The Robens Centre for Occupational Health and Safety

Inspection 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, clients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Inadequate**

Overall summary

This service is rated as Inadequate **overall.** (Previous inspection July 2018 – the service was not rated and was found not to be providing safe care in accordance with the relevant regulations).

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at The Robens Centre for Occupational Health and Safety as part of our inspection programme and to follow up on previous breaches of regulations.

CQC inspected the service on 02 July 2018 and asked the provider to make improvements regarding infection control. We checked these as part of this comprehensive inspection and found that the provider had not made sufficient improvement to address those concerns.

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 general exemptions from regulation by CQC which relate to particular types of service and these are set out in of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At The Robens Centre for Occupational Health and Safety services are provided to clients under arrangements made by their employer. These types of arrangements are exempt by law from CQC regulation. Therefore, at The Robens Centre for Occupational Health and Safety, we were only able to inspect the services which are not arranged for clients by their employers.

The clinical director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider also had a nominated individual, this is a person nominated by the organisation to supervise the management of the regulated activities provided. Since our inspection the nominated individual who was in post at the time of our inspection has left the service and a new nominated individual is now in place.

We reviewed feedback from clients through the completion of 22 Care Quality Commission comment cards. Feedback was consistently positive, with clients telling us that staff treated them with kindness, dignity and respect. Clients also told us they felt they were given the information they needed to make decisions in a way that they could understand.

Our key findings were:

- The service was offered on a private, fee paying basis only.
- The clinic had good facilities and was equipped to treat clients and meet their needs.
- Assessments of a client's treatment plans were thorough and followed national guidance.
- Clients received full and detailed explanations of any treatment options.
- The clinic encouraged and valued feedback from clients and staff.
- Feedback from clients was positive.
- There was a lack of effective governance processes in place including those related to the assessment and management of risk, oversight of training and management of health and safety.
- Staff had received basic training in infection control. However, there was a lack of processes in place to ensure the effective management of infection prevention.
- Systems and processes for protecting clients from abuse were not sufficient.
- There was little focus on continuous improvement and opportunities to learn from incidents and complaints were sometimes missed.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure patients are protected from abuse and improper treatment
- Ensure all premises and equipment used by the service provider is fit for use
- Ensure care and treatment is provided in a safe way to patients.

Overall summary

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Record verbal complaints and use them to improve the quality of care.
- Seek client feedback on clinical care in addition to customer satisfaction.
- Embed the use of quality improvement work into the culture of the service.
- Improve how clients can be involved in decisions about care and treatment, in particular client's whose first language is not English and those with visual or hearing impairments.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a nurse specialist adviser and a second CQC inspector.

Background to The Robens Centre for Occupational Health and Safety

The Robens Centre for Occupational Health and Safety is a trading business of the University of Surrey. It is located in a building within a research park. The building has wheelchair access and consulting rooms are accessible on the ground floor.

The Robens Centre for Occupational Health and Safety is registered with the Care Quality Commission under the Health and Social care Act 2008 to provide the following regulated activity:

- Treatment of disease, disorder or injury and diagnostic and screening procedures.

The service provides independent travel health advice, travel and non-travel vaccinations and blood tests for antibody screening. Services are offered to clients over the age of 12 months intending to travel abroad. Clients can receive both information and necessary vaccinations, and medicines. The clinic is also a registered Yellow Fever vaccination centre. The service is staffed by a team of registered nurses qualified in travel vaccination.

Travel clinic opening times are: Monday 8.40am to 4.30pm, Wednesday 12pm to 8pm and Saturday 8.30am to 3.30 pm.

The Robens Centre for Occupational Health and Safety runs services from 4 Huxley Road, The Surrey Research Park, Guildford, Surrey, GU2 7RE.

Further information can be found on the services website,

During our visit we:

• Spoke with receptionists, administrative staff and travel nurses, one of whom is the registered manager and the nominated manager who is a registered nurse.

• Reviewed comment cards where clients shared their views and experiences of the service.

• Looked at documents the clinic used to carry out services, including policies and procedures.

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

• 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.

Inadequate

Are services safe?

We rated safe as inadequate because of concerns regarding safeguarding, procedures to prevent the spread of infection, the management and storage of substances hazardous to health, assessment and mitigation of risk and the procedures to ensure the safe storage of vaccines.

The impact of our concerns is moderate for clients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We have told the provider to take action (see full details of this action in the Enforcement actions at the end of this report).

