Poland Medical LLP

Poland Medical - Coventry

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 13 January 2019 to ask the service the following key questions: Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations with regard to ongoing clinical oversight.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The CQC inspected the service on 20 May 2018 and 10 October 2018 and asked the provider to make improvements regarding safe care and treatment and good governance. A Notice of Decision with two conditions was issued as a result of findings during the May 2018 inspection. One condition was lifted after the October 2018 follow up inspection, but the condition relating to clinical oversight remained. We checked all areas as part of this comprehensive inspection and found that, whilst most areas of concern had been addressed, some of the issues highlighted at the previous inspections had not been resolved. The full reports for both inspections can be found by selecting the 'all reports' link for Poland Medical Coventry on our website at www.cqc.org.uk.

Poland Medical is an independent provider of medical services and treats both adults and children at their location in Coventry. Services are provided primarily to Polish people who live in the UK and who choose to access the services as an adjunct to the NHS services for which they are entitled to register.

The owner of the service is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We received 10 comment cards, all of which were complimentary about the standard of service provision.

Our key findings were:

- Clinical governance had improved. The Responsible Officer, who was the clinical lead, carried out annual performance audits for all doctors. These audits were supplemented by random audits which were carried out once a month. However, the level of improvement was not consistent across all medical records and more work needed to be done to ensure that the improvement in medical record keeping was consistently maintained. Therefore we found that the condition which related to the standard of clinical oversight had been partially met.
- A more comprehensive medical record template was in use. An additional gynaecological template had also been introduced.
- The collection of NHS details and the request to consent to share information with patients' GPs were more consistent, however the actual sharing of information remained infrequent.
- All doctors had undertaken comprehensive training regarding Fraser guidelines and Gillick competency.
- The service did not have a separate quality improvement programme, or carry out targeted clinical audits.
- There was minimal evidence of learning from significant events.
- Communication methods with staff were more effective and embedded.
- The policies and procedures were working documents.
- Emergency medicines stocked were appropriate for the risks associated with the range of procedures carried out at the clinic.

We identified regulations that were not being met and the provider must**:**

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

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Review the scope of quality improvement activities to include more clinical audits.
- Review the process for documenting learning points and actions as a result of discussions of significant events.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Poland Medical - Coventry

Detailed findings

Background to this inspection

Poland Medical is registered with the Care Quality Commission (CQC) as an independent provider of medical services. Both adults and children are treated at the Coventry location. Poland Medical, Coventry, is registered with the CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Poland Medical provides non-urgent services to a population which is mainly Polish. Services are available to people on a pre-bookable appointment basis. The clinic employs doctors on a sessional basis most of whom are specialists who provide a range of services from gynaecology to psychiatry. Medical consultations and diagnostic tests are provided by the clinic. No surgical procedures are carried out.

The clinic employs 12 doctors all of whom are registered with the General Medical Council (GMC) with a licence to practise. The doctors work across both the West London and Coventry locations. Other staff include the registered manager, the duty manager and reception staff. Poland Medical is a designated body (an organisation that provides regular appraisals and support for revalidation of doctors) with one of the specialist doctors as the Responsible Officer (an individual within a designated body who has overall responsibility for helping with revalidation). The Responsible Officer is also the clinical lead for the clinic.

Poland Medical is open on Saturdays and Sundays from 10am until 6.30pm. Appointments are available with a gynaecologist on Tuesday evenings from 4pm until 7pm. A cardiologist and a gynaecologist offer appointments on a Thursday evening from 4pm until 7pm. Appointments may be arranged on other days by prior arrangement via the West London clinic. The provider is not required to offer an out of hours service or emergency care. Patients who require emergency medical assistance or out of hours services are requested to contact NHS Direct or attend the local accident and emergency department.

Details about Poland Medical are available to download from the website: www.polskaprzychodnia.co.uk.

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor. The team was supported by a Polish translator.

During our inspection we spoke with two doctors, one of whom was the Responsible Officer, the duty manager and two reception staff. The registered manager was unable to be present. We also viewed procedures and policies which related to compliance with the remaining condition served in the Notice of Decision as a result of findings during the May 2018 inspection.

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.

Are services safe?

Our findings

At our previous inspection in October 2018 we found that the service was not providing safe care in accordance with the relevant regulations:

- Medical records were not always accurate, complete, contemporaneous or legible.

At this inspection on 13 January 2019, we found that there was evidence of improvement following the introduction of audits of medical records, but that the improvement was not consistently maintained. However, no significant concerns about patient safety arose from the medical records that we examined.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were reviewed annually and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. The policies outlined clearly who staff should contact for further guidance if they had any concerns about a patient's welfare.
- The service had systems to check that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients 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. It was the clinic's policy that all staff had a Disclosure and Barring Service (DBS) check. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). We saw that IPC audits were carried out every six months. The most recent IPC audit was carried out in January 2019. No issues were highlighted.
- There was a Legionella management policy and we noted that water checks were carried out every month.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We noted that portable appliance testing and equipment calibration were carried out by external contractors on an annual basis.
- There were systems for safely managing healthcare waste.

