J M A Healthcare Limited

Gosforth Private Clinic

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, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

This is our first inspection of this location. We rated it as inadequate because:

- The provider was unable to provide any policies, procedures, risk assessments or standard operating procedures that they used to make sure patients were safe from the risk of harm.
- There was no policy in place accessible to staff about how to manage deteriorating patients.
- There was no information for staff working at the service about their responsibilities in relation to clinical records.
- There were no clinical records held onsite, the provider was unclear how clinicians documented in and managed clinical records and there was no policy stating how or where clinical records should be stored.
- The provider was unable to assure us that there was a consent policy or that staff followed the correct process to obtain patient consent.
- The provider had no duty of candour policy and was unsure of their full responsibilities in the case of an incident requiring formal duty of candour.
- The provider kept staff files, but these were not all up to date. There was no process in place to assure the provider that staff had an up to date registration, revalidation or performance appraisal nor was there a system in place to check staff working at the service had undergone up to date statutory and mandatory training.
- There was a limited governance processes in place, and this did not include how the provider monitored performance to ensure care and treatment was delivered in line with national guidance or the regulations.
- The provider did not have a safeguarding policy that was accessible to all staff. The safeguarding lead had not undergone the relevant training required to be a safeguarding lead and the staff we spoke with did not fully understand their responsibilities in relation to safeguarding vulnerable adults or children or who they would contact should they have concerns about the safety of a person.
- There was limited evidence of cleaning schedules and when we inspected the clinic rooms, we found some equipment to be visibly dusty. National guidance had not been followed for two procedures carried out in theatre. This increased the infection control risk to patients.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we suspended the provider in respect to the regulated activities for a limited time to give the provider opportunity to take action to reduce risks to patients. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

However:

- The reception area was visibly clean and tidy.
- The building was easy to access for those with a disability.
- Cleaning equipment and substances hazardous to health were locked away.
- Portable appliance testing (PAT), servicing and calibration, were completed and up to date.
- Social media feedback about Gosforth Private Clinic was predominantly positive and patients felt cared for.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	We rated it as inadequate because: • The service had enough staff to care for patients however there was a lack of evidence that they had training in key skills, understood how to protect patients from abuse, or managed safety well. The service did not control infection risk well. • There was no evidence staff assessed risks to patients, acted on them or kept good care records. There was no policy to inform staff how and where care records should be kept. • There was no assurance managed medicines well. The service had no process in place to manage safety incidents and learn lessons from them. Staff did not collect safety information or use it to improve the service. • There was no evidence to show staff provided good care and treatment or gave them pain relief when they needed it. • Managers did not monitor the effectiveness of the service nor made sure staff were competent. There was no evidence staff supported patients to make decisions about their care. Staff worked together for the benefit of patients. • There was no formal process for people to give feedback. People could only access the service by appointment but did not have to wait too long for treatment. The service planned care to meet the needs of their patients and took account of patients' needs. • Leaders did not run services well using reliable information systems. Staff were not supported to develop their skills. • There was no written vision, values or strategic plan staff could access or apply to their work. There was no clarity from the provider about staff roles and accountabilities. The service had not engaged with patients to plan and manage services. We rated this service as inadequate because it was neither safe, effective, responsive nor well led. We were unable to rate the key question of caring due to lack of evidence.

Summary of findings

Diagnostic and screening services

Inadequate

We rated it as inadequate because:

- The service had enough staff to care for patients however there was a lack of evidence that they had training in key skills, an awareness of safeguarding processes to protect patients from abuse, or managed safety well. The service did not control infection risk.
- There was no evidence staff assessed risks to patients, acted on them or kept good care records. There was no policy to inform staff how and where care records should be kept.
- There was no assurance the service managed medicines well. The service had no process in place to manage safety incidents and learn lessons from them. Staff did not collect safety information or use it to improve the service.
- There was no evidence to show staff provided good care and treatment or gave them pain relief when they needed it. Managers did not monitor the effectiveness of the service nor made sure staff were competent. There was no evidence staff supported patients to make decisions about their care. Services were available by appointment only. Staff worked together for the benefit of patients.
- The service planned care to meet the needs of their patients and took account of patients' individual needs. There was no formal process for people to give feedback. People could only access the service by appointment but did not have to wait too long for treatment.
- Leaders did not run services well using reliable information systems. Staff were not supported to develop their skills. There was no written vision, values or strategic plan staff could access or apply to their work. There was no clarity from the provider about staff roles and accountabilities. The service had not engaged with patients to plan and manage services.

We rated this service as inadequate because it was not safe, responsive, or well led. We were unable to rate the key question of caring due to lack of evidence. We inspect but do not rate the key question of effective for diagnostic and screening services.