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- The provider conducted some safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- The service did not have systems in place to assure that an adult accompanying a child had parental authority. The service did not confirm parental authority when providing services to children.
- The service worked with other agencies to support clients and protect them from neglect and abuse. Staff took steps to protect clients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). It was the provider's policy to request a Disclosure and Barring Services (DBS) check for all staff.
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to report concerns; however we saw an example of a safeguarding referral that demonstrated a lack of understanding of safeguarding.
- The leaders in the service told us that any member of staff could act as a chaperone, but a clinical member of staff would be used if available. Non-clinical staff who could be asked to act as chaperones had not received training for the role.
- There was not an effective system to manage infection prevention and control. No infection control audit had been carried out. Only one member of clinical staff had received infection prevention training suitable for healthcare staff involved in direct patient care. The service did carry out a monthly cleanliness walk around but this did not identify risks or learning points. We saw that cleaning materials were not stored appropriately, for example, we saw that a mop was stored wet and head down in a damp bucket and damp cleaning cloths were draped over cardboard boxes. There was only a single mophead which was used to clean all the hard floors, including those in the toilets, kitchen and clinical rooms, which risks spreading contamination. Not all clinical staff we spoke with were aware of who was the infection control lead within the service.
- The service leaders told us that there were no current risk assessments in place for the control of substances hazardous to health (COSHH). The most recent COSHH risk assessment was dated 2006 and did not relate to the substances used within the service at the time of our inspection. There were no COSHH data sheets available for the substances used within the service. We saw that cleaning substances were not stored appropriately, for example, a box containing acid toilet descaler was stacked on top of other cardboard boxes. There were also empty cardboard boxes stored on top of the cleaning chemicals making it difficult to access. The cleaning materials were stored behind a partial wall in an open plan office and we saw that some of the containers of cleaning fluids were leaking onto shelving and the floor.
- We saw evidence that Legionella risk assessments, water testing and water temperature monitoring was carried out by the landlord.
- The provider was unable to provide evidence that all equipment was safe and maintained according to manufacturers' instructions. We saw several different dates for portable appliance testing (PAT) on electrical equipment, the oldest of which was 2012. The provider had not undertaken risk assessment of individual items to determine which equipment should be PAT tested.

Inadequate

Are services safe?

- There were systems for safely managing healthcare waste.
- The provider carried out environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them. However, we noted some of these were out of date. The service had discussed in a staff meeting in August 2016 the risks that might be encountered should they reduce the age of the clients they would treat. This hypothetical risk assessment did not identify all risks, for example parental authority was not considered. The service started providing services to clients under 12 years of age at the end of 2016. No formal risk assessment was carried out prior to providing services to children aged between 12 months and 12 years. No risk assessment had been carried out since the service was introduced.
- The fire risk assessment carried out in June 2017, on behalf of the landlord, stated it should be reviewed after two years, but this had not been reviewed at the time of our inspection. We observed that fire extinguishers within the service were two months overdue routine servicing.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage clients with severe infections, for example sepsis.
- There were suitable medicines and equipment to deal with medical emergencies which were checked regularly. However, oxygen warning signage was not in place.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept clients safe, they were available to relevant staff in an accessible way. The records only contained information given to the service by the clients. Staff we spoke with told us that they were aware that clients may not disclose relevant medical history.
- The service did not share information directly with the patient's GP but instead gave copies of records they felt relevant, such as malaria prophylaxis recommendation forms, to the patient to give to their GP.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- The medical records for patients who had received yellow fever vaccinations were clearly marked so that they were not destroyed at the end of the standard retention period. Yellow fever vaccine provides lifelong protection.

Safe and appropriate use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- We found that the service had not taken appropriate action when the recorded temperatures of fridges used to safely store vaccines were outside of the recommended range. We saw this had occurred on multiple occasions in the last three months, however no reason for the increased temperature was recorded. On the day of inspection, the service downloaded the data from the data loggers for each fridge and this demonstrated that the temperatures had only exceeded the maximum recommended temperatures for short periods of time and the service assured themselves that the integrity of the vaccines was maintained. Data loggers are electronic devices that capture ongoing fridge temperatures at regular intervals.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking expiry dates of medicines and staff kept accurate records of medicines.
- We noted that there was no evidence in clinical records we reviewed that patients were told when the vaccines

being administered were unlicensed. For example, imported rabies vaccines which were licenced in another country but did not have a UK marketing authorisation.

Track record on safety and incidents

The service did not have a good safety record.

- There was a lack of comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity but did not always use this information to help it to understand risks.

