection Evidence Table

Gardiner Crescent Surgery (1-4444378811)

Inspection date: 15 and 20 September 2022

Date of data download: 14 September 2022

Current overall rating: Not rated

Gardiner Crescent Surgery was inspected on 26 May 2022 and was rated as inadequate overall and inadequate for providing safe, effective, responsive and well led care. The provider was rated as requires improvement for providing caring services. This inspection was an announced focused inspection, carried out on 15 and 20 September 2022.

The purpose of this inspection was to review actions taken by the provider in response to warning notices issued following the May 2022 inspection for non-compliance with Regulations 12, safe care and treatment, Regulation 16, complaints, Regulation 18, staffing and Regulation 19, fit and proper persons. These warning notices were issued by the Care Quality Commission in June 2022 with a compliance date of 1 August 2022.

At the inspection in May 2022, the provider was rated as inadequate and told they must improve. The service was placed in special measures.

This inspection on 15 and 20 September 2022 was not rated.

Safe

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

<table>
<thead>
<tr>
<th>Safeguarding</th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure and Barring Service (DBS) checks were undertaken where required.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At the inspection in May 2022 the provider could not evidence compliance or oversight of child and adult safeguarding training, or that this was appropriate to the staff members role. At this inspection in September 2022 we found that staff were trained to the required safeguarding level, in line with the latest intercollegiate guidance.

At the inspection in May 2022, the practice was unable to evidence notes of safeguarding meetings and we were told that a safeguarding register was not in place. At this inspection we saw that two safeguarding meetings had taken place and the practice was able to identify patients with safeguarding needs. However, we found that a child protection plan which had been received by the practice was not discussed at the subsequent meeting and this had not been picked up or highlighted by the team. We
Safeguarding

were told that records of safeguarding meetings were sent to health visitors, however, notes were brief in the meeting minutes and the patient notes. This would not assist multi-disciplinary teams to keep patients safe. We highlighted our concerns to the team.

At the inspection in May 2022, we were not assured that the process of obtaining Disclosure and Barring Service (DBS) checks for members of non-clinical staff was embedded into the team. At this inspection in September 2022 we found that all staff had a DBS check in place with the exception of one member of staff for whom a risk assessment was in place.

Recruitment systems

Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).

Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.

At the inspection in May 2022, we found that the provider had failed to ensure that recruitment procedures were established and operated effectively or undertake the necessary relevant checks.

During the inspection in May 2022 we reviewed the recruitment records of 4 staff. All 4 of the records which we reviewed were incomplete. The provider had failed to obtain proof of identity including having a recent photograph or evidence of satisfactory conduct in previous employment, retain an application form, curriculum vitae, or interview summary for all staff. The provider had also failed to obtain a complete employment history including reasons for any gaps, or verify by obtaining documentary evidence, relevant qualifications cited in the application.

At this inspection in September 2022 we reviewed the records of 3 permanent and 2 locum staff. None of these records were complete. We found there were gaps in obtaining signed contracts, proof of identity or clinical registration, evidence of satisfactory conduct in previous employment, employment history and no explanation for a gap in employment.

Additionally, whilst the record of staff immunisations had been updated this remained incomplete.

Safety systems and records

Health and safety risk assessments had been carried out and appropriate actions taken.

Date of last assessment: September 2022

Date of fire risk assessment: July 2022

Actions from fire risk assessment were identified and completed.

Explanation of any answers and additional evidence:

When we inspected in May 2022, we found actions from a fire risk assessment undertaken in December 2021 were incomplete. The health and safety policy was limited in scope and the health and safety risk assessment did not reflect the premises or building security risks that we identified on inspection. We
found the provider had not managed the risk of legionella; a water safety policy was in place, but this was not followed.

During our inspection in September 2022 we found improvements had been made, a revised policy was in place. Comprehensive risk assessments had been undertaken and resulting actions had been carried out. Risks relating to the management of legionella had been mainly addressed, although there was still some servicing to be undertaken.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff had received effective training on infection prevention and control.</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control audits were carried out.</td>
<td>Yes</td>
</tr>
<tr>
<td>Date of last infection prevention and control audit: June 2022</td>
<td></td>
</tr>
<tr>
<td>The practice had acted on any issues identified in infection prevention and control audits.</td>
<td>Partial</td>
</tr>
<tr>
<td>The arrangements for managing waste and clinical specimens kept people safe.</td>
<td>Partial</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:

When we inspected in May 2022, we found the provider did not have oversight of the infection prevention and control (IPC) training of the staff team. Cleaning schedules were not in place for the environment or clinical equipment. An IPC audit from 11 May 2022, noted that there was no hot water in the patient toilet; this had not been rectified on the day of our inspection.

