Rejuvenate Aesthetics Clinic Ltd

Inspection report

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SO16 2HW
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Rejuvenate Aesthetics Clinic Ltd on 18 August 2023. This was the first inspection of the service which was registered in May 2022. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Act.

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 exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Rejuvenate Aesthetics Clinic Ltd provides a range of non-surgical cosmetic interventions, for example fillers, dermaplaning, microneedling and skin booster injections which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The nurse director 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 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.

Although we were unable to speak with patients during our visit, we viewed written feedback provided to the service by patients following their appointment.

Our key findings were:

- Best practice guidance was not always followed in providing treatment to patients. For example, weight management prescribing requirements.
- There was a lack of auditing of clinical and prescribing practices.
- There was a lack of performance review, clinical supervision and peer review for clinical staff.
- Clinical records were not always sufficiently detailed.
- Monitoring of cold chain processes were not sufficient to ensure the safe storage of medicines requiring refrigeration.
- There were processes in place for managing medical emergencies but these did not include details of how to manage a medical emergency when only one member of staff was working.
- Emergency medicines were in place, however these had been obtained for a named patient rather than for business use.
- Risk assessments were carried out but these were not always sufficiently detailed to address all risks.

Overall summary

- Fire safety processes were in place. Staff had participated in fire drills and had received fire safety training.
- There were general health and safety risk assessments in place.
- There was a lack of governance and effective monitoring processes to provide assurance to leaders that systems were operating as intended.
- Information was not always shared appropriately with other services.
- The premises were well-maintained, with all the necessary health and safety measures in place.
- Arrangements for chaperoning were not effectively managed. It was not clear to patients when a chaperone was available.
- The service had systems and processes in place to ensure that patients were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Patients were routinely asked to provide feedback on the service they had received. Feedback from patients using the service was very positive.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We took enforcement action and issued a warning notice against the provider in relation to Regulation 12(1) Safe care and treatment.

We issued a requirement notice against the provider in relation to Regulation 17(1) Good governance.

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

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

- Make it clear to patients when chaperones are available.
- Improve the approach to prescribing off-label medicines against clinical needs of an individual patient where there is no suitable licensed medicine available.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

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

Background to Rejuvenate Aesthetics Clinic Ltd

Rejuvenate Aesthetics Clinic Ltd operates from a shop front premises on the ground floor of a self-contained unit which is leased by the provider. The service is located in the Swaythling area of Southampton at 4 Market Buildings, High Road, Southampton, SO16 2HW.

The service is staffed by a nurse who is the owner and a part time administrator/receptionist.

The service opening times are:

Tuesday, Wednesday and Friday 10am to 6pm

Thursday 12pm to 8pm

Saturday 10am to 5pm

Further details can be found on the service's website www.rejuvenate-clinics.com

The service is registered with the CQC under the Health and Social Care Act 2008 to provide the following regulated activity:

- Treatment of disease, disorder or injury.

Services provided that are regulated by CQC include injection for hayfever, treatment for excessive sweating, vitamin B12 injections and prescription weight loss.

How we inspected this service

Before we visited the service we reviewed the information available to us on the service website and our own internal systems. We reviewed the information provided to us by the service as part of our pre-inspection information return.

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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

Prescribing was not always in line with manufacturers' or best practice guidance; information was not always shared appropriately with the patients' own GP; clinical records were not always sufficiently detailed; there was insufficient monitoring of cold chain processes to ensure the safe storage of medicines; there were insufficient processes in place to respond to a medical emergency and emergency medicines had been inappropriately obtained on a named patient basis.

