Brighton Station Health Centre

Quality Report

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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

Overall rating for this service	Good
Are services safe?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brighton Station Health Centre on 7 June 2016. The overall rating for the practice was good, but breaches of legal requirements were found in the safe domain. The practice sent us an action plan detailing what they would do in relation to the shortfalls identified and the action taken in order to meet the legal requirements in relation to the following:-

- The provider did not do all that was reasonably practicable to ensure that the systems and processes for monitoring the safe storage of medicines within the practice were followed and understood by all staff and that prompt action was taken to mitigate the risk of medicines being stored outside of the required temperature range.

This inspection was an announced focused inspection carried out on 1 March 2017 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 on 7 June 2016.

This report covers our findings in relation to those requirements and also additional improvements made since our last inspection. The full comprehensive report on the January 2016 inspection can be found by selecting the 'all reports' link for Brighton Station Health Centre on our website at www.cqc.org.uk.

Overall the practice is rated as Good.

Our key findings across the areas we inspected were as follows:-

- The provider had put new systems and processes in place for monitoring the safe storage of medicines within the practice. They were generally followed and understood by staff and most were aware of the action that was needed to be taken to mitigate the risk of medicines being stored outside of the required temperature range.
- However there was one episode when the maximum temperature remained above the recommended maximum for the storage of medicines and had not been acted on.

There were also some areas identified at our inspection in June 2016 where the provider should make some improvements, these were:

Summary of findings

- To ensure that action plans to address low areas of patient satisfaction were sufficiently thorough and cover all identified areas for improvement through the range of feedback sources available.
- To continue with plans to improve recruitment of medical staff, including exploring a variety of ways to promote recruitment.
- Take action to improve performance for atrial fibrillation related indicators.
- Take action to improve patient experience of GP consultations and the helpfulness of reception staff.

At this inspection we found that:

- The service surveyed five per cent of its patients per month. The surveys were analysed and referred on to a monthly quality assurance (QA) meeting for further analysis and consideration. The overall result for January 2017 was that 99.6% of 253 patients were very likely or likely to recommend the service. The service also analysed feedback left on their web page and any direct verbal or written feedback from patients.
- The service continually advertised for new staff, had involved the Care UK central recruitment team and regularly attended job fairs to improve the recruitment of medical staff.
- Performance for atrial fibrillation related indicators was now similar to local and national averages at 100% compared with 97% (local) and 99% (national).
- We saw that the practice had held two training sessions specifically for receptionist staff since the last inspection.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that all staff are fully aware of the protocols relating to the recording and reporting of temperatures of fridges containing medicines and must reinforce to staff the actions to be taken when there are temperatures recorded outside the recommended ranges.

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?

Requires improvement

- At this inspection we found that new systems and processes in place for monitoring the safe storage of medicines within the practice had been put in place. These were generally followed and understood by staff. However one incident had occurred where a maximum temperature above the recommended range had been recorded over four days without action being taken.

Brighton Station Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector.

Background to Brighton Station Health Centre

Brighton Station Health Centre is a GP treatment centre offering general practitioner, sexual health and walk-in services. The GP and walk-in services are open from 8am to 8pm seven days a week. The sexual health service provides walk in appointments from 9am to 11.45am and from 2.30pm to 6.30pm and pre-bookable appointments from 8am to 8.40am. Telephone lines for the centre are open from 8am to 8pm. There is a clinical director who is an advanced nurse practitioner and a service manager who is the CQC registered manager. The service is provided by Care UK who provide central support that includes clinical and policy guidance as well as other support functions such as clinical governance and quality assurance. There is one salaried male GP and eight self-employed GPs, one of whom works regular sessions. There are four advanced nurse practitioners with additional bank advanced nurse practitioners providing the walk-in service. There are three sexual health practitioners with additional bank sexual health practitioners providing the sexual health service. There are a range of administrative and reception staff.