We found 2 sharps bins at the Craghead Medical Centre site which were not signed or dated in line with legal requirements. One bin was also noted to be overfilled.

We found that whilst the IPC policy was accessible, it was not specific to the practice and therefore would not direct staff to the best course of action to take.

During our inspection in September 2022 we found some improvements had been made. A practice specific policy was in place, staff had received IPC training, there was hot water available in the patient toilet and a further audit had been undertaken. Sharps bins were signed and dated and not overfilled.

However, we identified further concerns. The provider told us they were in dispute with their cleaning contractor and did not have any records to demonstrate that both premises were appropriately cleaned.

Actions from the IPC audit such as to ensure mops were clean, dry and ready for use and to move mops and buckets at the Gardiner Crescent site away from the toilet had regressed back. The IPC audit advised that chemicals should have been stored away from the hand wash basin but were viewed in this area on the day of inspection. During the site visit we also found that cleaning equipment was not stored properly and some equipment at both sites was soiled and visibly dirty.

We identified concerns in relation to the control of substances that are hazardous to health (COSHH). There was no safety information or guidance for staff in place at the Craghead site. The information held at the Gardiner Crescent site was limited and did not represent the types of chemicals used.
The provider did not have effective arrangements in place to ensure that equipment was safe to use. We randomly sampled the single use equipment that was available at both sites. We found 5 out of date blood bottles were stored at the Craghead site then 1 out of date blood bottle and an out of date swab at the Gardiner Crescent site.

**Risks to patients**

**There were gaps in systems to assess, monitor and manage risks to patient safety.**

<table>
<thead>
<tr>
<th>Y/N/Partial</th>
<th>There was an effective induction system for temporary staff tailored to their role.</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Explanation of any answers and additional evidence:**

When we inspected in May 2022, we found that an effective induction process was not in place for permanent or locum staff. Staff recruitment records showed incomplete or absent induction records.

During our inspection in September 2022, we found this remained the case. The provider had implemented an induction policy which contained proformas for information checking, orientation and policies. However, this had not been followed by the provider. We looked at records for 3 permanent members of staff and 2 temporary members of staff. None contained evidence of an effective induction process to orientate staff to important policies, safety and clinical information to ensure they understood their roles and responsibilities.

During our inspection in May 2022 we found that no staff had been trained in how to deal with patients with suspected sepsis.

When we inspected in September 2022, we saw staff had received appropriate training.

**Information to deliver safe care and treatment**

**Appropriate and safe use of medicines**

**The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation**

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC’s internal systems are updated and data for 2022/23 is released.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Practice</th>
<th>CCG average</th>
<th>England average</th>
<th>England comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022)</td>
<td>1.43</td>
<td>1.05</td>
<td>0.82</td>
<td>Variation (negative)</td>
</tr>
<tr>
<td>Medicines management</td>
<td>Y/N/Partial</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>----------------------</td>
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<td></td>
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</tr>
<tr>
<td>Blank prescriptions were kept securely, and their use monitored in line with national guidance.</td>
<td>No (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.</td>
<td>No (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice had a process and clear audit trail for the management of information about changes to a patient’s medicines including changes made by other services.</td>
<td>Yes (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.</td>
<td>No (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Partial (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.</td>
<td>No (6)</td>
<td></td>
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</table>

As part of our inspection, we conducted a series of searches of clinical records to assess the practice’s procedures around medicines management and prescribing.

1. During the May 2022 inspection we found that the provider did not ensure the safe monitoring of prescription stationary once it was distributed throughout the practice.

   When we inspected in September 2022, we found improvements had not been made. There was no policy available for staff to follow and we saw a large number of prescriptions stored in a drawer in a consultation room at the Gardiner Crescent site. These were not securely stored as the key was in drawer lock.

2. At the May 2022 inspection we found the provider did not assess and review patients with asthma in line with NICE guidance or provide clear management plans. Appropriate and structured medication reviews were not always conducted and some patients with long-term conditions including those with thyroid issues or with diabetic retinopathy were not suitably reviewed.