Lessons learned and improvements made

The service did not always learn or make improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses however incidents were not always recorded. Leaders and managers supported them when they did so. The service had recorded two significant events since our last inspection. However, staff we spoke with described other incidents that had not been recorded.
- There were some systems for reviewing and investigating when things went wrong. However, we noted that not all incidents had been recorded and the service did not always identify all the learning points from incidents. Where the service had identified learning points these were shared with staff and action had been taken to improve safety in the service. For example; following staff feedback the service had increased the appointment length for certain types of appointment.
- The provider was not fully aware of the requirements of the Duty of Candour. However, the provider told us they encouraged a culture of openness and honesty.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team.

Requires improvement

Are services effective?

We rated effective as requires improvement because of concerns regarding staff training and consent.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider assessed needs and delivered vaccinations in line with relevant and current evidence based guidance and standards such as the National Travel Health Network and Centre.
- Where guidance allowed for the use of medicines not licensed in the UK, for example vaccines imported when the UK licensed product was not available, the provider told us that clients were verbally informed by the administration team at the time of booking that an unlicensed vaccine may need to be used. We saw no evidence recorded in the clients medical records that the clinician advised the client at the time the vaccine was administered that an unlicensed vaccine was used.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was involved in limited quality improvement activity.

- The service had an audit plan for 2019 but did not demonstrate that completed clinical audits had been used as a quality improvement tool.
- Staff we spoke with told us that they had not been involved in audits but they told us they thought the service leaders carried out audits. The clinical director told us they undertook audits of consultation records.
- We saw evidence of regular audits of consultation records. As a result of these the service had identified administrative improvements such as colour coding forms to distinguish between paediatric and adult records. Also the service had determined that nurses were not completing the consultation forms in a consistent way and some had developed their own templates. This was discussed at a staff meeting.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation. We saw evidence that clinical staff were all appropriately trained to give the vaccines they administered.
- There was a lack of oversight of training. When asked, the leaders in the service were unable to demonstrate the non-clinical training that staff had been provided with by The University of Surrey and therefore were unable to assure us that staff had completed appropriate training. The service did not maintain clear up to date records of skills, qualifications and training.
- All staff had undertaken a basic level of infection control training since our last inspection. The service told us that one of the five nurses working in the travel health service had received clinical level infection control training.
- Staff we spoke with told us that the service supported their training and that they were encouraged and given opportunities to develop.
- Staff whose role included immunisation had received specific training and could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

Staff worked together to deliver effective care and treatment.

- Patients received coordinated and person-centred care.
- Before providing treatment, nurses at the service ensured they had adequate knowledge of the patient's health.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people travel health advice so they could self-care.
- Risk factors were identified and highlighted to patients.

Requires improvement

Are services effective?

- Where clients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. We saw an example of young adult client with complex travel plans and some health concerns who was signposted to more suitable sources of treatment.

Consent to care and treatment

The service did not always obtain consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making for adult clients.
- The theoretical risk assessment which was carried out before the introduction services provided to children aged between 12 months and 12 years identified a risk of giving a vaccination against the child's wishes. It stated that consent would be obtained from parent or guardian for all children under 16 years of age. We did not see evidence recorded in the clinical records that clinical staff treating children had considered the child's capacity to consent.
- Staff supported clients to make decisions. Where appropriate, for adult clients, they assessed and recorded a client's mental capacity to make a decision.
- The service monitored the process for seeking consent through reviews of consultation notes.

Good

Are services caring?

We rated caring as good.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of customer care clients received
- Feedback from clients was positive about the way staff treated people
- Staff understood clients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all clients.
- The service gave clients timely support and information.

Involvement in decisions about care and treatment

Staff did not help patients to be involved in decisions about care and treatment.

- Interpretation services were not available for clients who did not have English as a first language. Staff told us that clients who did not have English as a first language were encouraged to bring family or friends to translate for them. The staff we spoke with were not aware of any confidentiality or privacy issues when using family or friends to translate.
- Clients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff we spoke with told us there was no specific help for clients with hearing or visual impairments.

Privacy and Dignity

The service respected respect patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if clients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as good.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their clients and improved services in response to those needs. For example, the service introduced a service for children aged between 12 months and 12 years to enable families travelling with children to be treated together.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Clients had timely access to initial assessment and treatment. Where the service was unable to accommodate a client's needs they were given details of other local services who may be able to meet their needs.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Clients with the most urgent needs had their care and treatment prioritised.
- Clients reported that the appointment system was easy to use.
- The service offered appointments one evening a week and on Saturday mornings. Appointments were available out of school hours.
- The service also offered longer appointments for clients who were nervous about injections.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. The service told us they had not received any written complaints since our last inspection.
- The service did not record verbal complaints.
- The service informed clients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy and procedures in place.

