

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Dr Roshanali Hirani
Overview of the service	Dr Roshanali Hirani provides primary care services for patients at Charnwood Surgery in Mountsorrel, Leicestershire. The GP is a sole practitioner, working with a practice nurse and support staff.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 August 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

We spoke with four patients and four of the six members of staff, including the GP. One of the patients we spoke with was the chair of the patient participation group (PPG). One patient told us, "I've got no complaints." Another patient told us, "They do their job and I'm quite happy with that." We found that staff were supported in their work, so that patients received a service from qualified, trained staff.

We saw that patients experienced care and treatment that met their needs and that they were given appropriate information, so they were involved in decisions about their treatment. We found that the provider had systems for seeking patients' views and that these views were taken into account. One patient told us, "It [the practice] is very responsive because it's small."

Patients told us they thought the practice was kept clean. One patient described the cleanliness of the practice as, "Generally quite good." However, we found the provider did not have effective systems to ensure patients and staff were protected from the risk of infection.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 23 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our

decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment. The four patients we spoke felt involved in decisions about their treatment. The GP described to us how he explained the risks and benefits of treatment options before recommending any treatment. People had enough information to be able to make informed decisions.

People who use the service were given appropriate information and support regarding their care or treatment. The patients we spoke with told us they were given information, in an appropriate format, for example verbally and in leaflets or through direction to a website. One person commented, "When I ask he [the GP] normally tells me." Another patient told us, "If there's anything wrong, [the GP] rings us up." There was a range of information leaflets available in the waiting room. These provided information about specific medical conditions as well as other health and social care services. The leaflets were well organised and displayed so that patients could easily see the information.

People's diversity, values and human rights were respected. We saw that there was a chaperone policy in place for patients who required an intimate examination. This was displayed in the waiting room so that patients knew they should expect to be offered a chaperone. The GP insisted that all patients requiring an intimate examination had a chaperone and recommended that this be a trained member of staff, rather than a friend or relative. This meant patients were protected from the risk of inappropriate or unnecessary examination. Staff who had received chaperone training demonstrated a good knowledge of their responsibilities and were able to describe to us what they would do if they had any concerns regarding an examination.

Written information was not routinely offered in languages other than English. Staff told us that almost all patients using the service spoke English as their first language. Three staff

at the service spoke a range of Asian languages and this meant they could communicate effectively with the minority of patients who did not speak English as a first language.

There was a ramp to the front door so wheelchair users and other patients with limited mobility could get into the building. Receptionists sat directly opposite the door, so they could see patients arriving. All staff told us that if they saw someone arriving who needed help, they would go to the door to assist. During our inspection, we saw that all staff offered help routinely to patients, as part of a respectful, polite welcome.

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with four patients at the practice and four members of staff. Patients we spoke with were happy with the care and treatment they had received. One patient told us of a staff member, "X was very good. X had obviously looked at my notes. X listened – and that's worth a lot." When we asked patients if staff treated them with respect, they all agreed, two responding, "Definitely." and one, "Very much so."

Patients we spoke with told us that they were able to make appointments at a time that suited them. Patients told us they were able to get appointments on the day if they needed to. One patient told us, "We can make an appointment when we want. We get in pretty quick."

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw there were protocols on the nurse's treatment room, to remind them of appropriate treatment for common long term conditions. A recent appraisal by the commissioner, NHS England, had identified that there were no staff at the practice trained to provide diabetes care. The provider had worked with the commissioner to arrange for a specialist diabetic nurse to attend the practice to provide specialist advice and treatment to patients with diabetes. Three of the four patients we spoke with said they had regular appointments for health checks. They told us they received reminders for these checks. Staff told us how they had a system for making contact with patients in writing or by telephone dependent on their individual circumstances. This meant patients had appropriate support from trained staff and were encouraged to attend for regular reviews.

One of the staff we spoke with was trained as a phlebotomist. This meant patients could have blood taken at their convenience, at regular clinics. Because the staff member worked at the practice in another role, they could take blood from patients needing more urgent testing, when they attended their GP appointment.

We asked the provider what systems they had in place to ensure patients knew who to contact when the practice was closed. The provider told us that there was a message on the answer phone, giving contact numbers for out of hours services. We saw there was

information in the waiting room to help patients decide which service they should use when their GP was not available. Three of the patients we spoke with knew who they should contact outside of the practice opening hours. This meant that patients who needed care out of normal practice opening hours knew how to get help.