   When we inspected in September 2022, we found ongoing concerns relating to the assessment and review of patients with asthma. Our clinical records searches found that some patients with asthma who were prescribed 2 or more courses of rescue steroids had not received an adequate assessment at the time they were prescribed. Of the 5 records we looked at in detail, 3 patients had not received appropriate monitoring and all 5 patients had consultations over the telephone which did not allow for adequate examination. NICE guidance suggests that patients should be followed up within 48 hours of an acute exacerbation of asthma to check response to treatment. None of the 5 such patients we identified had been followed up within a week of an acute exacerbation.

   Some medication reviews were not properly documented. Records showed brief notes. There was evidence of missing information about compliance with medicines, any monitoring due or undertaken or engagement with the patient.
<table>
<thead>
<tr>
<th>Medicines management</th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our clinical searches found that 5 patients prescribed ACE inhibitors had not received all of the required monitoring. We found that 3 patients had not received appropriate monitoring before further prescriptions were issued. Two other patients were booked in for blood tests, but this was not until October 2022. All 5 patients were at risk of abnormal kidney function.</td>
<td></td>
</tr>
<tr>
<td>(3) In May 2022 we found gaps in clinical coding and the provider could not evidence clinical oversight of results.</td>
<td></td>
</tr>
<tr>
<td>When we inspected in September 2022, we found the provider had made improvements to clinical coding and we saw evidence they had clinical oversight of test results.</td>
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<tr>
<td>(4) In May 2022 we saw information which showed a 34% increase in the prescribing of antibiotics. At that time there were no plans in place to respond to this increase.</td>
<td></td>
</tr>
<tr>
<td>When we inspected in September 2022, we found some progress has been made, however this was limited. Meetings to discuss antibiotic prescribing had been held and an action plan subsequently developed. At the time of our inspection many actions were noted to be ongoing and in progress. There had been no review of individual prescribing habits and the provider could not evidence any reduction in inappropriate prescribing.</td>
<td></td>
</tr>
<tr>
<td>(5) When we inspected the practice in May 2022, we found the provider did not maintain up to date records to support the regular checking of emergency medicines, oxygen and the defibrillator at the Craghead site. The emergency medicines held did not align to the provider’s policy and signage as to their location at the Gardiner Crescent site was incorrect.</td>
<td></td>
</tr>
<tr>
<td>When we inspected in September 2022, we found some improvement had been made in that weekly checks of medicines were taking place. However, we identified some ongoing concerns. We observed a poster at the Gardiner Crescent site, which stated that emergency medicines were stored in the administration area behind reception. However, we found the medicines were stored in a different location, which meant there was a risk staff would not be able to locate them promptly in the event of an emergency.</td>
<td></td>
</tr>
<tr>
<td>The Medical Emergency Policy contained a list of emergency medicines which would be held, but this did not correlate to the actual medicines stored at both sites. For example, the policy stated that “We do not store or use opiates in practice or in the emergency bags. Naxalone as an immediate antidote is not required.” However, on the day of inspection we saw Naxalone was held at both sites.</td>
<td></td>
</tr>
<tr>
<td>The policy stated that “Budesonide 0.5 mg nebulizer solution has been used for this list instead of dexamethasone”, however, on the day of the inspection neither medicine was in place nor was there a nebuliser which was required to administer this medicine, therefore if available, this could not have been used in the event of an emergency.</td>
<td></td>
</tr>
<tr>
<td>We also identified some out of date equipment at the Gardiner Crescent site; a paediatric airway device and hypodermic needles.</td>
<td></td>
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</tbody>
</table>
**Medicines management**

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>(6) In May 2022, we found arrangements to ensure vaccines were safely stored were ineffective. Vaccine refrigerators were at risk of being turned off as appropriate safeguards were not in place. There were gaps in the recording of refrigerator temperatures and records showed that out of range temperatures were not reviewed and monitored. When we inspected in September 2022, we found some improvements had been made in that there were arrangements in place to prevent the refrigerators being turned off. However, there were still some gaps in the recording of refrigerator temperatures and the data logger which monitored temperatures had not been downloaded since 8 August 2022. The practice had reported a failure of 1 of the vaccine refrigerators. However, it was not clear whether the provider had followed their cold chain policy following this incident.</td>
<td></td>
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**Safety alerts**

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a system for recording and acting on safety alerts.</td>
<td>Partial</td>
</tr>
<tr>
<td>Staff understood how to deal with alerts.</td>
<td>Partial</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:

When we inspected in May 2022, we found the provider did not review and act upon all safety alerts.