Summary of findings

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Summary of this inspection

Background to Gosforth Private Clinic

Gosforth Private Clinic is registered for the regulated activities of diagnostic imaging, surgery, and treatment of disease, disorder, and injury. Patients could either contact the clinic directly to book an appointment or be referred by either a GP or another provider.

Gosforth Private Clinic carries out advanced ultrasound procedures, pregnancy scans, hair transplants, cardiology tests, blood tests and diagnostic tests, private GP appointments, skin, and cosmetic clinics.

The clinic had a registered manager who had been in post since the clinic opened in 2015.

This was our first inspection of Gosforth Private Clinic since registration.

The main service provided by this clinic was diagnostic and screening services however, it also carried out some surgical procedures. Where our findings also apply to other services such as surgical services, we do not repeat the information but cross-refer to the main service.

What people who use the service say

We looked at reviews of the service on social media because this was the only source of patient feedback available to us. Gosforth Private Clinic had received mostly positive feedback about the care and treatment people received at the clinic in the past 12 months.

Patients made comments about how well they were looked after and how professional, kind, and caring staff were throughout consultations and procedures.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The team that inspected the service comprised of two CQC inspectors. The inspection team was overseen by Sarah Dronsfield Head of Hospital Inspection.

Outstanding practice

We did not find any outstanding practice during our inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

We told the service that it must take action to bring services into line with the following legal requirements. This action related to treatment of disease, disorder, or injury, surgical procedures, and diagnostic and screening procedures:

- The service must ensure there is a written consent policy and carry out regular checks to make sure it is being followed. (Regulation 11).
- The service must ensure that mandatory training in key skills is available, particularly safeguarding, to all staff (Regulation 12(1)).
- The provider must ensure there is a process for ensuring and recording that all staff have undergone an annual appraisal. (Regulation 12(2)
- The provider must have written admission criteria in place to ensure only patients suitable to be seen by the service are admitted (Regulation 12(1))
- The service must develop processes to assess and record the environmental risks to the health and safety of service users of receiving the care or treatment (Regulation 12 (1)).
- The service must have a written standard operating procedure and protocols for staff to follow in the case of a patient becoming unwell, deteriorating, or having a scan which identifies an anomaly (Regulation 12(1))
- The provider must make sure staff have access to all equipment in the case of an emergency and that this equipment is checked regularly and any out of date items replaced immediately. (Regulation 12(2)
- The service must ensure that all training records are up to date and have a system in place to make sure all staff have the relevant up to date registrations, skills, and competencies for their role (Regulation 12(2)).
- The service must have a policy and process for the proper and safe management of medicines (Regulation 12(2)(g)).
- The service must ensure staff responsible for safeguarding lead roles have the correct level of safeguarding training (Regulation 13 (1)).
- The service must develop a system to ensure that any abuse or suspected abuse is escalated through the correct channels. (Regulation 13(2)).
- The service must ensure staff are able to demonstrate they would recognise possible abuse and be clear about who should be contacted if there is a concern about a person being the victim of abuse. (Regulation 13)
- The service must develop an accessible, written safeguarding policy in place for staff to refer to. (Regulation 13(3)).
- The service must make sure premises where care and treatment are delivered are clean and suitable for the purpose intended. (Regulation 15)
- The provider must ensure when surgery is carried out, all infection prevention and control guidelines such as air exchange are followed (Regulation 15)
- The service must maintain securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (Regulation 17 (1)(3)).
- The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (Regulation 17 (1)(3)).
- The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities (Regulation 17 (1)(3)).
- The service must develop a system to monitor the quality of the experience of service users and monitor the safety and quality of the services provided. (Regulation 17(2)(a))
- The provider must have a process in place for recording serious incidents, investigating them, learning lessons, and sharing lessons learned to all staff working at the service. (Regulation 17(2)(d))
- The provider must have policies and procedures in place to support a culture of openness and transparency and ensure that all staff follow them. (Regulation 20(1))

Summary of this inspection

- The provider must develop a system to demonstrate how they continually monitor and evaluate the services provided including by carrying out clinical audits or other evaluation of practice to provide assurance that best practice guidelines are followed. (Regulation 17)
- The service must ensure systems or processes are established and operated effectively to ensure staff are recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations) (Regulation 19).
- The provider must ensure there is a Duty of Candour policy in place which describes the actions staff need to take if things go wrong in relation to care or treatment. (Regulation 20.1)

Action the service should take to improve:

- The provider should ensure that infection prevention and control policies are followed and that contractors have the knowledge and experience to be able to carry out the tasks they are hired to do.
- The provider should ensure the complaints process is accessible to patients and details the timescales the provider works to.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Diagnostic and screening services	Inadequate	Inspected but not rated	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Surgery safe?

