Browd Medical Limited

La Maison Medicale

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 25 April 2018 to ask the service the following key questions; - are services safe, effective, caring, responsive and well-led.

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

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

Background

La Maison Médical is private doctors' clinic based in South Kensington, in the south-west part of central London. The service provides services to the whole community. A large number of patients registered with the service have French as either their primary or second language. The service provides patients with access to a number of clinical specialists, a number of which are located primarily in France, but are registered to practice medicine in the UK. These specialists have experience in a number of areas including general medicine, dermatology, gynaecology, urology, as well as providing physiological and lifestyle assessments. These clinical specialists are contracted to work at the service when their services are required by a registered patient.

The services offered by La Maison Médicale are provided to adults and children as private patients.

The service is situated in a rented basement floor of a terraced converted building, which has consultation/ treatment rooms, a patient waiting area, patient toilets and rooms for administrative staff.

The nominated individual (the point of contact between the Commission and the service) is the registered

Summary of findings

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.

La Maison Médicale is registered to conduct the following regulated activities under the Health and Social Care Act 2008:-

- Treatment of disease, disorder and injury
- Diagnostic and screening procedures

Prior to our visit, the service was provided with feedback cards for their patients to complete with their views about the service by completing comments cards. Seventeen feedback cards were completed prior or during our inspection of the service.

Our key findings were:

- Staff had been trained with the skills and knowledge to deliver care and treatment.
- There was no evidence of clinical staff meetings and/or opportunities to share clinical learning/knowledge.
- The service had systems to keep people safe and safeguarded from abuse, however these were not clearly defined.
- The service did not have adequate medicines in place in the event of a medical emergency at the service.
- Information about services and how to complain was available. Information about the range of services and fees were available.
- The service had not conducted a recent review of service policies and procedures.
- The service had good facilities and was (with the exception of emergency medicines) equipped to treat patients.
- There was no oversight or quality assurance of the work of clinical work conducted at the service.
- The service kept patient information secure.
- The service did not conduct fire drills and did not have a trained fire warden on site

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

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

The areas where the provider could make improvements and should:-

- Review arrangements for the provision of training, specifically in relation to infection control, information governance and Mental Capacity Act 2005 training.
- Review arrangements regarding written guidance relating to the continuation of business in the event that the service could not operate from it registered address.
- Review arrangements to obtain up-to-date an Legionella testing certificate.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- The service had some defined processes and systems in place to keep patients safe and safeguarded from abuse, but these were not clearly defined.
- The information needed to plan and deliver care and treatment was available to staff in a timely and accessible way.
- The service did not conduct fire drills and did not have a fire warden on site.
- The service operated safe and effective recruitment procedures to ensure staff were suitable for their role.
- The service did not have oxygen or a defibrillator on site.
- There were no medicines held on site with the exception of medicines to be used in the event of a medical emergency. The range of emergency medicines we viewed was not suitable for all patients registered with the service.
- We observed the premises and equipment to be visibly clean and tidy.
- The provider had systems in place to support compliance with the requirements of the duty of candour.
- There were no arrangements in place for the management of infection prevention and control.

Are services effective?

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

- The service had no comprehensive programme of quality improvement activity or routinely reviewed the effectiveness and appropriateness of the care provided.
- There was no program of quality improvement and audits used to drive service improvement.
- There were no systems in place to keep all clinical staff up to date with new guidance. The service did not subscribe to medicine alert updates. Clinical staff had access to best practice guidelines and used this information to deliver care and treatment that met patient's needs.
- The service had an in-house induction programme for newly appointed administrative staff, but there was no evidence of a similar programme for clinical staff.
- We saw that the service gained verbal consent from the client (or their representative if under 18) before treatment commenced.

Are services caring?

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

- During our inspection we observed that members of staff were courteous and helpful. Staff we spoke with demonstrated a patient centered approach to their work.
- We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The service employed multi-lingual staff who spoke a number of languages including French, German and Arabic.

Are services responsive to people's needs?

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

Summary of findings

- The service opening times ensured that patients who could not attend the service during normal working hours had the opportunity to do so outside of these times.
- Patients had a choice of time and day when booking their appointment.
- The service had a system for handling complaints and information about how to make a complaint was available for patients. We saw that complaints were appropriately investigated and responded to in a timely manner.
- Patients could contact the service in person, by telephone or by the service website.