During this inspection in September 2022 we reviewed action taken following a Medicine and Health Products Alert issued in May 2022. This related to a study which suggested that Pregabalin may slightly increase the risk of major congenital malformations if used in pregnancy. The alert advised that clinicians should provide counselling to patients using Pregabalin on the potential risks to an unborn baby. Our searches found that in some cases patients were only informed of this after their pregnancy had begun.
Effective

Effective needs assessment, care and treatment

Effective care for the practice population

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>When we inspected the provider in May 2022, we found the provider had failed to ensure there were enough suitably qualified staff to enable the review of vulnerable patients and carers. This included those living with chronic obstructive pulmonary disease (COPD), carers and those with a learning disability.</td>
</tr>
<tr>
<td>We found there was no reflective register for patients with a learning disability and we were told of a further 92 patients who may have met the criteria for support.</td>
</tr>
<tr>
<td>During the inspection in September 2022 we found some improvement had been made, for example, in identifying patients with learning disabilities. Clinicians had reviewed those with a possible diagnosis and formulated an up to date and reflective register:</td>
</tr>
<tr>
<td>However, the provider was unable to evidence the number of reviews of patients with a learning disability. Staff told us they thought they had undertaken 8 to 10 reviews, or 2 per month. The provider had begun to send out text messages to carers to offer health checks, but progress was limited.</td>
</tr>
<tr>
<td>A temporary nurse had been employed to carry out COPD reviews; these were ongoing.</td>
</tr>
</tbody>
</table>

Effective staffing

The practice was unable to fully demonstrate that staff had the skills, knowledge and experience to carry out their roles.

<table>
<thead>
<tr>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff had the skills, knowledge and experience to deliver effective care, support and treatment.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

When we inspected in May 2022, we found the provider did not maintain oversight of staff training and could not provide assurance that their mandatory training policy had been followed. Staff had not had any form of appraisal or supervision and two members of staff told us they had been left alone in a clinic seeing patients without clinical support on site. There was no formal process of clinical supervision, a policy was in place, but this was not followed.

During our inspection in September 2022 we found some improvements had been made. Staff had undertaken mandatory training, although the system to oversee this still required improvement.

We saw evidence that staff had received appraisals, but a system to provide formal clinical supervision was yet to be implemented.
Responsive
Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

<table>
<thead>
<tr>
<th>Complaints</th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints received in the last year.</td>
<td>5 since previous</td>
</tr>
<tr>
<td>inspection – May 2022</td>
<td></td>
</tr>
<tr>
<td>Number of complaints we examined.</td>
<td>4</td>
</tr>
<tr>
<td>Number of complaints we examined that were satisfactorily handled in a</td>
<td>4</td>
</tr>
<tr>
<td>timely way.</td>
<td></td>
</tr>
<tr>
<td>Number of complaints referred to the Parliamentary and Health Service</td>
<td>0</td>
</tr>
<tr>
<td>Ombudsman.</td>
<td></td>
</tr>
</tbody>
</table>

Information about how to complain was readily available.                       | Y                 |
There was evidence that complaints were used to drive continuous improvement. | N                 |

Explanation of any answers and additional evidence:

When we inspected the provider in May 2022, we found that there was no functioning system in place to effectively manage the receiving, recording, handling or responding to complaints made by service users or other persons in relation to carrying out the regulated activity. Complaints were not discussed or reviewed at meetings or shared with the team.

We found that the provider had failed to carry out the necessary investigations or take any action in response to complaints. The staff team were not involved in the review or discussion of complaints and patients were not responded to.

During this inspection in September 2022, we found similar concerns in relation to the management of complaints. There were 3 different systems in use to monitor complaints. There were variations and inconsistencies across those systems.

The practice complaints policy stated that complainants would be informed that they may complain to the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied. We looked in detail at 2 complaints that had been investigated. Neither response letters advised complainants of their option to complain to the PHSO.

The complaints policy stated that complaints would be responded to within 3 working days. It was not clear from the records reviewed whether this was followed. There was no evidence that 2 complaints received during August and September 2022 had been responded to within 3 working days.

We found in 2 cases that there was no evidence to demonstrate that actions or learning from complaints had been carried out.