Marine Medical Group

Quality Report

Blyth Health Centre
Thoroton Street
Blyth
Northumberland
NE24 1DX
Tel: 01670 544125
Website: www.marinemedical-blyth.nhs.uk

Date of inspection visit: 27 June 2016
Date of publication: 11/08/2016

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 16 July 2015. A breach of legal requirements was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment. We found care and treatment was not provided in a safe way for service users because some aspects of the management of medicines were unsafe. Specifically:

• Monitoring records showed some temperature sensitive medicines were being kept in a refrigerator whose temperature had exceeded the recommended safe maximum temperature. No action had been taken in response to this, and staff involved with the recording of refrigerator temperatures were not aware of the process to follow.

• The health care assistant had administered influenza vaccines to patients without using Patient Specific Directions (PSDs) that had been produced by the prescriber.

• Blank prescription forms were not always handled in accordance with national guidance, as records were not kept of the first and last serial numbers of boxes of loose-leaf blank prescriptions on receipt into the practice.

We undertook this focused inspection on 27 June 2016 to check that the provider had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marine Medical Group on our website at www.cqc.org.uk

Our key findings were as follows:

• Care and treatment was provided in a safe way for service users through the proper and safe management of medicines for the purposes of the regulated activity.

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

The practice is rated as good for providing safe services.

At this visit we checked to ensure medicines were handled safely. There had been concerns at the previous inspection about the way that medicines were managed. At this inspection we saw that improvements had been made to address the shortfalls that had led to the requirement notice we issued following our last visit.

Summary of findings

What people who use the service say

We did not speak with any patients during this focused inspection.

Marine Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC pharmacist inspector.

Background to Marine Medical Group

The practice is based within the Blyth Health Centre in Blyth, Northumberland. The practice serves people living in the Blyth area and extends as far south as Seaton Sluice. The practice provides services to patients from one location: Blyth Health Centre, Thoroton Street, Blyth, Northumberland, NE24 1DX. We visited this address as part of the inspection.

The practice is located in a purpose built building and provides services to patients at ground floor level. They offer on-site parking, including disabled parking, accessible WC's and step-free access. They provide services to around 10,500 patients of all ages based on a Primary Medical Services (PMS) contract agreement for general practice.

The practice has four GP partners and seven GPs in total (three male, four female). There are also two practice nurses, one healthcare assistant, a practice manager, an IT/ medicines manager, office manager, administrator, two medical secretaries and nine reception and administrative support staff.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments were available from 8.30am to 10am every morning and from 3pm to 5pm every afternoon. Extended hours' surgeries were offered on Monday and Wednesday mornings between 7.30am and 8.30am.

Information taken from Public Health England places the area in which the practice is located in the third more deprived decile. In general, people living in more deprived areas tend to have greater need for health services. The practice's age distribution profile is weighted towards a slightly older population than national averages. There are more patients registered with the practice over the age of 65 years than the national average.

The service for patients requiring urgent medical attention out-of-hours is provided by the 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We undertook an announced focused inspection of Marine Medical Group on 27 June 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice, after our comprehensive inspection on 16 July 2015, had been made. We inspected the practice against one of the five questions we ask about services: Is the service safe? This is because the service had not been meeting some legal requirements at the inspection on 16 July 2015.

Detailed findings

How we carried out this inspection

We carried out an announced visit on 27 June 2016. We spoke with staff from the practice that were involved with, or had responsibility for, the management of medicines. We looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Medicines Management

The arrangements for managing medicines in the practice kept patients safe. At our last inspection the practice's monitoring records showed some temperature sensitive medicines were being kept in a refrigerator whose temperature had exceeded the recommended safe maximum temperature. No action had been taken in response to this, and staff involved with the recording of refrigerator temperatures were not aware of the process to follow. At this visit we saw that the practice had obtained two new refrigerators with two sources of temperature reading. Both refrigerators also had data logging equipment attached. We checked the records of the refrigerator temperatures completed in the last three months. We found they were all within the recommended range for the safe storage of vaccines contained within the refrigerator, of between two and eight degrees Celsius. All relevant staff had completed immunisation and vaccine training; this was documented on the training spread sheet and included the date when update training was required. There was also a new process in place with an action plan for steps to take in the event of a refrigerator malfunction and guidance for staff on resetting the temperature. The practice had also completed the cold chain and refrigerator storage self- audit tool produced by NHS England.

At our last inspection we saw that the health care assistant had administered influenza vaccines to patients without using Patient Specific Directions (PSDs) that had been produced by the prescriber. At this inspection we saw that the health care assistant had completed immunisation and vaccine training and that a PSD had been produced by the prescriber. (A PSD is an instruction to administer a medicine to a list of named patients where each patient on the list has been individually assessed by that prescriber.) We also saw a list of patients, assessed as suitable and signed by the prescriber, which had been used when influenza vaccines were administered by the health care assistant.

At our last inspection we saw that blank prescription forms were not always handled in accordance with national guidance, as records were not kept of the first and last serial numbers of boxes of loose-leaf blank prescriptions on receipt into the practice. At this visit a new process was in place to log the dates of all prescriptions received by the practice. Practice staff had been trained on the process and one member of administration staff we spoke with could clearly demonstrate how the new process worked.