




Kinloss Medical Centre

Kinloss Barracks, Forres, Scotland IV36 3UH

Defence Medical Services inspection report

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 given to us by the practice and patient feedback about the service.

Overall rating for this service	Good	
Are services safe?	Good	
Are services well-led?	Good	

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Summary

About this inspection

We carried out an initial announced comprehensive inspection of Kinloss Medical Centre on 16 November 2021. We rated the service as requiring improvement overall with a rating of requires improvement for the well-led key question. The safe, effective, caring and responsive key questions were rated as good.

An announced comprehensive follow up inspection was undertaken on 21 February 2023. The practice was rated as good overall with a rating of requires improvement in the well-led key question. The other key questions were rating as good.

A copy of the previous inspection report can be found at:

<https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#medical>

We carried out this announced focused follow up inspection on 23 April 2024. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

As a result of this inspection the practice is rated as good overall in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services well-led? – good

CQC does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against CQC's observations and recommendations.

This inspection is one of a programme of inspections the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- Although the dispensary was closed at the time of the inspection, systems for managing medicines had been strengthened to minimise risks to patient safety.
- Quality improvement activity had improved with an increase in clinical audits over the last 12 months. This included monitoring and auditing outcomes for patients undergoing rehabilitation and the referral pathway.

- Team building activities were taking place and training had been provided to improve team cohesion.
- Healthcare governance processes had been reviewed and streamlined and all staff had access to the processes.
- Remedial action had been taken to improve the infrastructure.

We identified the following notable practice, which had a positive impact on patient experience:

- In the absence of a pharmacy technician, outsourcing was well managed and considered the needs of patients, particularly in terms of travel. Patients had the choice of 3 outsourced pharmacies. Prescriptions were then registered to allow the account to reconcile prior to payment. We considered this an area of good practice.
- It was identified by the Primary Care Rehabilitation Facility (PCRF) that level 2 physical training (PT) was not well organised. A reconditioning PT programme was developed and outlined in a patient booklet. Designed to take place over 8 weeks, the programme aimed to improve capability and allow a graduated return to fitness with a view to eventual return to mainstream PT. It was showing positive outcomes at the time of the inspection.

The Chief Inspector recommends to Defence Primary Healthcare and the wider organisation:

Whilst remedial action had been taken to rectify individual concerns with the infrastructure, a sustainable solution should be found to ensure the infrastructure is safe and appropriate for patients, staff and others who use the building.

The Chief Inspector recommends to the practice:

Undertake regular Valproate (medicine to treat epilepsy and bipolar disorder) searches to ensure patients prescribed this medicine are receiving appropriate treatment and care

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team included a CQC inspector and a pharmacy technician specialist advisor.

Background to Kinloss Medical Centre

Located in Kinloss Barracks, the medical centre provides a primary care, occupational health and rehabilitation service to a registered patient population of 1,400, including highly deployable engineering regiment. In addition, occupational health services is provided for 250 reservist. Families of military personnel are not registered at the practice so are signposted to local NHS practices.

Facilities within the building include a dispensary and a PCRf. The Department of Community Mental Health is based within the building but was not included in this inspection.

The practice works closely with Lossiemouth Medical Centre and shares some resources. There is an aspiration to create a combined practice with Lossiemouth Medical Centre.

An emergency triage clinic (referred to as sick parade) is held in the mornings from 08:00 to 09:30 hours. Routine appointments are available on Monday, Tuesday and Thursday from 09:30 to 16:30 hours, from 09:30 to 12:30 hours on Wednesday and 09:30 to 16:00 hours on Friday.

The staff team

Doctors	Senior Medical Officer (civilian) Two Regimental Medical Officers (one currently deployed) Two General Duties Medical Officer (both deployed) Civilian Medical Practitioner
Medics	Two Medical Sergeants Five Combat Medical Technicians (seven deployed or vacant positions)
Practice nurses	Band 6 Two part time Band 5 nurses Military nurse Health care assistant
PCRF	Two physiotherapists Two exercise rehabilitation instructors
Pharmacy	Post vacant
Practice manager	One civilian
Administrators	Four

Are services safe?