Are services well-led?

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

- There was a lack of systems in place for overall governance of the service and oversight of the provision of good quality care and treatment.
- The service had a range of policies and procedures; however the majority of these had not been reviewed or updated since 2011.
- There was a leadership structure in place and staff we spoke with felt supported by management.
- Systems were in place to ensure that all client information was securely stored.
- There were limited opportunities for clinical staff to share learning and good practice.
- There was no clear process to identify, understand, monitor and address current and future risks.

La Maison Medicale

Detailed findings

Background to this inspection

The visit was led by CQC inspector and included a GP specialist advisor.

During our visit we:

- Spoke with staff (a registered manager, one doctor, a practice manager, a clinical assistant and one receptionist)
- Reviewed personnel files, service policies and procedures and other records concerned with running the service

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

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

Safe systems and processes

The service had some systems to safeguard children and vulnerable adults from abuse. The service treated clients from babies upwards. The service did not have a safeguarding policy, but an 'Avoidance of Abuse Policy and Procedure'. When we reviewed this policy, we noted that the policy had not recently been updated and only focused on what to do in the event of suspected abuse of a patient by a member of La Maison Médicale staff. The policy did not look at the possibility of abuse of patients outside the service and what staff should do if they suspected abuse of a patient under their care. The avoidance and abuse policy outlined what to do and who to go to for further guidance internally, but did not have contact details for the local authority safeguarding team. When we spoke with the practice manager regarding this, they were able to produce a document with recent information regarding the local authority safeguarding team, but this document was not readily available to clinical staff. Of the clinical staff records we looked at, we noted that staff were trained to either safeguarding level two or three. On the day of inspection, staff told us that the practice manager and the service manager were responsible for the reporting of the suspected abuse of patients.

- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks or the equivalent check in France were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All clinical staff who worked at the service had been DBS or Extrait de Casier Judiciaire (French equivalent) checked. Each clinical member of staff had their own indemnity insurance and this was noted on the staff records we looked at.
- Patients were advised verbally that a chaperone was available if they required one. The service had acquired the service of a specialist chaperone, if a patient required one. However, we saw no documents to say the chaperone had been DBS checked or risk assessed to conduct this duty.

There were limited systems to manage infection prevention and control.

- The service did not conduct infection control audits. The service current infection control strategy and action plan was dated 2011. A review of the strategy scheduled for 2012 had not occurred. The strategy stated that the service was to conduct quarterly audits, but there was no evidence of this occurring when we inspected. When we asked the service about infection control audits they told us that they had not been conducting these. Similarly, when we asked about infection control training for all staff (which was due to occur annually) we were told that this had not occurred.
- The service had a cleaning schedule in place that covered all areas of the premises. We observed treatment rooms used by the service to be clean, had hand washing facilities and had taken appropriate measures for the disposal of clinical waste. Systems were in place to ensure that clinical waste was appropriately disposed of. Sharps bins were appropriately used and stored correctly, however we did not see any information in clinical rooms of what to do in the event of a needle-stick injury. We spoke to the service regarding this and were told that all staff were aware of protocol in the event of an injury.
- The service did not have risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We spoke with the practice manager regarding this matter. They believed that this was a function that was conducted by the building landlord but was unsure when the last assessment had been conducted as there was no record of it held by La Maison Médicale.

Risks to patients

- There was a designated member of staff who managed the day-to-day running of the service, who planned and monitored the number of staff required for the service.

Are services safe?

The service manager monitored the impact on safety for patients if there was an increase for services. We were told staff would conduct additional sessions to meet any increase in demand for services.