There were arrangements in place to deal with foreseeable emergencies. We saw there was emergency medical equipment and medication at the practice. We saw evidence that staff had received training in their use and in cardiopulmonary resuscitation. There was clear guidance for staff about what to do in a medical emergency. This was posted in the staff room so all staff could easily access it.

We saw that there were systems in place to check the emergency drugs. The provider may find it useful to note that although we found all the emergency drugs were in date, the record for recording each drug's expiry date had not been completed. This meant that drugs might go out of date, because systems for checking them were not used effectively.

We saw there was a fire safety policy and properly maintained fire safety equipment was available. Staff were able to describe what action they would take in case of a fire. The provider may find it useful to note that they had not done any fire drills, so staff had not had the opportunity to rehearse what they would do and to identify any problems with their procedures.

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

Systems in place to reduce the risk and spread of infection were not effective because staff did not have appropriate guidance and checks on cleanliness and infection control failed to identify gaps and issues.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The patients we spoke with were satisfied with the cleanliness of the premises. One patient commented that the cleanliness was, "Generally quite good." However, we found the provider's systems were not effective in ensuring the premises were clean.

People were not protected from the risk of infection because appropriate guidance had not been followed. The provider had a comprehensive infection prevention and control policy. The procedures describing how they would meet the policy were not adequate for staff to ensure best practice was followed.

There was no clear definition of roles and responsibilities in relation to infection prevention and control. We saw that the practice nurse had recently attended a workshop on infection prevention and control and was designated as the practice link for infection prevention and control. The practice manager told us that the practice nurse would be talking to all staff about infection prevention and control at their next practice meeting. The procedures identified the GP as the infection prevention and control lead for the practice. He acknowledged he was accountable but did not identify any tasks he was responsible for in relation to infection prevention and control. This meant no staff member had taken responsibility for ensuring guidance was followed.

The environment and equipment was suitable for maintaining good infection prevention and control. The provider had a plan to replace unsuitable flooring and wall coverings with materials more suitable for infection control. Equipment was in good repair, so could be cleaned effectively and disposable options were used where possible, for example disposable couch protectors and disposable curtains around couches. However, not all the curtains had the date on which they were installed recorded and there was no policy for when the curtains would be disposed of and replaced. None of the staff we spoke with knew when the curtains would be replaced. This meant equipment and supplies for infection control were not used effectively.

The provider did not have any policy for cleaning reusable equipment such as blood pressure cuffs. The staff we spoke with did not clean blood pressure cuffs. There was a risk of infection being spread between patients because diagnostic equipment was not cleaned regularly.

The provider's risk assessments did not include the risk of Legionella. This is a bacterium that can affect water supplies and cause legionnaire's disease. The practice manager explained that there was no standing water in the building so they had not thought this was necessary. However, there were no written risk assessments to confirm what had been taken into account in assessing environmental risks.

We saw an infection control audit for the practice completed in August 2013. This showed the practice was fully compliant, but the areas of non-compliance we identified were not included in the audit. This meant the audit was not effective in identifying gaps in infection control practice.

People were not cared for in a clean, hygienic environment. A cleaner worked at the practice once a week. For the other four days the practice was open, staff at the practice were responsible for maintaining cleanliness. Staff we spoke with were aware of their responsibility for maintaining the general cleanliness of the building. However, there was no guidance for the cleaner or other staff about the cleanliness standards expected or how to achieve these. The cleaner used a tick sheet to record that they had cleaned each area, but there was no information about how frequently specific tasks should be completed.

In one treatment room, we found a layer of dust under the treatment couch and on window sills. We looked at the cleaning equipment and found two mops stored outside in a mop bucket, without any protection from dirt outside. The mop heads were visibly dirty as was the bucket. Cloths apparently used for cleaning were dirty and stored with unused clean cloths. There was no system to identify which cloths should be used for different areas, for example keeping cloths for toilet areas and clinical areas separate. There was a cleaning audit available for use quarterly but this had not yet been used to check and record cleanliness. Patients received treatment in areas that were not cleaned adequately because standards and guidance about cleanliness were not available.

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The four patients we spoke with were confident staff were qualified and well trained.

Staff received appropriate professional development. We saw that all staff received regular training updates in relevant subjects. All staff had an annual appraisal where they could request support with their professional development. There was an induction checklist for new staff. We saw this was being used to record training and support being given to a newly recruited staff member. The training records did not specify which training was considered mandatory for each staff role. However, all staff knew what training they were expected to do and with what frequency. This included chaperone training for receptionists, safeguarding children and vulnerable adults for all staff and basic life support.