Inadequate

Mandatory training

For our detailed findings on mandatory training please, see the safe section in the diagnostic imaging report

Safeguarding

For our detailed findings on safeguarding please, see the safe section in the diagnostic imaging report.

Cleanliness, infection control and hygiene

The service did not control infection risk well. The service had no systems to identify and prevent surgical site infections. Staff did not use equipment and control measures to protect patients, themselves, and others from infection.

The service had a contract in place for deep cleaning the theatre environment, but this was with a domestic cleaning company and the contract contained no information about the specific requirements of ensuring the theatre was a sterile environment or how the cleaning service would do this.

The contract the service has in place to remove clinical waste was with the domestic provider therefore we were not assured clinical waste was being disposed of in a safe way.

The location had carried out a small number of surgical procedures and in all cases air exchange processes were not followed. This is not in line with national guidance Health Technical memorandum (HTM) 03-01. This increased the risk of infection for patients undergoing those procedures.

We did not see whether staff used records to identify how well the service prevented infections as there were no clinical records held at the location.

Inadequate

Surgery

Environment and equipment

We found no evidence that staff carried out daily safety checks of specialist equipment and found that the air exchange unit in theatre had not been serviced in the last 12 months, although records showed, and the provider confirmed, the theatre had been used for surgical procedures during that period. This increased the risk to patients of infection and break down of equipment.

Assessing and responding to patient risk

Staff did not complete or update risk assessments for each patient or remove or minimise risks.

We found no evidence to demonstrate staff could identify or quickly act upon patients at risk of deterioration.

There was no process in place to help identify deteriorating patients and no policy in place to inform staff of the escalation process.

Nurse and Allied Health Professional staffing

For our detailed findings on Nurse and Allied Health Professional staffing please, see the safe section in the diagnostic imaging report.

Medical staffing

For our detailed findings on Medical Staffing please, see the safe section in the diagnostic imaging report.

Records

For our detailed findings on Records please, see the safe section in the diagnostic imaging report.

Medicines

The registered manager told us the service did not use any medicines however, the clinic had carried out hair transplants recently. These require pain relief and local anaesthetic. The registered manager told us the hair transplant surgeon brought their own medicines with them. We were therefore not assured the registered manager fully understood what medicines were being used at the clinic, where they were being stored and whether they were being stored safely.

Incidents

For our detailed findings on Incidents please, see the safe section in the diagnostic imaging report.

Inadequate

Surgery

Are Surgery effective?

Inadequate

Evidence-based care and treatment

For our detailed findings on Evidence based care and treatment please, see the Effective section in the diagnostic imaging report

Nutrition and hydration

For our detailed findings on Nutrition and hydration please, see the Effective section in the diagnostic imaging report

Pain relief

The registered manager told us there was no medication used at the service. Therefore, pain relief was not available to patients.

There was no evidence that pain relief was administered to patients undergoing hair transplant procedures. Therefore, we had concerns about how pain was managedfor these patients.

There were no records on site during our inspection to check whether pain relief was administered to patients.

Patient outcomes

For our detailed findings on patient outcomes please, see the Effective section in the diagnostic imaging report.

Competent staff

For our detailed findings on Competent staff please, see the Effective section in the diagnostic imaging report.

Multidisciplinary working

For our detailed findings on Multidisciplinary working please, see the Effective section in the diagnostic imaging report.

Seven-day services

For our detailed findings on Seven-day services please, see the Effective section in the diagnostic imaging report.

Health promotion

For our detailed findings on Health promotion please, see the Effective section in the diagnostic imaging report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We saw no evidence the patients who had undergone hair transplant procedures had been consented in line with best practice.

Inadequate

Surgery

For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards please, see the Effective section in the diagnostic imaging report.

Are Surgery caring?

Insufficient evidence to rate

We were unable to rate this key question as no patients were receiving care at the time of our inspection.

There were no patients using the service at the time of our inspection. However, social media feedback about Gosforth Private Clinic was predominantly positive and patients stated they felt cared for.

Are Surgery responsive?

Inadequate

Service delivery to meet the needs of local people

For our detailed findings on Service delivery to meet the needs of local people please, see the Responsive section in the diagnostic imaging report.

Meeting people's individual needs

For our detailed findings on Meeting people's individual needs please, see the Responsive section in the diagnostic imaging report.

Access and flow

For our detailed findings on Access and flow please, see the Responsive section in the diagnostic imaging report.

Learning from complaints and concerns

For our detailed findings on Learning from complaints and concerns please, see the Responsive section in the diagnostic imaging report.

Are Surgery well-led?

Inadequate

Leadership

For our detailed findings on Learning from complaints and concerns please, see the Well-led section in the diagnostic imaging report.