Safety systems and processes

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

- The provider conducted safety risk assessments. Staff received safety information from the service as part of their induction and refresher training. The service had implemented a series of brief audits to monitor the effectiveness of internal processes but in some cases they failed to identify some risks. For example, the control of substances hazardous to health (COSHH) audit failed to identify that cleaning substances were not stored securely.
- The service had systems to safeguard vulnerable adults from abuse. At the time of our inspection, all staff had received up-to-date safeguarding adults and safety training appropriate to their role. Treatment was offered to those aged over 18 years of age and no children were treated by the service. However, in the event that children may attend the service whilst accompanying an adult, or staff may have contact with adults who may pose a risk to children, staff had not received training in the safeguarding of children in line with current guidance and competency frameworks. Following our inspection the service updated its training requirements and provided evidence that since our inspection all staff had completed safeguarding children training to a level appropriate to their job role. The service also updated its safeguarding policy to include information about safeguarding children and contact details for the local childrens' safeguarding team.
- The provider described how they would carry out staff checks at the time of recruitment and had a checklist to ensure checks were complete. However, we reviewed two personnel files and found they only contained Disclosure and Barring Service (DBS) checks (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). Since our inspection the provider told us they had retrospectively completed recruitment checks.
- Staff who acted as chaperones had received a DBS check. However, at the time of our inspection, they had not received any training for the role. Since our inspection the service provided evidence that staff who act as chaperones had, following our inspection, completed training for this role. Staff told us that chaperones were offered and we saw there was a sign in reception offering a chaperone. However, chaperones were not available every day the service operated as the nurse worked alone on some days. It was not clear to patients when booking appointments whether a chaperone would be available.
- There was an effective system to manage infection prevention and control (IPC) and regular IPC audits were carried out. The premises appeared clean and tidy. We saw daily and weekly cleaning checklists were completed. Appropriate personal protective equipment, including gloves and aprons, were available. A basic Legionella risk assessment had been carried out which determined no further action was required. (Legionella is a particular bacterium which can contaminate water systems in buildings).
- The provider ensured facilities and equipment were safe and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

Requires Improvement

Are services safe?

- We saw that fire and health and safety risk assessments were in place. Fire equipment had been regularly maintained and the fire alarm was tested weekly. We saw evidence fire evacuation drills were carried out every 6 months.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe reactions, for example anaphylaxis. However, the medical emergency policy did not contain information on how to manage a medical emergency when staff members were working on their own. Non-clinical staff had not completed training in basic life support. This meant they were not appropriately trained to respond to a medical emergency. However, at the time of inspection, we saw evidence all staff were booked onto a basic life support course in September 2023.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. However, we found emergency medicines had been obtained on a named patient basis, which meant the medicine should only be administered to that patient.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- At our inspection, on 18 August 2023, we found individual care records were stored on a secure, password-protected electronic system. We reviewed individual care records relating to 6 patients who had received treatment within the service.
- Individual care records were not always written and managed in a way that kept patients safe. The care records we saw showed information needed to deliver safe care and treatment was not always recorded in sufficient detail. For example, where patients reported previous medical history or prescription medicines they were taking, these were not fully explored in the individual care records. We found there was a lack of a clear rationale for treatment recorded in the individual care records we reviewed.
- The service had limited systems for sharing information with other agencies to enable them to deliver safe care and treatment. The service did not share any information directly with the patient's own GP. We found where patients were prescribed a steroid injection for the treatment of hayfever, those patients were not provided with any record of treatment to pass on to their GP. Where patients were prescribed an injection to support weight loss, they were given a letter to share with their GP. However, we found information contained within the letter was not sufficiently detailed to keep patients safe. For example, the correspondence did not contain baseline measurements such as blood pressure recordings, even when these were abnormal and may require further GP intervention.
- 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.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, emergency medicines and equipment, did not always minimise risks. We found there was insufficient monitoring of cold chain processes to ensure the safe storage of medicines. All actual temperatures recorded had been within the required range but the service was not recording minimum and maximum temperatures, so could not be assured that the temperatures had remained within the required range. We noted that a second temperature probe which displayed an upper and lower temperature range was showing temperatures outside of the required range at the time of inspection. Since our inspection the provider told us they had amended their temperature recording processes to include minimum, maximum and reset of the temperatures, as well as actual temperatures.

Requires Improvement

Are services safe?