Staff did not receive regular formal supervision. One staff member told us they met weekly with the practice manager to discuss any concerns or issues. All staff told us they attended monthly practice meetings where they shared learning from complaints and any other changes or incidents. However, one staff member we spoke with did not feel well supported because there was no formal system for accessing support and guidance. They did not feel they had enough information about their role and expectations to be able to perform their role confidently. The lack of formal supervision meant staff did not have the opportunity to discuss their performance and support needs.

Staff were able, from time to time, to obtain further relevant qualifications. We saw that some staff had been supported to gain additional clinical skills and qualifications. For example, a receptionist had trained to become a phlebotomist and the practice nurse was updating her skills in chronic obstructive pulmonary disease (COPD) care.

The practice manager told us that clinical staff were responsible for maintaining their own continuous professional development (CPD) and registration with their professional bodies (for example the General Medical Council and Nursing and Midwifery Council). The provider may find it useful to note that they had no system for checking that clinical staff were maintaining their professional development. This meant clinical staff were not encouraged to maintain and improve high standards of care, because the provider did not

have a system for monitoring qualified health workers' development.

We looked at the GP's CPD record and appraisal for the previous year. These showed the GP was continuously seeking opportunities to develop his practice, by attending lectures, seeking advice from specialist colleagues, subscribing to trade journals and websites and attending monthly locality meetings with other GPs. This meant patients were cared for staff who kept their knowledge and skills up to date.

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The provider had a range of systems to monitor and assess the quality of the service. The provider participated in a range of clinical audits run by the local Clinical Commissioning Group (CCG). These included current audits into cancer and kidney care and an annual audit of osteoporosis. The results of these audits across the CCG area led to recommendations for improvements in patient care in these areas. The practice also participated in prescribing scheme audits to ensure medicines were prescribed safely and effectively, making efficient use of resources.

We saw a report from a recent practice appraisal by NHS England, the commissioner of primary care. This reflected that the provider had taken action recommended by the previous appraisal. We found that recommendations from this year's appraisal were already being acted on. For example, the provider had submitted a business case to recruit a female GP. This was so that women patients could choose to see a woman and also to broaden the clinical expertise available at the practice. This showed the provider used support available from external organisations to assess and monitor the quality of the service.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. One patient told us, "It [the practice] is very responsive because it's small." The Patient Participation Group (PPG) had been running for about a year. From talking to the chair of the PPG, staff at the service and looking at minutes from their meetings, we found that through this group, patients were strongly encouraged to contribute to decision making about the service. The PPG was kept informed of the provider's plans for the future including recruitment. We saw that the group was well supported by the provider and that their recommendations were considered seriously. The PPG helped to produce and analyse the provider's annual patient survey, which showed patients were satisfied with the service. Areas identified for improvement and discussed through the PPG were opening hours and being able to overhear the GP from the waiting room. Effective solutions to both of these had been introduced. The provider also collected patients' views through the NHS Choices website, a comments box in the waiting room and the provider's own website. This showed patients'

views about the service were taken into account from a range of sources.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. The practice manager explained to us that the system for recording incidents had recently been reviewed and that the policy had changed as a result. The changes meant that the provider would be able to analyse incidents better to identify any trends. We saw that incidents had been recorded and appropriate action taken in response to each incident. Staff told us that learning from all incidents was discussed at practice meetings and we saw the minutes from the meetings to confirm this. Systems in place meant that the practice learnt from incidents and used them to reduce the risk of them reoccurring.

The provider took account of complaints and comments to improve the service. We saw the provider's complaints procedure was displayed in the waiting room. Patients told us they would be confident to raise complaints with receptionists, the practice manager or the GP. We saw the provider kept a record of all complaints. There was one complaint under investigation at the time of our inspection, but all other complaints received since April 2013 had been resolved satisfactorily. Patients could be confident their complaints and comments would be responded to and used to improve the service.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010
Maternity and midwifery services	Cleanliness and infection control
Treatment of disease, disorder or injury	How the regulation was not being met: The provider had not protected patients, employees and others from the risks of acquiring an infection. (Regulation 12 (1) (a) (b) (c) This was because they had failed to operate an effective system to assess the risk of, detect and control the risk of infection (12(2)(a)) and They had failed to maintain appropriate standards of cleanliness in relation to the premises and equipment. (12 (2)(c)(i)(ii))

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 23 November 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.


You can tell us about your experience of this provider on our website.


How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

 **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

 **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

 **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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