Inadequate

Surgery

Vision and Strategy

For our detailed findings on Vision and strategy please, see the Well-led section in the diagnostic imaging report.

Culture

During this inspection, we were unable to speak to staff other than the registered manager and lead clinician therefore we were unable to assess the culture within the organisation.

Governance

For our detailed findings on Governance please, see the Well-led section in the diagnostic imaging report.

Management of risk, issues, and performance

For our detailed findings on Management of risk, issues, and performance please, see the Well-led section in the diagnostic imaging report.

Information management

For our detailed findings on Information management of risk, issues, and performance please, see the Well-led section in the diagnostic imaging report.

Engagement

For our detailed findings on Engagement please, see the Well-led section in the diagnostic imaging report.

Learning, continuous improvement and innovation

For our detailed findings on Learning, continuous improvement, and innovation please, see the Well-led section in the diagnostic imaging report.

Inadequate

Diagnostic and screening services

Safe	Inadequate
Effective	Inspected but not rated
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Diagnostic and screening services safe?

Inadequate

Mandatory training

The service did not provide mandatory training in key skills to all staff or make sure everyone completed it.

The provider did not deliver any statutory or mandatory training. Staff accessed training via their main employer.

The service had no process to make sure everyone was up to date with their mandatory training.

The provider did not have a comprehensive system in place, including completed records to ensure all staff were up to date with all their training requirements. They had no process for gathering evidence to provide them with assurance or to alert staff when they needed to update their training.

Safeguarding

Staff did not understand how to protect patients from abuse or work well with other agencies to do so. Staff did not have training on how to recognise and report abuse and they were unclear how to apply it.

The provider did not have a written safeguarding policy that all staff were aware of or could access.

The safeguarding lead did not have the level of training specified by intercollegiate guidancefor their role as safeguarding lead.

Staff underwent safeguarding training with their main employer. The service did not have a process in place to assure themselves all staff were up to date with their adult and children's safeguarding training in line with intercollegiate guidance.

We were not confident that all staff would recognise abuse, know how to report it or who to report it to. This was because the two staff we spoke with were unable to demonstrate they would recognise abuse.

Staff did not understand their responsibilities in identifying adults and children at risk of, or suffering, significant harm and were unable to articulate which other agencies they should inform to protect patients.

Staff did not know how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service did not control infection risk well. The service had no systems to identify and prevent surgical site infections. Staff did not use equipment and control measures to protect patients, themselves, and others from infection.

The provider had a cleaning contract with a domestic cleaning service to remove clinical waste therefore we were not assured clinical waste was being disposed of in a safe way.

We did not see whether staff used records to identify how well the service prevented infections as there were no clinical records held at the location.

Some equipment such as echocardiogram equipment was visibly dusty, and the provider was only able to supply us with one completed cleaning schedule dated three months before our inspection. We were not assured that cleaning took place regularly.

There were no patients at the service during our inspection so we could not observe staff practice. There was no cleaning policy to refer to therefore, it was unclear if staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Some of the equipment was visibly dusty during our inspection.

Some items such as ultrasound probes were stored in open cardboard boxes on the floor. All stock should be stored above ground level to avoid the risk of contamination.

We saw stock stored in communal areas and the recovery and clean utility areas. We were not assured that infection prevention and control measures would be undertaken properly because of this which increased the risk of harm to patients.

PPE (Personal Protective Equipment) was available for staff use.

Waiting areas were clean and had suitable furnishings which were clean and well-maintained.

Environment and equipment

The maintenance and use of facilities, premises and equipment did not keep people safe. Staff were not trained to use them. It was unclear how staff managed clinical waste.

We found no evidence that staff carried out daily safety checks of specialist equipment. This increased the risk to patients of infection and break down of equipment.

On inspection, we saw stock stored in communal areas and the recovery and clean utility areas. We were not assured that staff could access equipment and stock easily when needed.

The service had enough suitable equipment to help them to safely care for patients however we found no evidence that staff had undergone training about how to use equipment. We were therefore concerned that patients were at risk of harm because of this.

Portable appliance testing (PAT), servicing and calibration, were completed and up to date.

Inadequate

Diagnostic and screening services

The building was easy to access for those with a disability.

Cleaning equipment and substances hazardous to health were locked away.

The service had suitable facilities to meet the needs of patients' families such as a waiting area.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. We found no evidence of how staff identified and quickly acted upon patients at risk of deterioration.

Staff did not complete or update risk assessments for each patient or remove or minimise risks.

The provider did not have any written admission or acceptance criteria in place to ensure only patients suitable to be seen by the service were cared for by the clinic.

We found no evidence to demonstrate staff could identify or quickly act upon patients at risk of deterioration.

There was no tool in place to help identify deteriorating patients and no policy in place to inform staff of the escalation process.