- The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Staff who were prescribers confirmed there were no arrangements in place for clinical supervision of their prescribing practices. Since our inspection the provider has told us they now have clinical supervision arrangements in place and this will include audits of prescribing practices.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- Staff prescribed and administered medicines to patients but this was not always in line with current national guidance. Where there was a different approach taken from national guidance there was a lack of clear rationale recorded to support the prescribed treatment to ensure patient safety.
- For example, we saw that Semaglutide (under the brand name of Ozempic) injections had been prescribed to promote weight loss. The provider worked under guidance and initial training provided by an external training provider to deliver this service. Ozempic is not licensed for use as a weight loss treatment in the UK, this is termed as 'off-label' use. Off-label means that the person prescribing the medicine wants to use it in a different way than that stated in its licence.
- Current national guidance states that where Semaglutide is prescribed as a treatment for managing weight this should only be prescribed to patients with a body mass index (BMI) over 30, or over 27 if there is a weight related disease such as high blood pressure. We reviewed 4 individual care records for patients prescribed this injection and found 2 patients had a BMI below 27 when their first prescription was issued. There was no clear rationale documented in the individual care records to support this decision.
- There was a lack of documented protocols for prescribing off-label medicines.

Track record on safety and incidents

The service had a good safety record.

- There were risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped to understand risks however, we found some risks hadn't been identified by the service. For example, the medical emergency policy and procedure did not contain specific information on how to manage a medical emergency when only one member of staff was working.

Lessons learned and improvements made

The service learned and made 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.
- The service had only recorded one significant event since they started providing services and this was not related to the treatments that are regulated by CQC.
- 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 provider received and acted on patient safety alerts. For example, following a Medicines and Healthcare products Regulatory Agency alert regarding supply issues, the service recently stopped prescribing Ozempic injections to support weight loss.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

There was a lack of arrangements for appraisal and supervision; clinical records were not always sufficiently detailed; there was a lack of comprehensive audit, and prescribing was not always in line with current guidance.

Effective needs assessment, care and treatment

The provider had some systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians had not always assessed needs and delivered care and treatment in line with current legislation, standards and guidance relevant to their service.

- Patients' immediate and ongoing needs were assessed but not always in sufficient detail. For example, we saw that Kenalog injections were prescribed and administered within the service for the treatment of hayfever. Kenalog is a medicine licensed for use in the UK but when used for the treatment of hayfever, this is termed as 'off-label' use. Off-label means that the person prescribing the medicine wants to use it in a different way than that stated in its licence.
- Our review of clinical records found there was a lack of documented treatment rationale to support the off-label use of Kenalog for the treatment of hayfever. Records did not always clearly document what other treatments had been previously tried nor the extent of patients' hayfever symptoms to support the treatment plan and clinical decision making.
- Our review of clinical records confirmed patients prescribed weight loss injections were not managed in line with prescribing requirements as set out by the manufacturer or national guidance.
- We reviewed clinical records relating to 6 patients who had received treatment within the service. We saw that the service used a template for the patient to complete, including details of their previous medical history, medicines being taken and known allergies. However, there was no evidence in the clinical record that responses were explored fully prior to treatment being given. For example, a patient answered 'yes' to having respiratory problems when requesting a hayfever injection but no discussion of this was recorded in the clinical record.
- When we reviewed clinical records we found it wasn't always clear whether a consultation had taken place face-to-face or by telephone.
- Arrangements were in place to treat returning patients and those requiring follow up. For example, we saw patients prescribed injections to support weight loss had been followed up regularly.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was unable to demonstrate quality improvement activity.

- The service was unable to demonstrate that it gathered and used information about care and treatment to make improvements.
- The provider had implemented a series of brief audits to monitor the effectiveness of internal processes. However, the audits lacked detail, failed to identify some risks and in some instances, failed to result in required actions being completed. For example, an audit of supervision and appraisal processes had failed to identify the lack of arrangements to support the peer review and supervision of the lead nurse.

Requires Improvement

Are services effective?

