Newcastle Premier Health Limited

Newcastle Premier Health

Inspection report

Newcastle Premier Health,
4th Floor of Dobson House, Regent Centre,
Gosforth, Newcastle upon Tyne
NE3 3PF
Tel: 01916053140
Website: www.newcastlepremierhealth.com

Date of inspection visit: 27 November 2018
Date of publication: 17/12/2018

Overall summary

We carried out an announced focused inspection on 27 November 2018 to ask the service the following key questions - Are services safe?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

We had previously inspected the service on 8 January 2018 and found that the service was not providing safe care and treatment in accordance with Regulation 12 of the Health and Social Care Act 2008.

We carried out this inspection to check whether the service had made improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The full comprehensive report on the January 2018 inspection can be found at: www.cqc.org.uk/location/1-4287806730.

The service provides an independent GP, travel clinic and mental health service. This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC, which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At Newcastle Premier Health, the majority of services provided are occupational and vocational health assessments and services to patients under arrangements made by their employer and other organisations. They also provide private aesthetic cosmetic treatments. These types of services are exempt by law from CQC regulation. Therefore, at Newcastle Premier Health, we were only able to inspect the services that fall within the scope of regulation under the Health and Social Care Act.

n January 2018, we noted quality improvement and clinical audit activity had focused on the occupational health aspect of the business. The provider had planned to develop their approach to encompass the area within the scope of regulation under the Health and Social Care Act to support them to improve patient outcomes. In November 2018, we found the service had made good progress with implementing this. They planned to carry out three audits a year to check the quality of the service offered and so far, had carried out audits of the:

- Infection prevention and control arrangements;
- Prescribing arrangements;
- Travel vaccination service. In particular, this checked the patient group directions (PGDs) implemented following the last CQC inspection. (PGDs are the legal framework by which nursing staff who are not prescribers are authorised to administer or supply medicines.)

Summary of findings

These were single cycle audits, but each audit indicated a planned appropriate timescale in which to complete the audit cycle to check on the improvements made.

Our key findings were:

- The service had improved systems to keep people safe and safeguarded from abuse. This included clarity on the role of chaperones, embedding infection prevention and control policies and checking the level of safeguarding training clinicians had received.
- The service had implemented patient group directions to legally authorise nursing staff who were not prescribers to administer or supply specified medicines.
- The service had reviewed the emergency medicines they held to treat patients in a medical emergency and now held supplies in line with national guidance or had in place a valid risk assessment to show why a recommended medicine was not required.
- The service had not yet improved their approach to learning and making improvements as a result of patient and medicine safety alerts. However, they had started to implement arrangements which would support a clear audit trail of prescribed medicines to support them to identify and take action to protect patients who may be at risk as identified by patient safety and medicine alerts.

There was an area where the provider could make improvements and should:

- Review the process for managing patient safety and medicine alerts so there is a systematic process for identifying and taking action to protect patients who may be at risk.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Newcastle Premier Health

Detailed findings

Background to this inspection

The Care Quality Commission registered Newcastle Premier Health Limited to provide an independent doctors service from one location:

- Newcastle Premier Health, 4th Floor of Dobson House, Regent Centre, Gosforth, Newcastle upon Tyne, NE3 3PF.

We inspected the services within the scope of the Health and Social Care Act 2008. This included the private GP, travel clinic and private mental health services.

Our inspection team was led by a CQC Lead Inspector and included a CQC Medicines Inspector.

During our inspection, we spoke with the registered manager, the clinical executive director, the clinical manager. We also viewed personnel files, training records, service policies and procedures and other records about how the service is managed.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions during a comprehensive inspection:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Safety systems and processes

The service had improved systems to keep people safe and safeguarded from abuse.

In January 2018, we found there were some areas the service should improve to ensure there were systems to keep patients safe and safeguarded from abuse. This included:

- The service was not always carrying out recruitment checks prior to deploying staff.
- Staff were unclear of the role and responsibility as a chaperone and the procedural guidance for chaperones was also unclear.
- They did not have in place infection prevention and control policies, but provided these after the inspection.
- The service had not routinely checked the level of safeguarding training clinicians had received.

In November 2018, we found the service had addressed most of the concerns identified. In particular:

- The service had implemented revised recruitment policies and procedures. Recruitment records demonstrated appropriate recruitment checks were carried out. However, although the service applied for disclosure and barring service (DBS) checks prior to employing staff, we saw staff took up post before the results of these checks were known. The service assured us any staff employed prior to completion of DBS check were carrying out induction and training only, and did not provide care or treatment for any patients until after the DBS check had been received and considered by the service.
- The service had implemented revised policies and procedures for the chaperone service to address the concern identified. The service had provided training to all staff on the role of a chaperone. They were reviewing which staff members would act as chaperones, and whilst this was being determined, this role was being carried out by either a nurse or the service manager.
- The infection prevention and control policies had been implemented.
- The service now routinely checked the level of safeguarding training clinicians had received and maintained a training matrix to demonstrate this and identify when refresher training was required.

Risks to patients

There were now systems to assess, monitor and manage risks to patient safety.

In January 2018, we told the provider to improve one area to ensure there were systems to assess, monitor and manage risks to patient safety. This was because they did not hold emergency medicines for treating a range of medical emergencies such as suspected bacterial meningitis; hypoglycaemia or epileptic fit. The service did not adequately assess the risk to document why these were not needed. This was not in line with guidance for emergency equipment in the Resuscitation Council UK guidelines and the guidance on emergency medicines is in the British National Formulary (BNF).

At this inspection, we found the service had reviewed the emergency medicines they held to treat patients in a medical emergency and now held supplies in line with national guidance. Where they had decided not to hold stock of a recommended medicine, there was a valid risk assessment in place to show why it was not required.

Safe and appropriate use of medicines

The service had made improvements and there were reliable systems for appropriate and safe handling of medicines.

In January 2018, we found the documentation to authorise nursing staff who were not prescribers to administer or supply medicines was not in line with the Human Medicines Regulations 2012.

In November 2018, we found the service had addressed this area of concern. They had implemented and embedded patient group directions (PGDs) to legally authorise nursing staff who were not prescribers to administer or supply specified medicines. We saw these had been developed in line with the requirements of the Human Medicines Regulations 2012. The service had carried out a clinical audit to check the implementation of these.

Lessons learned and improvements made

The service had not yet improved their approach to learning and making improvements as a result of patient and medicine safety alerts.

Are services safe?

In January 2018, we found there was a system for receiving and acting on safety alerts. However, we told the provider they should implement a more systematic approach for identifying and mitigating individual risk identified in patient safety and medicine alerts.

In November 2018, we found there was still not a systematic process in place. However, since the last inspection they had started to implement a prescribing unit within their clinical system. Once fully embedded this would allow the service to run queries on all medicines prescribed. They told us this would allow them to carry out more detailed analysis and clinical audits of their prescribing, including to evidence systematic follow up of patient safety and medicine alerts.