There were no policies in place for staff to refer to about and dealing with any specific risk issues such as falls, pressure damage, infection, or cardiac arrest.

The provider had a resuscitation trolley. This was checked every six weeks. Staff had identified out of date items on the trolley which were waiting to be replaced when we inspected. We checked the trolley at inspection and identified further items that needed to be replaced as these were also out of date.

The service carried out pregnancy scans however there was no written policy in place to tell staff what they should do in the case of an anomaly being identified during the scan. This meant there was a risk to patients that action may not be taken by the provider to seek further help or assurance.

The provider could not supply us with any risk assessments completed for patients whilst receiving care at the clinic. They told us individual clinicians carried out risk assessments at initial consultation, but we were unable to look at any on the inspection because there were no clinical records held on site.

Nurse and Allied Health Professional staffing

The service had enough nursing and allied health professionals to keep people safe however we were not assured that all staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The provider did not know or stipulate what skills and competencies staff should have to enable them to fulfil their role safely.

There was no written process in place to show the provider routinely monitored professional registration and revalidation of their staff.

Inadequate

Diagnostic and screening services

Not all staff records contained information about registration and revalidation checks or independent references therefore we were not assured the provider had carried out the necessary checks.

Medical staffing

The service had enough medical staff working to keep patients safe however we were not assured that all medical staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Not all staff files contained information to confirm their qualifications, skills, experience, competencies, or independent references.

Four of the clinicians who worked at the clinic had evidence of up to date revalidation within their staff files however the provider did not send us evidence for one member of medical staff.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not stored securely or easily available to all staff providing care.

The provider had no process to inform and direct clinical staff about their responsibilities in relation to clinical records.

The provider had no system in place to manage patient records. They did not know whether clinicians kept clinical records of patients they had seen or where and how they were stored. The provider could not assure us that records were stored securely as they told us each clinician managed their own clinical records. The provider did not know how clinical records were stored by individuals and had not provided a secure place for clinical records to be kept on site.

It was unclear whether staff kept detailed records of patients' care and treatment. The provider was unsure if records were clear, up-to-date, stored securely or followed any retention policy because the records were offsite.

Because there were no clinical records on site during our inspection, we were unable to check whether they were comprehensive or met record keeping standards. The provider had not carried out any clinical record audits.

Because there were no clinical records held onsite, not all staff could access them in the case of an emergency.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

The registered manager told us the service did not use any medicines and there were no emergency medicines kept on the trolley with the resuscitation equipment.

Ultrasound jelly was stored correctly and in date.

Inadequate

Diagnostic and screening services

Incidents

The service did not manage patient safety incidents well. Staff did not recognise and report incidents and near misses. Managers did not investigate incidents or share lessons learned with the whole team and the wider service. When things went wrong, there was no assurance that staff apologised or gave patients honest information and suitable support. Managers did not ensure actions from patient safety alerts were implemented and monitored.

The provider told us there had never been an accident, incident or near miss however there was no policy or procedure in place to record such events if they did happen.

We found no evidence to corroborate whether staff knew what incidents to report or how to report them.

We found no evidence to corroborate whether staff raised concerns and reported incidents and near misses in line with provider policy as there was no policy.

The provider was unable to demonstrate how they shared learning about incidents with their staff.

The staff we spoke with did not fully understand duty of candour or their responsibilities to be open and transparent and give patients and families a full explanation if and when things went wrong.

We were unable to assess whether managers debriefed and supported staff after any serious incident because there was no incident reporting system in place.

Are Diagnostic and screening services effective?

Inspected but not rated

Evidence-based care and treatment

The service had no evidence it provided care and treatment based on national guidance and evidence-based practice. There was no evidence managers checked to make sure staff followed guidance.

There was no evidence to show the service provided care and treatment based on national guidance and evidence-based practice. This was because there were no written operating procedures or policies in place.

The registered manager could not be assured that care was delivered in line with best practice or the regulations.

The provider had no policies or procedures to show how they protected the rights of patients subject to the Mental Health Act 1983. However, one staff member told us they had not received any referrals for patients subject to the Act.

There were no policies to support staff to plan and deliver high quality care according to best practice and national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural, and other needs.

Inadequate

Diagnostic and screening services

Staff gave patients enough food and drink to meet their needs

Staff made sure patients had enough to eat and drink whilst attending for procedures.

Drinks were made available where appropriate to patients attending for diagnostic tests.

Pain relief

Patients did not receive pain relief from staff working at the service because the service did not keep any medication on site.

The registered manager told us there was no medication used at the service.

There were no records on site during our inspection to check whether pain relief was administered to patients.

We were unable to corroborate whether staff assessed patients' pain using a recognised tool or gave pain relief in line with individual needs and best practice.