We rated the practice as good for providing safe services.

Although the safe key question was rated good at the previous inspection, improvements were identified including shortfalls with:

- medicines management
- the infrastructure
- lone working
- heat injury training.

At this inspection we found the recommendations we made had been actioned.

Risks to patients

Since the last inspection, staff had received training in how to manage a patient presenting with a heat injury.

Safe and appropriate use of medicines

Specific to medicines, the recommendations made at the last inspection were in relation to:

- clinical coding and review of patients on repeat medicines
- expiry dates of medicines and consumables
- checks of blood glucose devices with control solutions
- high risk medicines (HRM) and shared care agreements with secondary care
- the safe storage of the controlled drug (CD) key
- cancellation, obliteration or alteration of entries in the CD register
- warning signage for flammable gases
- medical gas cylinder training for staff.

Since the last inspection the dispensary had closed because the pharmacy technician had left and, despite unsuccessful attempts, the practice was continuing to try and recruit to the post. At the time of the inspection, prescriptions were outsourced locally. Outsourcing was well managed and considered the needs of patients, particularly in terms of travel. Patients had the choice of 3 outsourced pharmacies. Prescriptions were then registered to allow the account to reconcile prior to payment. We considered this an area of good practice.

Significant improvement had been made in relation to the review of patients on repeat medicines and clinical coding. Patient records had been audited and showed an increase

in compliance from 19% to 63%. Given the audit sample was 77 patients, we were advised reviews for the 22 remaining patients would be completed before the end of the year. Clinical coding had improved and the Senior Medical Officer (SMO) said they regularly reminded the doctors about using the correct coding.

Work had taken place to ensure all patients prescribed a HRM had a shared care agreement (SCA) in place, with 1 exception whereby a secondary care consultant stated no SCA agreement was required. This had been added as an alert to the patient's record.

The CD cupboard keys were held securely in an envelope in a blister safe and were signed out when used. We checked the CD register and all entries were correct with no cancellations, obliterations or alterations. A count of a number of items demonstrated that all were correct. An accountable drug returned by a patient and used to treat moderate to severe pain and was not recorded on the accountable drug register. This was corrected during the inspection and added to the register. After the inspection, the practice provided evidence to confirm a new standard operating procedure (SOP) had been put in place to ensure any returned medication was handled properly.

New blood glucose devices had been secured and control solutions were being regularly checked.

Additional warning notices were had been placed around the gas storage area. Gas handling training was planned to take place on 24 April 2024. Staff we spoke with had a good awareness of how to manage gases.

We checked 10 medicines/consumables alongside the DMICP (electronic patient record system) stock record and they were all correct and in-date.

In the absence of a pharmacy technician, we discussed with the SMO how their key roles were being managed, such as the checking of fridge temperatures and the management of medical alerts. We reviewed the fridge temperatures for the last 3 months and noted temperatures were regularly checked and within the expected parameters.

From our conversations with various staff, it was clear Medicines and Healthcare products Regulatory Agency (referred to as MHRA) alerts were discussed and acted on. However, the Central Alerting System (CAS) spreadsheet had only two entries for 2024. The practice manager confirmed after the inspection that the CAS spreadsheet had been updated to reflect all alerts received.

A range of medicine audits were completed between February 2023 and March 2024 including an antibiotic audit, HRM audit and 2 SCA audits. A valproate search was undertaken 6 monthly with the most recent search taking place in April 2024. As no patients were identified, a full audit was not written up.

Track record on safety

The infrastructure was identified as a concern at the last 2 inspections and a recommendation made to Defence Primary Healthcare and the Defence Infrastructure Organisation. We had a detailed look around the building and noted improvements had been made to the infrastructure. The hot water system was broken on the day of the previous inspection. Staff advised that this had been a one time system failure and since then there had been no further issues with the hot water.

We were advised that the practice was priority 1 for a new building but there were no firm plans when this would take place as funding had not yet been agreed. Although not recorded, the practice manager undertook regular health and safety checks of the building and reported any concerns accordingly.