- The service did have a health and safety related policy, but this had not recently been reviewed or up dated. In addition, there was no evidence that checks for equipment used within the service had been conducted. For example, there were no portable appliance testing certificates for electrical equipment used on site, neither was there a record of calibration of service equipment such as scales. We were told that if an item of equipment was not working that the practice manager for the service would be informed and that they would then identify a company to conduct the required repair.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. For example, the service told us about an incident where they recently provided assistance to a patient who had injured themselves on the pavement outside the service.
- The emergency medicines held by the service were easily accessible and staff knew of their location. However, the medicines on site were not appropriate to deal with an on-site medical emergency. The service did not have medicines to assist with raising blood sugar levels quickly, aspirin or adrenaline to be used with children on site. Adrenaline is used if a patient goes into sudden anaphylaxis shock. Records showed that the medicine kept on site by the service were checked regularly to ensure they were in date and safe to use.
- There was no oxygen or a defibrillator on site on the day of inspection. We expressed our concern to the service regarding the lack of oxygen on site without a risk assessment having been conducted as to why it was not required. Subsequent to our inspection, we received evidence that both the oxygen and defibrillator had been ordered for the service. In addition, the service had arranged with an external provider for staff to be trained on using the defibrillator.

Information to deliver safe care and treatment

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

- Written information about clients was treated confidentially. All papers containing sensitive information was stored in secure lockable cabinets. The service complied with the Data Protection Act 1998.
- Individual care records were written and managed in a way that kept patients safe. The service had a bespoke clinical recording system. Each patient had a patient record which detailed information needed to deliver care and treatment. The patient record had different levels of accessibility and it was possible for clinical staff to lock certain parts of the clinical record so that it was only accessible to a certain member of clinical staff. Access to all patient records was by individual password staff log-in and was available to staff in a timely and accessible way. Patient records contained a record of all consultations, test results, assessments and treatment plans. We viewed a sample of these records and found that these had been completed to a satisfactory standard. Some patient records were completed in French as well as English.
- The service asked new patients to complete a registration form before the first appointment with a clinician but did not request verification (by way of utility bill, driving licence, ID card/passport) of those registering at the service. Similarly, the service did not require proof of identification from adults registering children with the service.

Safe and appropriate use of medicines

- There were no medicines held at the service with the exception of emergency medicines for use in a medical emergency.
- Clinical staff we spoke with on the day of inspection told us that they prescribed medicines to patients and gave advice in accordance to with evidence based guidelines, such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. However, this was not monitored or reviewed by the service.

Lessons learned and improvements made

There was a system for recording and acting on significant events and incidents, but there was no service policy which informed staff on the process for recording and acting on significant events and incidents. Staff we spoke with understood their duty to raise concerns and report and discuss incidents and near misses. On the day of inspection we viewed an incident report which described what the service did when a patient (who was leaving the service) fell

Are services safe?

and obtained an injury on the pavement outside the service. The patient was assisted by two clinical members of staff, who assessed the injury and provided the relevant medical assistance. Following the assessment and treatment, the patient was advised to attend the service for follow up sessions (at cost to the service) to ensure that the injury sustained was healing correctly. The patient left the service, continued with their planned activities and was contacted by the service later the same day to check how they were feeling. The form we viewed detailed the lead up to the incident and what happened subsequent to members of the service attending to the patient outside the service. We noted that the incident had been entered on the patient's electronic record and that treatments received in relation to this incident had not been charged to the patient. We saw no evidence that this incident and any learning that came out of the incident had been shared amongst the majority of staff.

The provider had systems in place to support compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

- Clinical staff we spoke to told us that they assessed needs and delivered care and treatment in line with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However, the delivery of treatment and care was not monitored or reviewed by service management. We reviewed a sample of patient records which demonstrated that care and treatment was appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service did not actively review the effectiveness and appropriateness of the care provided.

- The service did not conduct any quality improvement activities such as clinical audits, in order for the service to review the effectiveness and appropriateness of the clinical care provided.
- There were no systems in place to monitor the care and treatment and the quality of consultations with patients by clinical staff.
- The service had a prescribing protocol, but there was no evidence that any audit of prescribing done by clinicians at the service had been conducted.

Effective staffing

Evidence reviewed showed that clinical staff had skills and knowledge to deliver effective care and treatment.

- The service had an on the job induction programme for newly appointed administrative staff that covered such topics as expected conduct, patient confidentiality, record keeping and use of the service computer system. The induction programme did not cover infection prevention and control, fire safety or health and safety. There was no evidence of an induction programme for clinical staff joining the service.
- The service conducted annual performance reviews/ appraisals for all staff. Administrative staff had regular support from the practice manager, to enable them to carry out the duties of their role. This support included informal meetings and coaching. Of the clinical staff files we checked, we noted that all staff had evidence of their last revalidation.
- We saw evidence that staff had recently completed training such as basic life support and for clinical staff, safeguarding. However, training such as infection control and information governance had not been completed.
- There was a clear staffing structure that included senior staff, clinical staff and administrative staff.