- We found no evidence of clinical auditing or quality improvement activity within the service. There was no audit or clinical oversight of prescribing practices and no prescribing clinical supervision for the staff member who was a prescriber. Audits of clinical records, to monitor compliance against the provider's expected standards of record keeping, only ensured completeness for example that consent had been obtained, they did not review other aspects of record keeping or prescribing.
- There was adequate auditing of infection prevention and control processes.

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

- At the time of our inspection, on 18 August 2023, no staff had received training in safeguarding children and staff who acted as chaperones had not received training for this role. Since our inspection the provider has sent us evidence to show that staff have now completed safeguarding children training to an appropriate level for their role and that staff acting as chaperones have completed training for this role.
- Relevant professional (nurse) was registered with the Nursing and Midwifery Council (NMC) and were up to date with revalidation
- Up to date records of skills, qualifications and training were maintained. There was a policy and training matrix in place which set out expectations of training for each staff group.
- We saw that administrative staff had received an annual appraisal.
- There was a lack of clinical appraisal and supervision in place for the nurse prescriber. We found that the nurse was working in isolation, with no formal support mechanisms identified. There was a lack of arrangements to promote reflective practice or peer review.
- Clinical staff undertook online updates and completed training courses when introducing new treatments to the service. For example, injections for weight loss.

Coordinating patient care and information sharing

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

- Patients received person-centred care.
- Staff did not communicate effectively with other services. For example, the service did not inform the patient's own GP when treating patients with an injection for hayfever. Letters provided to patients to give to their GP when prescribed weight loss injections did not contain baseline measurements even when these were not in the expected range.
- Before providing treatment, the nurse ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. However, we found that previous medical history and medicines history were not always explored sufficiently in the individual care record to ensure safe prescribing and treatment.

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 advice so they could self-care.
- Risk factors were identified and highlighted to patients although the risks were not always clearly documented in the individual care records. Patients were provided with comprehensive information sheets which documented potential risks and complications.

Requires Improvement

Are services effective?

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.
- We saw clearly documented consent in the patient care records that we reviewed.

Good

Are services caring?

We rated caring as Good because:

Staff demonstrated an awareness of the need to prioritise kindness and empathy in their interactions with patients.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service actively sought feedback on the quality of care patients received via a satisfaction questionnaire sent out to patients, through the practice management system, following their appointment. We saw that reviews received in this way were very positive.
- Prior to the inspection we reviewed publicly available information regarding patient experiences at the service and found that these were all very positive about the service they had received.
- Feedback from patients was positive about the way staff treated people.
- The service gave patients timely support and information about their treatment.

Involvement in decisions about care and treatment

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. Information about pricing was available to patients on the service's website and within the service.
- Interpretation services were available for patients who did not have English as a first language.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consulations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the nurse and escorted into the consultation/treatment room.
- Staff knew if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Chaperones were available some of the time that the service operated. At the time of our inspection staff who acted as chaperones had not completed training for this role but since our inspection the provider has sent us evidence that the staff member had since completed chaperone training. It was not made clear to patients, when booking an appointment online, when a chaperone would be available.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Flexible appointment times supported patient choice.

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, where appropriate, telephone consultations were offered for patient convenience.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, an interpretation service was available for patients whose first language was not English.

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 and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Listening and learning from concerns and complaints

- At the time of our inspection the service had not received any complaints.
- Information about how to make a complaint or raise concerns was available online and from the reception area.
- The service had complaint policy and procedures in place.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

There was a lack of effective processes to ensure that systems and processes were operating how leaders intended. Audits were not always effective at identifying risk, recruitment checks had not been completed and there were no written protocols to support prescribing. There was a lack of clinical supervision, peer review, reflective practice and clinical audit.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the future of services.
- Leaders were visible and approachable.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

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.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The service did not always have a culture of high-quality sustainable care.

