Observatory Medical Centre

Quality Report

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Date of inspection visit: We did not visit the surgery as part of this review because they were able to demonstrate that they were meeting the standards without the need for a visit.
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Are services safe?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Our previous comprehensive inspection at Observatory Medical Practice on 16 August 2016 found breaches of regulations relating to the safe care and treatment. The overall rating for the practice was good. However, they were rated requires improvement in the safe domain. The full comprehensive report from the August 2016 inspection can be found by selecting the 'all reports' link for Observatory Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced focused desktop inspection (we have not visited the practice but requested information to be sent to us) carried out on in March 2017. It was conducted to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection. This report covers our findings in relation to those requirements and improvements made since our last inspection.

We found the practice had made improvements since our last inspection. The information requested in March 2017 identified that the practice was meeting the regulation that had previously been breached. We have amended the rating for this practice to reflect these changes. The practice is now rated good for the provision of safe, effective, caring, responsive and well led services. In addition the practice made improvements to its services where we suggested this could improve services for patients.

Our key findings were as follows:

- Improvements had been made in the storage of medicines and procedures for when vaccines were potentially compromised.
- Liquid nitrogen storage had been reviewed and improvements made.
- Child immunisations had been reviewed, training provided to staff and a review of children who had not attended undertaken.
- A change to medicine review processes had been implemented to improve uptake within required timescales.
- The practice undertook its own survey to identify whether patient feedback was accurately portrayed in the national survey and this found positive feedback on the areas which had been of concern.

In addition to the areas where we told the provider they must make improvements, there were also actions where we suggested the provider should make improvements. In response they undertook the following actions.

- A review of child immunisations had been undertaken and action to improve uptake.

Summary of findings

- The process for medicine reviews had been changed to increase uptake for timely reviews.
- The practice undertook their own survey in October 2016 to focus on areas where the national survey had identified less positive feedback from patients when compared to local and national averages. The practice's own survey of 453 patients showed patient feedback was significantly better in the practices own survey in these specific areas.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

When we inspected the practice in August 2016 we found risks to patients were mainly assessed and well managed. However, there were issues identified in the monitoring of a fridge used for storing medicines and risks related to liquid nitrogen were not always managed.

The practice had taken appropriate action and is now rated good for the provision of safe services.

- A medicine potentially required for the treatment of hypoglycaemia had been reviewed and followed national guidance.
- We reviewed an updated risk assessment on the storage of liquid nitrogen. The storage of the substance had been reviewed and changes made to ensure it was well ventilated in the event of a leak.
- An amended cold chain policy had been implemented since our previous inspection in August 2016 and the system for monitoring fridges had improved.

Observatory Medical Centre

Detailed findings

Background to Observatory Medical Centre

The Observatory Medical Practice has recently changed its name from Jericho Health Centre – Dr Kearley and partners. The practice provides services from Jericho Health Centre, Walton Street, Oxford, Oxfordshire, OX2 6NW. It has a modern purpose built location with good accessibility to all its consultation rooms. The premises are shared with another GP practice. The practice serves 11,200 patients from the surrounding town.

The practice demographics show that there is a higher amount of patients registered between 20 and 24, due to registering patients from two Oxford University colleges. According to national data there is minimal deprivation among the local population. There are patients from minority ethnic backgrounds, particularly foreign students, but the population is mostly white British by origin.

• There are six GP partners at the practice, five female and one male. There is also one part time male assistant GP and one salaried male GP.

There are four practice nurses, a phlebotomist and one healthcare assistant. A number of administrative staff, a practice manager and an operations manager support the clinical team.

• This is a training practice and GP Registrar placements were taken at the practice.

• There are 5.5 whole time equivalent (WTE) GPs and 2 WTE nurses.

• The practice is open between 8.30am and 6pm Monday to Friday. Between 8am and 8.30am and 6pm and 6.30pm the practice is supported by an external service to ensure patients can access a duty doctor if required. There are extended hours appointments on Saturdays from 8:30am to 11:30am.

• Out of hours GP services were available when the practice was closed by phoning 111 and this was advertised on the practice website.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection took place on 16 August 2016 and we published a report setting out our judgements. These judgements identified a breach of regulations. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time.

We carried out a follow up focussed desk-top inspection on 1 March 2017 to assess whether the necessary changes had been made, following our inspection in August 2016. We focused on the aspects of the service where we found the provider had breached regulations during our previous inspection. We found the practice was meeting the requirements of the regulations that had previously been breached.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, review the breaches identified and update the ratings provided under the Care Act 2014.

Detailed findings

How we carried out this inspection

We requested information on 1 March 2017 following the completion date of the practice's action plan.

We looked at documentation related to:

- Medicines management processes and monitoring.
- Risk assessment of liquid nitrogen storage.
- Care related data and procedures.
- Patient survey information

This report should be read in conjunction with the full inspection report of CQC visit on 16 August 2016. The report from that inspection can be found by selecting the 'all reports' link for Observatory Medical Practice on our website at www.cqc.org.uk.

Good

Are services safe?

Our findings

When we inspected the practice in August 2016 we found risks to patients were mainly assessed and well managed. However, there were issues identified in the monitoring of a

fridge used for storing medicines, the storage of one emergency medicine and risks related to liquid nitrogen were not always managed.

Since August 2016 actions had been taken regarding risks we identified.

Monitoring risks to patients

- An emergency medicine potentially required for the treatment of hypoglycaemia had been reviewed and now followed national guidance.
- We reviewed an updated risk assessment on the storage of liquid nitrogen. The storage of the substance had been reviewed and changes made to where it was stored. It had been moved to a room where it was possible to open a window in the event of a leak and there was a ventilation system to enable the gas to escape from the room. There was no independent external ventilation to remove the gas from the room and building in the event of a significant lea. However, the practice had sought professional advice that the ventilation was adequate.
- An amended cold chain policy had been implemented since our previous inspection in August 2016. This included action to take in the event that appropriate temperature ranges were breached. Data loggers had been installed to monitor the temperatures of the fridges used for storing medicines. We saw that temperatures recorded were within ranges for the dates submitted to us other than for one date. We saw the incident for the out of range recording was followed up and appropriate action was taken to ensure the viability of the vaccines.