There were no audits of clinical records to show whether any patients received pain relief during their care and treatment. Therefore, we were not assured that staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment for patients and therefore there was no evidence they made improvements and achieved good outcomes for patients.

Staff did not monitor the effectiveness of care and treatment. The provider did not carry out any formal assessments of the quality of care and treatment they delivered.

The service had participated in an audit, but the registered manager did not know what the audit related to and therefore could not tell us the audit outcome or if there was an action plan in place as a result.

There was no process for measuring if outcomes for patients were positive, consistent, and met expectations, such as national standards and therefore, we found no evidence of results being used to improve patients' outcomes

There was no programme of audits to check improvement over time and therefore, the manager and staff did not use information from the audits to improve care and treatment.

Quality improvement was not checked or monitored.

Competent staff

The service had no process to make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff records were held onsite. We looked at eight sets of records, six had pieces of information such as references or training certificates missing. They were stored securely.

Inadequate

Diagnostic and screening services

The service did not make sure staff were competent for their roles because there was no robust process in place to do this.

The provider did not carry out appraisals of staff. They relied on the appraisal carried out by the person's main employer to keep themselves informed. There was no process in place to clarify whose responsibility it was to ensure appraisals were added to the staff record held at Gosforth Private Clinic. We could not be assured that all staff had undergone a recent appraisal. The registered manager told us staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. However, it was not clear what qualifications or skills were required by the service.

The provider did not deliver any statutory or mandatory training. They relied on the employee's main employer to carry out training. There was no process in place to make sure the provider had up to date training records for staff and therefore we were not assured that all staff working at the service were up to date with all their statutory and mandatory training.

There was no induction policy and therefore we were not assured managers gave all new staff a full induction tailored to their role before they started work.

Staff who worked at the service did not have appraisals carried out by leaders at Gosforth Private Clinic.

Staff were not supported to develop through regular, constructive clinical supervision of their work at Gosforth Private Clinic and there was no clinical educator to support the learning and development needs of staff.

We found no evidence of minuted staff meetings during our inspection other than for the Medical Assurance Committee which was held six monthly for medical staff only.

The registered manager did not identify any training needs their staff had nor did they give them the time and opportunity to develop their skills and knowledge whilst working for Gosforth Private Clinic.

Staff did not have the opportunity to discuss training needs with their line manager and were not supported to develop their skills and knowledge through their role at Gosforth Private Clinic.

The registered manager told us they made sure staff received any specialist training for their role however we were unable to corroborate this because staff training records were not easily accessible.

We found no evidence that the registered manager had a process by which to identify poor staff performance promptly or supported staff to improve.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together to provide care.

Staff worked across health care disciplines when required to care for patients.

Staff did not hold regular and effective multidisciplinary meetings to discuss patients and improve their care

We were unable to corroborate whether staff referred patients for mental health assessments when they showed signs of mental ill health or depression because there were no clinical records to look at.

Inadequate

Diagnostic and screening services

Seven-day services

Services were not available seven days a week to support timely patient care.

Gosforth Private Clinic provided services by appointment only to patients who paid for their appointments.

Gosforth Private Clinic did not provide seven-day services for their patients, although some services were provided in the evenings and at weekends. Patients needing medical care other than by pre booked appointment would access the NHS.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

One member of staff we spoke with told us they assessed each patient's health when attending and provided support and advice if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was no evidence patients were supported to make informed decisions about their care and treatment nor evidence national guidelines were followed. Patients who lacked capacity to make their own decisions were not seen at this service.

Because there was no written consent policy and there were no clinical records on site, we could not be assured staff followed the correct two stage process for consent. We could not be assured that patients were fully informed of the risks associated with any procedure they underwent.

We were not assured staff supported patients to make informed decisions about their care and treatment. This was because we could not access patient records and the provider had not carried out any quality checks of records to ensure national guidance was being followed.

We could not be assured staff understood how and when to assess whether a patient had the capacity to make decisions about their care because there was no evidence for us to inspect and base a decision.

Are Diagnostic and screening services caring?

Insufficient evidence to rate

We were unable to rate this key question as no patients were receiving care at the time of our inspection.

There were no patients using the service at the time of our inspection. However, social media feedback about Gosforth Private Clinic was predominantly positive and patients stated they felt cared for.

Inadequate

Diagnostic and screening services

Are Diagnostic and screening services responsive?

Inadequate

Service delivery to meet the needs of local people

The service could not demonstrate how they planned and provided care in a way that met the needs of local people and the communities served.

One of the doctors told us patients in need of additional support or specialist intervention were referred to the appropriate NHS hospital because their needs could not always be met by the clinic.

Facilities and premises were appropriate for the services being delivered.