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. Clinical staff and senior administrative staff had received training in the identification and management of patients with severe infections, for example sepsis. There were patient information leaflets about sepsis in reception.
- The clinic was equipped to deal with medical emergencies and staff were trained in emergency procedures.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

- Not all patient medical records were written and managed in a way that kept patients safe. For example, we examined 20 medical records and found that 20% (4 out of 20) were not clear, accurate and legible. In the remaining 80%, we noted that consultation text was identical in the medical records of three different

patients. There were no significant concerns about the management of any patients whose medical record we examined, although in one instance we did note a lack of recording of physiological data relating to the care of a child that would have been appropriate.
- A new medical record template was introduced after the May 2018 inspection. We noted that it was more comprehensive than the previous version. An additional gynaecological template had also been developed.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. This was documented on the patient's medical record.
- The service had a system in place to retain medical records in line with DHSC guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. We saw that referrals were now documented in the patient's medical record.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks.
- Emergency medicines stocked were in line with risks associated with the range of procedures carried out at the clinic. There was a flowchart for the management of emergency medicines which included doses of emergency medicines.
- The service kept prescription stationery securely and monitored its use.
- The Responsible Officer (RO), who was also the clinical lead, carried out an annual medicines audit for each doctor to ensure that prescribing was in line with best practice guidelines for safe prescribing. The RO had carried out one audit for each doctor, so it was too soon to determine whether the system had made a difference.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- There were effective protocols for verifying the identity of patients including children.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

- There was a system for recording and acting on significant events. We noted that seven had been recorded for the Coventry location in the past year. Staff understood their duty to raise concerns and report incidents and near misses. The management team supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. However, there was minimal evidence of learning from events and no analysis of trends. We noted that discussion of events from both the Coventry and London locations was a standing agenda item at clinical governance meetings, but we did not see documented evidence of discussions about any learning points. The service explained that this was due to the fact that minor incidents were recorded, which did not require any learning or changes to procedures.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- When there were unexpected or unintended safety incidents the service provided support, information and an apology to affected patients. Copies were kept of all correspondence.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. We saw that alerts were emailed to all doctors and relevant staff and that a record was kept of action taken on the hard copy of the alert.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in October 2018 we found that the service was not providing effective care in accordance with the relevant regulations:

- There was limited evidence of a quality improvement programme to include the use of targeted clinical audits.

When we undertook the inspection on 13 January 2019, we found that there was some evidence of improvement, but that the service was still not providing effective care, and that the quality improvement programme could be broadened to include medicine specific audits.

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 care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. We were shown an example of how guidance was circulated to all doctors.
- Patients' immediate and ongoing needs were assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. However, we found that the recording of the assessments was of an inconsistent standard.
- Clinicians had enough information to make or confirm a diagnosis, but this was not consistently documented in detail in the medical records.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service carried out some quality improvement activity.

- We were shown an initial audit which a doctor had carried out on patients with high blood pressure in May 2017. Results showed that the doctor needed to improve consistency in recording patients' height and body weights. A repeat audit had not been done.
- The clinical lead for the organisation audited every doctor's medical record keeping and prescribing once a year, but this had not resulted in consistent improvement.

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.
- Doctors were registered with the General Medical Council (GMC) and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- We saw that doctors had undergone comprehensive training in Fraser guidelines and Gillick competency since our May 2018 inspection. Doctors' understanding was tested by taking a scenario based test.
- The system for supporting and managing staff when their performance was poor or variable had strengthened. For example, we noted an improvement in the standards of record keeping since the inspection in May 2018, but it was not consistent for all doctors.

Coordinating patient care and information sharing

Staff worked together, and worked with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated with, other services when appropriate. For example, the patient's NHS GP or secondary care when the patient had consented to this, but the actual sharing of information remained infrequent.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines

Are services effective?

(for example, treatment is effective)

history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. Consent was recorded on the patient's medical record.
- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long term conditions such as asthma. Where patients agreed to share their information, we saw limited evidence of letters sent to their registered GP in line with GMC guidance.
- Patients assessed as being vulnerable were referred to external services as appropriate.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. Patients who were referred to other services were followed up on an individual basis.

Supporting patients to live healthier lives

Patients were supported to manage their own health and maximise their independence.

- Where appropriate, staff gave patients advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their NHS GP for additional support.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained 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.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was complimentary about the way staff treated them.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- All patients who attended the clinic spoke either English or Polish. Staff spoke both languages, which meant that interpreters were not needed.
- Information on the clinic's website could be downloaded in Polish or English.
- Patients told us through comment cards that they were happy with the services provided by the clinic and that they thought that doctors were very professional.
- Information on the clinic's website included details of the specialist doctors, the scope of services offered and the schedule of fees.

Privacy and Dignity

The service respected patients' privacy and dignity.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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 patients and improved services in response to those needs. For example, the clinic now opened on a Thursday evening.
- The facilities and premises were appropriate for the services delivered.
- The premises were not suitable for patients with disabilities, because there was a step leading up to the main entrance and there was no disabled toilet. Patients with access problems were advised to contact the clinic in advance, so that they could be directed to an alternative local NHS or private clinic which had facilities for disabled patients.
- A hearing loop was provided for patients who were hard of hearing.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients were able to book appointments on alternative days by prior arrangement via the West London clinic. All appointments were pre-bookable; no urgent appointments were provided.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken as appropriate.