Coordinating patient care and information sharing

The service shared relevant information with the client's permission with other services.

- The service would ask for permission (from the patient) to inform their NHS doctor if a medicine or other similar treatment was prescribed as part of their treatment at the service.
- We were told that clinical staff were responsible for following-up on receiving test results for clinical samples sent by them (on behalf of the service) for external testing.

Supporting patients to live healthier lives

- This was achieved through the provision of individually tailored advice and support to assist patients. Patients who registered with the service had a consultation with an appropriate member of clinical staff. Patients were provided with a diagnosis, advice and treatment for the symptoms they currently were experiencing.

Consent to care and treatment

We found staff sought patients' consent to care and treatment in line with legislation and guidance.

- Not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We spoke with one member of clinical staff who told us that they had not received recent training regarding the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- We saw that the service gained verbal consent from the patient (or their representative if under 18) before treatment commenced. This was indicated on the

Are services effective?

(for example, treatment is effective)

electronic patient record held by the service. The service informed us that they did not require written consent from patients or their representative before treatment commenced.

- The service displayed in full, clear and detailed information about the cost of consultations, assessments, tests and further appointments. Prices are not displayed on the website, but prospective clients are informed of prices by reception staff when they first contact the service to make an appointment.

Are services caring?

Our findings

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

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and helpful, and treated clients with respect.

- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Staff informed us that if patients which to discuss a matter in confidence they were able to direct them to a private room.

The service had displayed our comment cards prior to our visit and had received 17 comments cards back. All of the comments cards received were positive about the standard of care received from the service. Due to timings on the day of inspection, we were unable to speak with any users of the service.

Involvement in decisions about care and treatment

Patients were involved in all aspects of the care and treatment provided.

- The service told us an interpreter service could be made available to patients who required one to understand what the service offered and to be fully involved in decisions concerning their care. In addition, a number of staff spoke another language in addition to English, such as French, Greek, German, Arabic and Lithuanian.

Privacy and Dignity

- Staff we spoke with during the inspection understood and respected people's privacy and dignity needs. The service had arrangements in place to provide a chaperone to patients who needed one during consultations.
- All clinical rooms contained privacy screens.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that the service was providing responsive services in accordance to relevant regulations.

Responding to and meeting people's needs and access to the service

Services were tailored in response to patient need.

- Clients could contact the service to make appointments in person, by telephone or by the service website.
- The service opened between the hours of 8:30am -8:30pm (Monday -Friday), and 8:30am-1pm (Saturday). The week day opening hours of the service reflected the service awareness that many of its clients would come to the service either before work or after they had finished work.
- The service provided consultations to clients from birth upwards (on a fee-paying basis). We were told that the service did not discriminate against any client group.
- The service was located in premises which were not accessible by all. The service was based on the basement floor of a converted listed building in South Kensington. The location of the service meant that access was restricted for wheel-chair users. The service told us that they would assist patients with young children down the iron staircase.
- The service website listed all clinical services available. The website was available in English and French.
- The service recently added podiatry services to its portfolio of services. This addition was introduced as a result of receiving enquiries from local stakeholders regarding where this service could be obtained.

Listening and learning from concerns and complaints

The service had a system for handling complaints and concerns.

- There was a lead member of staff for managing complaints, and the service had a process for dealing with complaints.
- Information for patients about how to make a complaint was available through reception staff and the practice manager. We saw no information on display at the reception desk or the waiting area to help patients at the service should they wish to make a complaint.
- We reviewed one complaint from a patient which focused on the issue of care received and fees. We found that the response to the complaint was satisfactorily handled an in a timely way.

Are services well-led?

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

Our findings

We found that the service was not providing well-led services in accordance to relevant regulations.

Leadership capacity and capability

- The service has a board of directors who were responsible for the oversight of the governance and care provided at the service.
- The practice manager was responsible for the day-to-day running of the service.
- Processes were in place to check on the suitability of and capability of staff in all roles.
- Staff we spoke with on the day of inspection told us that the practice manager was approachable, listened and supported them in their roles and responsibilities
- There was a clear leadership and staffing structure, and staff were aware of their roles and responsibilities.