Taking account of the '4 T's process' (transfer, tolerate, treat, terminate), the risk register was comprehensive, regularly reviewed and included detail of action the practice was taking to address each risk. Water, gas, electricity and fire checks were up-to-date.

Some minor issues we highlighted to the practice manager were addressed during or shortly after the inspection. These included: recording the dates the disposable privacy curtains were changed; locking the room that held substances hazardous to health (referred to as COSHH); removing a cloth chair from the toilet and reporting a light fitting that was not fitted correctly. The practice was unable to adjust the temperature of the old radiators, which were very hot and had flaking paint. A Statement of Need had been submitted in November 2023 for radiator covers. The Primary Care Rehabilitation Facility was cold in winter and the new physiotherapist had secured the installation of new heaters.

The practice manager advised that environmental cleaning standards had improved. The premises was cleaned in the morning and at lunchtime. The cleaning supervisor monitored the cleaning standards by undertaking regular walk arounds of the building.

A recommendation was made at the last inspection in relation the exercise rehabilitation instructor (ERI) working on their own. The ERI continued to see patients at Fort George on Tuesdays and work in the gym on their own with patients. The lone working risk assessment and SOP was revised in February 2024. The ERI carried a personal alarm when at Fort George. The gym was key coded so it was evident who was accessing the gym. The guard room was informed when the ERI was leaving the gym

Are services well-led?

We rated the practice as good for providing well-led services.

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. We found shortfalls with:

- healthcare governance organisation
- team culture and cohesion
- quality improvement work.

At this inspection we found the recommendations we made had been actioned.

Leadership, capacity and capability

Since the last inspection, the practice leadership team had changed. A full time civilian practice manager had been appointed who worked closely with the Senior Medical Officer to administer the governance of the practice. The leadership team said they were well supported by the regional area manager and regional pharmacist. The practice was managing prescriptions well in the absence of a pharmacy technician through the outsourcing of medicines.

To address environmental sustainability, recycling was encouraged, appliances were switched off when not in use and the heating turned off at weekends. Quick-response or QR codes and electronic information was used where possible.

Culture

At the last inspection, some staff described friction between staff members, which caused additional tension in the workplace and sometimes slowed decision making. All staff we spoke with highlighted that morale had significantly improved since the last inspection. A staff suggestion box had been introduced. A 'pop-up' lunch was held once a month and a newsletter to improve communication had been introduced. 'Civility training' had been held and staff had access to communication training.

Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. Staff were aware of the whistleblowing policy and access to Freedom to Speak Up Champions.

Governance arrangements

The practice manager had spent time restructuring and simplifying healthcare governance (HCG) information. An HCG workbook was used to bring together a range of governance activities, including the risk register, audit, health and safety and in-service training. The

workbook was clear and comprehensive. All staff had access to the workbook. A practice management action plan (MAP) was in place and it included the recommendations made at the last inspection. It was clear the MAP was monitored and updated as actions were addressed.

There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas.

Continuous improvement and innovation

Quality improvement activity was identified as underdeveloped at the last inspection. Audit activity, particularly clinical audit had improved. Between June 2023 and April 2024 asthma, diabetes and hypertension audits had been completed. In addition, a peer review of consultations had taken place. A quality improvement project (QIP) log was maintained. We noted a QIP identified by the PCRFB was not included on the wider practice QIP log. This was rectified promptly after the inspection.

Since the last inspection, quality improvement work had increased for the PCRFB. This included a more consistent use of patient outcome measures and monitoring the referral pathway. Audits undertaken included an electronic referral audit, non-attendance audit and a lower back pain audit.

The new physiotherapist to the practice identified that level 2 physical training (PT) was not well organised. A reconditioning PT programme was developed and outlined in a patient booklet. Designed to take place over 8 weeks, the programme aimed to improve capability and allow a graduated return to fitness with a view to eventual return to mainstream PT. It was showing positive outcomes at the time of the inspection.