Managers took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

It was unclear how the service took account of patients' individual needs.

The service saw patients living with mental health problems however, there was no evidence to assure us how their needs were met.

Because there were no clinical records on site or an admission and acceptance criteria, we were not assured that patients living with dementia and learning disabilities were supported in ways that met their individual needs. However, the registered manager told us they had not seen any patients living with dementia or a learning disability.

There was no written policy for patients to refer to about how to support patients with additional support needs such as dementia, learning disability or sensory loss. The registered manager told us each person would be individually assessed.

The organisation had no policy in place about how to support patients who needed an interpreter. Therefore, we could not be assured the service was accessing interpreters for patients. The registered manager and lead clinician told us they would encourage family members to act as interpreters which is not in line with recommended practice.

The service did not have information leaflets available in other languages that may be spoken by patients and the local community.

Staff helped patients access care with other services and providers**.**

Access and flow

People could access the service when they needed it. Staff monitored waiting times and made sure patients received treatment within agreed timeframes.

Staff worked to keep the number of cancelled appointments, treatments and operations to a minimum.

Inadequate

Diagnostic and screening services

We could not find any information or evidence about the process staff followed if patients had their appointments, treatments or operations cancelled at the last minute.

Staff told us they referred patients to other services when additional care or treatment was needed however we could find no evidence of this being done.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. We found no records about how complaints were investigated. There was evidence the service discussed concerns and complaints at a six monthly committee where lessons learned were shared. There was no evidence that patients were included in the investigation of their complaint or that the service exercised Duty of Candour.

Gosforth Private Clinic had no formal process for people to give feedback or raise concerns about care received other than via social media. The provider told us there had been no complaints however there was no procedure in place to record them if there were any.

The organisation had no Duty of Candour policy in place therefore we were not assured that the correct process would be carried out in the event of an incident that required the formal Duty of Candour process to be followed.

The service took concerns and complaints to the Medical Advisory Committee (MAC) where they were discussed.

The registered manager provided a verbal example of how they had managed and handled a complaint. They said patients, relatives, and carers could raise concerns via social media, and these would be responded to on the same platform.

We did not see information clearly displayed in patient areas about how to raise a concern and there was no written complaints policy in place for staff or patients to refer to or which clearly set out timelines or the responsibilities of the provider.

There was a regular agenda item for complaints to be shared with consultants at the six monthly Medical Advisory Committee (MAC). However, there were no complaints documented in the minutes provided to us.

Are Diagnostic and screening services well-led?

Inadequate

Leadership

Leaders did not have the skills and knowledge to run the service. They did not understand the responsibilities and obligations they had as the provider to meet the standards required by the reguations. They did not support staff to develop their skills.

The service was led by the registered manager. They were responsible for the governance of the service. Their management of the service was supported by a receptionist.

Inadequate

Diagnostic and screening services

The provider and registered manager was unable to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

We requested audits, policies, procedures, and protocols, for example, patient outcome audits, safeguarding policy, patient safety checklist and audit, clinical records audit, patient needs assessment, Mental Capacity Act policy, consent policy and consent audit, risk management policy and risk register. These were not provided to us at the time of or following the inspection.

Vision and Strategy

The service had ideas of what it wanted to achieve however there was no strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff did not understand how to apply their ideas, make plans, or monitor their progress.

The service had an ambition to increase the number of patients it saw and widen the scope of services provided to patients although there was no written strategy about how they would do this.

During this inspection, we have not received assurance the service has complied with all the regulations of the Health and Social Care Act 2008.

There was no outcome data to show the service provided high quality safe care for patients.

Culture

During this inspection, we were unable to speak to staff other than the registered manager and lead clinician therefore we were unable to assess the culture within the organisation.

Governance

Leaders did not operate effective governance processes throughout the service. There was no clarity about the roles and responsibilities of staff at all levels and there were no regular opportunities, apart from MAC meetings, for all staff to meet, discuss and learn from the performance of the service.

We asked for written policies, procedures, and documentation on and after inspection to demonstrate the service was meeting the regulations. We received some documentation, however, it did not contain the detail necessary to give assurance it covered all the necessary details, for example future recruitment in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations).

During this inspection, we were given assurance that further documentation would be provided for example complete staff files. The registered manager provided us with some references, some revalidation information and training information for some but not all staff employed by the service.

A service level agreement was in place with a cleaning company however we were not assured the company staff had the correct skills and knowledge to carry out cleaning in a clinical and theatre environment.

The MAC met every six months. We reviewed the minutes of two meetings and found there was limited discussion about practicing privileges and complaints at the meetings.

Inadequate

Diagnostic and screening services

Management of risk, issues, and performance

The registered manager did not use systems to manage performance effectively. They did not have plans to cope with unexpected events.