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 in the reception area. Staff treated patients who made complaints compassionately.
- The registered manager was the designated lead for handling complaints.
- The service informed patients of any further action that might be available to them should they not be satisfied with the response to their complaint.
- The service had a complaints policy and guidance for staff on how to deal with complaints. We saw evidence that the registered manager responded to email complaints on the same day that the complaint was received. We looked at three complaints and noted that they were handled in accordance with the complaints policy.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

At our previous inspection in October 2018 we found that the service was not providing well-led care in accordance with the relevant regulations:

- The system for monitoring the standard of medical record keeping needed further strengthening to become robust.

At the inspection on 13 January 2019, we found that, although a system for auditing medical records had been introduced, the outcome had not resulted in consistent high quality recording of consultations in the patients' medical records.

We have told the provider to take action (see full details of this action in the Enforcement Notice at the end of this report).

Leadership capacity and capability

- The management team could articulate the issues and priorities relating to the quality and future of services. They had a general understanding of the challenges and were working to address them. It was evident that progress had been made, but that areas of concern remained regarding the effectiveness of clinical governance and oversight.
- The Responsible Officer (RO) and registered manager were visible and approachable. It was clear that they worked closely with the team.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The registered manager and RO continually refined their strategy to accommodate or anticipate patient demands. For example, gynaecological appointments could be booked on Tuesday and Thursday evenings and cardiac appointments could be booked on Thursday evenings. We were told that a new gynaecologist had just been appointed and the clinic was planning to expand the services offered as a result.

Culture

- Staff felt respected and supported and knew that their contribution was valued.
- It was evident that the service was patient-focused.
- The RO and registered manager acted on behaviour and performance which was inconsistent with the vision and values.
- The service's culture promoted openness, honesty and transparency. Incidents and complaints were dealt with in a fair and timely manner. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing staff with the development they needed. This included appraisal and career development conversations. We saw evidence that staff received annual appraisals, which provided an opportunity to discuss development needs or requests for training. Staff were supported to meet the requirements of professional revalidation where necessary. They were given protected time for professional development and evaluation of their clinical work.
- There was an emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. We saw that staff had received equality and diversity training. Staff felt that they were treated equally.
- We were told that there were positive relationships between doctors, staff and the management team.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support governance and management and we noted progress in the effectiveness.

- Structures, processes and systems to support governance and management were set out, understood and more effective than in previous inspections. However, these needed to be strengthened to ensure consistent standards were maintained. For example, 19 out of 20 medical records that we examined during the inspection in October 2018 were found to be of an acceptable level. At the January 2019 inspection 16 out of 20 medical records were found to be of the required standard. Three out of the 16 medical records, which were of the required standard, contained identical text in the consultation record; this had not been detected by the audit system.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities
- There was a comprehensive suite of policies and procedures to promote safety and efforts had been made to ensure that these were now working policies.

Managing risks, issues and performance

There were appropriate processes for managing most risks.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had introduced processes to manage current and future performance. The RO audited doctors' consultations, prescribing and referral decisions on an annual basis in order to monitor their performance. The RO also carried out random audits of medical records each month. The results of the audits were used to address any identified weaknesses, but we noted that standards of record keeping were not consistent for all doctors.The system for auditing medical records was therefore not working effectively, which could have the potential to impact on patient safety and care.
- The registered manager and RO had oversight of safety alerts, incidents, and complaints.
- The provider had a Business Continuity Plan, which included detailed contingency arrangements in the event of an emergency.

Appropriate and accurate information

Poland Medical is an independent medical provider, so performance information from external sources was not available.

- Quality and sustainability were discussed in relevant meetings where all staff had access to information.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data and medical records.

Engagement with patients, staff and external partners

The service encouraged feedback from patients via comment cards and the annual patient survey.

- The in-house patient survey results for the Coventry location were uploaded to the Poland Medical website. The 2018 results were not available at the time of our inspection. Results showed that 100% of respondents were satisfied with the consultation that they received and that it was easy to make an appointment (the actual number of respondents was not available).
- Staff told us that they could provide feedback verbally to the duty manager or registered manager. The duty manager attended the formal staff meetings which were held at the London location.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement

There was evidence of systems and processes for learning and continuous improvement. The service had worked hard to improve on the areas highlighted for attention in previous inspections. The fact that the doctors were employed on a sessional basis made it more difficult to arrange professional development.

- We noted an increased focus on continuous learning and improvement since the previous comprehensive inspection in May 2018. For example, all doctors had received training in Fraser guidelines and Gillick competence and sepsis.
- The service discussed incidents and complaints. We saw evidence that meeting minutes were circulated to all staff, so that those who could not attend were informed of the outcome of discussions.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. **How the regulation was not being met:** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • 4 out of 20 patient records we reviewed contained sections that were illegible or incomplete • A further three records out of the 20 we reviewed contained identical patient information **Regulation 17(1)**