- Staff felt respected, supported and valued.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a lack of processes for providing all staff with the development they needed. There was a lack of arrangements for clinical supervision, appraisal, peer review or reflective practice to support the nurse in their ongoing professional development and to promote the safe care of patients. This meant that there was a lack of performance review, monitoring and evaluation of the clinical decision making being undertaken by clinical staff. However, since our inspection the service has told us they have arranged supervision, which will include regular review and audit of clinical and prescribing practices.
- Staff were supported to meet the requirements of professional revalidation where necessary. They were given protected time for professional time for professional development. However, there were no arrangements for ongoing reflective practice to support professional revalidation requirements.
- The service actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and management and regular informal communication.

Governance arrangements

Requires Improvement

Are services well-led?

There was a lack of clear responsibilities, roles and systems of accountability to support good governance and management.

- The provider had established some policies, procedures and activities to ensure safety but had not always assured themselves that they were operating as intended. The provider had implemented a series of brief audits to monitor the effectiveness of internal processes, for example: COSHH, safeguarding, infection prevention and control, staff personnel files and supervision and appraisal processes. However, the audits lacked detail, failed to identify some risks and in some instances, failed to result in required actions being completed. For example; the COSHH audit had failed to identify that cleaning substances were not securely locked away, the audit of personnel files, undertaken in October 2022, had identified that staff files did not include the required information but information had not been collated at the time of our inspection and the audit of supervision and appraisal processes had failed to identify the lack of arrangements to support the peer review and supervision of the lead nurse.
- Individual care records we looked at were not always written and managed in a way that kept patients safe. Some records lacked detail and did not fully reflect the rationale for treatment and clinical decision making.
- Staff were clear on their roles and accountabilities.

Managing risks, issues and performance

There was a lack of clarity around processes for managing risks, issues and performance.

- There were some processes to identify, understand, monitor and address current and future risks including risks to patient safety, however this was not always effective. For example, the medical emergency policy did not contain information on how medical emergencies would be handled when staff were working alone. This risk had not been identified by the service.
- The service did not have processes to manage current and future performance. Performance of clinical staff could not be demonstrated as there was a lack of audit of their consultations, clinical decision making or prescribing practices.
- Leaders had oversight of safety alerts, incidents, and complaints.

Appropriate and accurate information

The service did not have appropriate and accurate information.

- There was a lack of quality, governance and operational information to monitor performance and drive improvement. For example, there was a lack of audit of patient treatment outcomes.
- Records we viewed did not always contain sufficient or accurate data. For example 1 patient completed 2 health questionnaires and in one stated 'yes' to having a respiratory condition and in the other stated 'no'. There was no record of a discussion or further exploration of this in the patient's clinical record.

Engagement with patients, the public, staff and external partners

The service involved patients, the public and staff to support high-quality sustainable services.

- The service encouraged and valued feedback from the public, patients and staff and acted on them to shape services and culture. For example, the service opened late one evening per week and on Saturdays for patient convenience.
- Staff could describe to us the systems in place to give feedback.

Requires Improvement

Are services well-led?

- The service was transparent, collaborative and open with the public about performance. Reviews were available to be viewed on the service's website.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement however this was not comprehensive or effective. For example, quality monitoring audits were brief and did not support improvement in clinical practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 improve the quality and safety of the services being provided. In particular: • There was a lack of clinical supervision, peer review, reflective practice and clinical audit. • Audits were not always effective at identifying risk and in some instances failed to result in required actions being completed. • The provider had not fully assessed the risks associated with lone working arrangements. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: • Recruitment checks had not been completed for all staff. There was additional evidence of poor governance. In particular: • There was a lack of written protocols to support prescribing in line with current guidance.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose • Prescribing was not always in line with current guidance. • Relevant information was not always shared with patient's own GP. • Clinical records were not always sufficiently detailed. • There was insufficient monitoring of cold chain processes. • There were not adequate processes in place to respond to a medical emergency. • Medicines for emergency used had been obtained on a named patient basis rather than for business use. **The enforcement action we took:** We issued a warning notice that required the service to be compliant by 20 October 2023.