The service has not provided plans to carry out clinical or individual risk assessments for service users. This put service users at risk of harm as they may receive care and treatment which does not meet their needs.

The service did not provide policies or protocols to monitor or audit patient outcomes post-operatively. This meant the service could not compare their performance or clinical effectiveness to other similar services.

The provider had not identified the current risks at the registered location associated with running the service ('Risk Assessment') nor identified how the service will meet its duty of care to patients and staff (and others) by creating a culture of undertaking risk assessments.

Information Management

The service did not collect and analyse data to understand performance or make decisions and improvements.

At this inspection we were unable to identify up-to-date and comprehensive information on all patients' care and treatment. We were told clinical records were not stored at the location and the registered manager was unclear what clinicians did with the clinical records they made. We were not assured patient information and records were stored safely and securely in lockable cabinets, in line with the Data Protection Act 2018.

Engagement

There was no formal process for staff to engage with patients and the service did not collaborate with partner organisations to help improve services for patients.

There were no completed audits of patient feedback.

Learning, continuous improvement and innovation

There was no opportunity for staff to continually learn and improve services.

The registered manager did not demonstrate a good understanding of quality improvement methods or the skills to use them.

Staff were not encouraged to develop innovation or participation in research.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must make sure premises where care and treatment are delivered are clean and suitable for the purpose intended. (Regulation 15) • The provider must ensure when surgery is carried out, all infection prevention and control guidelines such as air exchange are followed (Regulation 15)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must maintain securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (Regulation 17 (1)(3)). • The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (Regulation 17 (1)(3)). • The service must ensure systems or processes are established and operated effectively to ensure compliance with the requirements to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities (Regulation 17 (1)(3)).

This section is primarily information for the provider

Requirement notices

- The service must develop a system to monitor the quality of the experience of service users and monitor the safety and quality of the services provided. (Regulation 17(2)(a))
- The provider must have a process in place for recording serious incidents, investigating them, learning lessons, and sharing lessons learned to all staff working at the service. (Regulation 17(2)(d))
- The provider must have policies and procedures in place to support a culture of openness and transparency and ensure that all staff follow them. (Regulation 20(1))
- The provider must develop a system to demonstrate how they continually monitor and evaluate the services provided including by carrying out clinical audits or other evaluation of practice to provide assurance that best practice guidelines are followed. (Regulation 17)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed • The service must ensure systems or processes are established and operated effectively to ensure staff are recruited in full accordance with Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA regulations) (Regulation 19).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was no written policy or process in place to ensure consent was taken in line with national guidance. There were no regular checks in place to make sure consent was taken safely.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service must ensure staff responsible for safeguarding lead roles have the correct level of safeguarding training (Regulation 13 (1)). • The service must develop a system to ensure that any abuse or suspected abuse is escalated through the correct channels. (Regulation 13(2)). • The service must ensure staff are able to demonstrate they would recognise possible abuse and be clear about who should be contacted if there is a concern about a person being the victim of abuse. (Regulation 13) • The service must develop an accessible, written safeguarding policy in place for staff to refer to. (Regulation 13(3)).
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that mandatory training in key skills is available, particularly safeguarding, to all staff (Regulation 12(1)). • The provider must ensure there is a process for ensuring and recording that all staff have undergone an annual appraisal. (Regulation 12(2) • The provider must have written admission criteria in place to ensure only patients suitable to be seen by the service are admitted (Regulation 12(1)) • The service must develop processes to assess and record the environmental risks to the health and safety of service users of receiving the care or treatment (Regulation 12 (1)). • The service must have a written standard operating procedure and protocols for staff to follow in the case of a patient becoming unwell, deteriorating, or having a scan which identifies an anomaly (Regulation 12(1)) • The provider must make sure staff have access to all equipment in the case of an emergency and that this equipment is checked regularly and any out of date items replaced immediately. (Regulation 12(2)

This section is primarily information for the provider

Requirement notices

- The service must ensure that all training records are up to date and have a system in place to make sure all staff have the relevant up to date registrations, skills, and competencies for their role (Regulation 12(2)).
- Th service must have a policy and process for the proper and safe management of medicines (Regulation 12(2)(g)).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour • The provider must ensure there is a Duty of Candour policy in place which describes the actions staff need to take if things go wrong in relation to care or treatment. (Regulation 20.1)

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
Treatment of disease, disorder or injury Diagnostic and screening procedures Surgical procedures	S31 Urgent suspension of a regulated activity **The provider must immediately suspend the carrying out of regulated activities from 17 September 2021 until 17 December 2021 at or from the following location: Gosforth Private Clinic** 18 Elmfield Road Gosforth Newcastle upon Tyne Tyne and Wear NE3 4BP