Services are provided from:

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There are approximately 6,650 registered patients within the GP practice. In addition the walk-in centre sees an average daily attendance of 65 patients and the sexual health service sees an average of 25 patients each day. The centre is contracted to provide level one and level two sexual health services and the walk-in minor injury and illness service for patients across Brighton and Hove.

The practice has a patient demographic where 85% of patients are aged between 20 and 49 years. Less than 7% are aged 50 and over and only 1% of patients are over the age of 65. Six percent of the patient population are under 18. Clinical prevalence of mental ill health and depression are

higher than CCG and national averages and the practice has a transient population due to the walk in centre and practice location.

Why we carried out this inspection

We undertook a comprehensive inspection of Brighton Station Health Centre on 7 June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall and good in the effective, caring, responsive and well-led domains, but requires improvement in the safe domain.

Detailed findings

The full comprehensive report following the inspection on June 2016 can be found by selecting the 'all reports' link for Brighton Station Health Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Brighton Station Health Centre on 1 March 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out a focused inspection of Brighton Station Health Centre on 1 March 2017. During our inspection we:

- Spoke to staff including the service manager, quality and governance lead, a practice nurse and an advanced nurse practitioner.
- Examined documentation and equipment relevant to the inspection.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 5 June 2016, we rated the practice as requires improvement for providing safe services as the registered provider had not always ensured that the systems and processes for monitoring the safe storage of medicines within the practice were followed and understood by all staff and that prompt action was taken to mitigate the risk of medicines being stored outside of the required temperature range.

When we undertook a follow up inspection on 1 March 2017 there were still concerns regarding the safe storage of medicines. The practice is still rated as requires improvement for providing safe services.

Overview of safety systems and process:

At the inspection in June 2016 we found that the arrangements for managing medicines, including emergency medicines and vaccines, in the practice generally kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However, on the day of inspection we found a vaccine fridge where the maximum temperature logs had been consistently outside the recommended range of two to eight degrees centigrade for several days although the daily temperature checks were within range. This meant that vaccines could have been stored outside the safe temperature ranges for several hours at a time. Staff told us that the high temperatures were probably reached when the fridge was in use (and the door opened) and that the issue with the consistent elevation recorded was due to a failure to reset the thermometer. However the monitoring process of the vaccine fridge did not highlight the consistently elevated temperatures and the fact that these were out of range did not trigger appropriate action to identify and address the cause.

At this inspection on 1 March 2017 we found that new systems had been put in place to ensure that vaccine fridge temperatures were recorded daily and that readings outside the range were discussed and acted on. There was a laminated protocol on how to make recordings and actions to be taken attached to the fridge door. The service were recording the fridge temperatures every fifteen minutes using a USB digital thermometer. Additionally the maximum, minimum and actual temperature were recorded first thing each morning from the external screen of a separate digital thermometer. The service held a meeting at 9am each morning when amongst other issues, the recorded readings were minuted and discussed. If a reading was outside the range then the USB thermometer readings would be checked to see how long the fridge was outside the range. There was a protocol in place on how to proceed in the event of a cold chain failure.

We spoke to two members of staff both of whom had a thorough knowledge of the procedures.

However there had been one period of four days where readings outside the normal range had been recorded but not been reported. The issue was picked up at the Monday morning meeting after the weekend, analysed and resolved. The USB readings did not show a raised temperature and therefore demonstrating that the rise in temperature was not prolonged. The issue occurred partly because there had not been morning meetings over the weekends and we saw minutes of the Monday meeting that reinforced that the meetings were mandatory over weekends and that fridge temperatures must be confirmed at each meeting. We were also told that since the episode an email was sent out every Friday to weekend staff reminding them that it was mandatory to hold morning meetings at the weekend.

All readings taken prior to and after this period were within the normal range except for one which had been identified, analysed and the explanation (an engineer had had the fridge open for a few minutes) had been recorded in the log.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not do all that was reasonably practicable to ensure the safe storage and monitoring of medicines requiring refrigeration within the practice.** **This was in breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**