

# Care Quality Commission

## Inspection Evidence Table

### Essex Lodge (1-582393811)

Inspection date: 1 May 2018

Date of data download: 14 May 2018

## Safe

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

Event	Specific action taken
A patient had requested a medicine to manage their condition on several occasions over a period of six days and experienced multiple barriers and delays obtaining their medicines. Staff brought their concerns to GPs and management attention but no effective action was taken and the patient subsequently attended hospital accident and emergency department with an acute exacerbation of their condition.	After our inspection the provider told us this would be investigated as significant event.
Two children were seen by a health care assistant (HCA) for a new patient health check. In accordance with the practice procedure for patient's under 18 this check should not be undertaken by a HCA. Elements of the checks undertaken were not appropriate or applicable to children such as smoking and mini mental state tests.	Management staff told us the wrong template had been used by the HCA and this issue would be investigated as significant event.
An outbreak of a respiratory disease affected at least five residents at a Care Home the practice provides primary medical services to. Two patients were admitted to hospital and another died. GPs visiting the home did not suspect flu and prescribed	The provider prescribed the medicines but no review was undertaken and it was not identified as a significant event until after we highlighted it at our inspection. After our inspection the provider told us it recognised that this should have been raised as a significant event which has now been actioned.

antibiotics. The outbreak was reported to Public Health England (PHE) by the care and nursing home. PHE arranged urgent swabs for flu and viral for symptomatic patients and asked the provider to prescribe medicines for patients and review the situation.	
A patients' clinical sample had been incorrectly labelled.	The significant events protocol was followed. Staff corrected the error and met to discuss actions to prevent recurrence that included further staff training and introducing a double checking process.
A patient was wrongly referred for and attended a clinical appointment that was intended for a patient with a similar name.	The significant events protocol was followed. Patients were contacted by staff that apologised for the error and a new referral was made. A new process was implemented to prevent recurrence.
Urgent correspondence received for a patient in a care facility was not acted upon for four days.	Significant events protocol was followed. A new procedure was developed for correspondence received from the care facility to ensure it would be managed in a timely manner.

## Effective

### Effective staffing

Question	Y/N
The registered person provided assurances that staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed	Y
The provider had a programme of learning and development.	Y
Any further comments or notable training: There was a training matrix to track learning and development needs and training delivered for all staff.	

### Consent to care and treatment

## Description of how the practice monitors that consent is sought appropriately

Forty seven of 55 patients at a care and nursing home the practice provides primary care services to have a DNAR in force. All 47 DNAR decisions were signed off as recorded by GPs employed by Essex Lodge but elements of the majority of the forms had been recorded by nursing or care home staff including a) "Does the patient have capacity to make and communicate decisions about CPR", b) "Summary of the main clinical problems and reasons why CPR would be inappropriate unsuccessful or not in the patient's best interests", c) "summary of communication with patients relatives or friends", and d) "members of the multidisciplinary team contributing to this decision" which indicates the provider is relying on assessments of capacity undertaken by nursing and care home staff. (CPR stands for cardiopulmonary resuscitation).

Thirty seven of the 47 forms had been reviewed and endorsed by the most senior health professional who were also GPs employed by Essex Lodge. GPs signed inappropriately completed DNAR forms such as 36 forms where patient's capacity to make this decision was either not recorded or unclear, many of these forms either only had a yes option or had both yes and no recorded.

GPs signed 13 forms that indicated the patient had capacity to make and communicate decisions about CPR where the "summary of communication with patient (or welfare attorney). If this section has not been discussed with the patient or welfare attorney" section was left blank.

Two DNAR forms were overdue a review.

One DNAR form clearly stated the patient had expressed they wanted to be resuscitated and there was no clear reason recorded why resuscitation should not be attempted.

Two DNAR forms had been amended by GPs without an indication of date the amendment was made.

After our inspection the practice told us it recognised DNAR errors were made and sent us evidence it had produced a DNAR policy and this issue was being dealt with as significant event.

## Well-led

### Leadership capacity and capability

#### Examples of how leadership, capacity and capability were demonstrated by the practice

There was inconsistent action taken in response to significant events including where patients subsequently experienced significant negative outcomes. Other significant events that were identified were well managed to improve safety and showed evidence of the duty of candour as indicated in the "safe" section of this evidence table.

Two staff told us on a daily basis there was no leadership or management cover after 3pm to 4pm. The response from the practice management team supported evidence there had been a lack of cover on some occasions and provided no assurance of an effective or embedded cover system in place. After our inspection the practice sent us a new rota that indicated appropriate cover arrangements.

Several staff told us leaders and managers excluded them, were bullying, condescending or belittling, and did not act on concerns that they reported and take them seriously including team relationships/ dynamics and significant events.

## Culture

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Practice computer system	NHS resources were used for a GP partner's private slimming clinic and cosmetic businesses such as all NHS appointments blocked on Tuesday afternoons and private slots allocated within that GPs partners NHS session.
Staff	Many of the private consultations were not evidenced because private patients were not registered and staff were asked to add and then immediately remove the private patient's appointments from the system which leaves no footprint on the system or audit trail. Practice staff routinely dealt with private patients in the reception area and told us some NHS patients had complained private patients were prioritised over NHS patients, but we found no evidence of this on the practice complaints log.
Observed on site	A partner GPs room contained large amounts of cosmetic surgery information leaflets and related products such as dermal fillers and "botox" in the medicines refrigerator. We observed private patients being turned away on the day of our inspection.
Staff told us and HR files	At least six staff were no longer working at the practice within the last two years and there was a high incidence of legal processes involved as well as legal disputes within the existing team. Some staff told us they were spoken down to or belittled.

## Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Learning from complaints and significant events	There was a log of 11 identified significant events. We saw several examples that contained evidence of appropriate analysis, learning and improvement to improve safety. However, we also found evidence of three significant events that were identified by staff or an external body that were not acted upon including where patients had subsequently attended accident and emergency, were admitted to hospital, or died. No analysis had taken place and therefore the causes of these patients experienced outcomes remained unclear.
Any additional evidence	
Practice computer system and related documentation	A training matrix was in place and appropriate staff training had been undertaken.

Anonymised patient DNAR forms.	Forms showed DNAR processes were not completed properly.
Data protection was not assured	Patient and staff information was shared on a conversation on WhatsApp. (WhatsApp is a free to download messenger app for smartphones that uses the internet to send messages, images, audio or video).