Inadequate

Are services well-led?

We rated well-led as inadequate because of concerns regarding the capacity and skills of the service leaders, governance arrangements and the management of risk.

Leadership capacity and capability;

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders lacked knowledge and oversight about issues and priorities relating to the quality and future of services. We saw evidence that the service had not made sufficient improvement to address concerns regarding the prevention and spread of infection identified at our previous inspection in July 2018.
- Leaders within the service were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The leaders in the service had not implemented effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The clinical director was the infection control lead and had received clinical infection control training. However, the service had not demonstrated that the infection control lead had attained the competency level required for this role.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.

Culture

The service did not have a culture of sustainable care.

- Staff felt respected, supported and valued.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The leaders in the service were not fully aware of the duty of candour.
- The service did not record verbal complaints and did not use them to identify trends.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The services leaders were unclear on the training that staff received through the University of Surrey and had no overview of all training received by staff or required for specific job roles.
- All staff received regular annual appraisals in the last year.
- There was an emphasis on the well-being of staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not clearly set out or effective.
- Staff were not always clear on their roles and accountabilities.
- Leaders had not established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a lack of clarity between The University of Surrey processes and responsibilities and those of the leaders within the service. For example; there was a significant event reporting process for the University of Surrey which the service did not engage with, and protocols provided by the University of Surrey had not been reviewed to ensure that they were appropriate for this service.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

Inadequate

Are services well-led?

- There was a lack of effective processes to identify, understand, monitor and address current and future risks, including risks to patient safety. The leaders in the service did not assure themselves that processes were operating as they expected, for example, the processes in place to maintain the cold chain.
- Leaders in the service did not have an overview of risk management within the service and did not monitor risk management activity undertaken on their behalf by the landlord. Some risk assessments had not been completed or were out of date.
- There was little understanding or management of risk in relation to the prevention of the spread of infection.
- Performance of clinical staff could be demonstrated through audit of their consultations. Leaders did not have complete oversight of safety alerts, incidents, and complaints, as not all incidents and complaints were recorded.
- There was limited evidence of clinical audit used routinely to improve quality. However, we did see evidence of some administrative quality improvement activity.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had some access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address identified weaknesses, such as improvements to the consultation templates. However not all weaknesses were identified, such as recording consent in the clinical records for children who were competent to consent who were under 16 years of age.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support

sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. Leaders in the service had an open door policy and staff were encourage to give feedback on an ad hoc basis as well as during meetings and appraisals. We saw evidence of changes to the service as a result of feedback from staff. For example; the length of certain types of appointments had been increased to give staff more time to complete consultations.
- Staff were not involved in audit activity.

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

- The service did not always make use of internal or external reviews of incidents or complaints. However, where learning was identified it was shared and used to make improvements. For example; following the amendment to the International Health Regulations to increase the validity of the international certificate of vaccination against yellow fever from 10 years to lifelong the service introduced a system to clearly identify records of clients who had received yellow fever vaccinations to ensure that they were retained.
- The service did not have a strategic plan in place to deliver quality improvement within the service. However, we saw minutes of travel team meetings where suggestions for improvements were discussed and where appropriate implemented.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met The registered person had failed to establish systems to prevent abuse. In particular: The service did not demonstrate through clinical records that they had systems in place to establish whether children under 16 years old had the capacity to consent to treatment. There was insufficient understanding of safeguarding procedures. Staff did not understand the criteria for appropriate referral to the safeguarding team. Staff who could be asked to act as chaperones had not all received training to undertake this role.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met… The registered person had failed to ensure that all equipment used by the service was properly maintained. In particular: Fire extinguishers had not been serviced in line with recommendations. The registered person could not provide evidence that portable electrical equipment was safe to use.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met…

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

The registered person did not assure themselves that systems and processes were operating as they expected.

The system for monitoring the cold chain.

The registered person did not assure themselves that action was taken by the landlord when risks were identified.

Risk assessments undertaken by the service were not always fully completed before introducing a new service or client group.

There was additional evidence of poor governance. In particular:

Leaders did not have a clear and up to date records of training. There was no oversight of training staff received.

Leaders in the service were not fully aware of their responsibilities under duty of candour.

It was not always recorded that clients had been told when medicines not licensed in the UK were used.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

Incidents were not always recorded or learning shared with all appropriate staff.

Staff were not involved in audit or quality improvement processes.