Vision and strategy

- Of the staff we spoke with, only the registered manager could describe some of the vision or values of the service.
- The service had a business plan which highlighted areas of activity to be conducted by the service within the next 12 months.

Culture

The service had a supportive culture towards staff and patients.

- Staff told us they supported and valued the work each other did. They told us they were comfortable discussing matters of concern with each other.
- The service was aware of and had systems to ensure compliance with the requirements of the duty of candour. Staff were encouraged to open and honest at all times and the practice manager told us was a no-blame culture within the service. Staff told us they felt confident to report concerns or incidents and felt they would be supported through the process. The service had a whistleblowing policy in place , which was overdue a review, having last been reviewed in 2011.

Governance arrangements

The service had ineffective governance arrangements in place.

- The service had a range of policies and procedures in place which were known to staff, however the majority of these were not regularly reviewed or updated when necessary. A large proportion of the service policies were dated 2011. Staff we spoke with knew where to access them if required.
- There were some systems were in place for monitoring the quality of the service and making improvements. Prior to the inspection, we received details of quality improvement activities for the service for 2018. Some of the activities had already taken place and number of others we were told, would be completed during the coming year. We noted that none of the listed activities not yet completed had an action plan or date of expected completion.
- There was no clinical oversight of the treatment and care given by clinical staff working at the service. Clinical staff worked when required at the service and did so autonomously.
- The service did not have systems to monitor the performance of the service and the service did not conduct regular clinical audits.

Managing risks, issues and performance

- The service did not have oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and incidents and the service was unable to provided evidence of actioning or cascading safety alerts. The service had not signed up for alerts and therefore was not able to disseminate them to relevant practice staff. We spoke to the practice manager about the importance of having access and disseminating the most recent information regarding medicine and medical devices incidents and alerts to staff. Before the end of the inspection, we were shown evidence that the practice manager had registered to receive these alerts.
- There was no clear process to identify, understand, monitor and address current and future risks. There was evidence that there was some monitoring of the service through the production of the service business plan, however the plan we reviewed had little detail of the risk to the service if the items on the business plan were not fulfilled. In addition, we saw little evidence of the service conducting risk assessments. For example, the service did not risk assess why it was not necessary to request identifying documents for parents registering children for treatment at the service.

Are services well-led?

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

Appropriate and accurate information

- The service had systems in place to ensure that all client information was stored and kept confidential.
- There were policies and IT systems in place to protect the storage and use of all client information. There was no evidence of recent information governance training for staff.
- The service did not have an up-to-date written business continunity plan, including what to do and who to contact in the event of the service not being able open.

Engagement with patients, the public, staff and external partners

Patients were encouraged to provide feedback on the service they received.

- Patients were asked to complete a survey about the service they had received when they attended. The service told us that feedback was monitored and action was taken if feedback indicted that the quality of the service could be improved.
- The service management had limited engagement with clinical staff employed by the service. With the exception of annual appraisals, the service had no systems in place to gather feedback from staff. There were no routine staff meetings. We spoke with the practice manager regarding this, who informed us that due to the location of some of the staff, this was proving difficult to arrange. Administrative staff had ad-hoc meetings, and held a formal meeting quarterly. These quarterly meetings were not minuted.
- The service told us they had had good relationships with local stakeholders, a result of which was the introduction of podiatry to their portfolio of services, following discussions with local pharmacies.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person(s) had systems or processes in place that failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, in particular with reference to having limited oversight over the clinical provision of services provided. The service did not risk assess not requesting verification of individuals registering with the service. The service did not conduct regular reviews of their policy and procedures or have systems in place to share learning and good practice amongst colleagues. In addition, the service did not have arrangements in place to have periodic portable appliance testing conducted on all electrical equipment in use at the service, and did not have evidence of recent risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella. The service did not have a nominated fire warden on site.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not do all that was practicable to ensure the emergency medicines kept on site were suitable for all patients. This was evidence through the service not holding medicines to help raise blood sugar levels quickly, aspirin or adrenaline to be used with children. In addition, the registered person did not do all that was practicable to ensure effective infection control was occurring within the practice. This was evidenced through the discovery no infection control audits conducted and no recent infection control training for staff.