The Hove Clinic Limited

The Hove Clinic

Inspection report

40 Wilbury Road
Hove
East Sussex
BN3 3JP
Tel: 01273 733830
Website: www.thehoveclinic.co.uk

Date of inspection visit: 15 January 2019
Date of publication: 14/03/2019

Overall summary

We carried out an announced comprehensive inspection on 22 March 2018, where we found that the service was not providing safe or well-led care in accordance with the relevant regulations. We carried out an announced focused inspection on 15 January 2019 to ensure that the service was providing care in accordance with the relevant regulations.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care.

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

The principal GP is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service had reviewed and improved systems to manage risk so that safety incidents were less likely to happen.
- There was not an effective process in place to monitor medicines within the service.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

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

- Ensure care and treatment is provided in a safe way to patients.

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

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

- Review staff vaccinations to ensure they are maintained in line with current Public Health Guidance.
- Review signage for rooms where oxygen cylinders are stored.

Summary of findings

- Review how equipment not owned or used by the services is stored.
- Review systems for recording recruitment checks and training records for employed GPs.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

The Hove Clinic

Detailed findings

Background to this inspection

The Hove Clinic provides private GP services. There is a principal GP and three sessional GPs (two male, two female). The Hove Clinic is also supported by a practice manager and reception/administration staff. The service is provided from the ground and first floors, in a converted residential building. The service has two consulting rooms and administrative areas. Services are offered Monday to Thursday 8am to 8pm, Fridays 8am to 5pm and Saturdays 8:30am to 12pm. The Hove Clinic provides services to adults and children under 18.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the private GP services, sexual health and minor surgery it provides. The service is registered by CQC to provide the following regulated activities; Maternity and midwifery services, Family planning services, Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures.

The inspection on 15 January was led by a CQC inspector who was accompanied by a second CQC inspector and a GP specialist advisor.

Information was gathered from the provider and reviewed before the inspection.

During our visit we:

- Spoke with a range of staff, including the principal GP and administrative/reception staff.
- Observed how patients were being cared for in the reception area.
- Looked at information the service used to deliver care and treatment plans.
- Reviewed documents relating to 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

At our inspection in March 2018 we found that this service was not providing safe care in accordance with the relevant regulations. This was because the service did not have effective systems, processes and risk assessments in place to keep staff and patients safe, for example, there was no clear lead for infection control.

At this inspection, 15 January 2019, we found that some improvement had been made however there were still concerns regarding providing safe services.

Safety systems and processes

All clinical staff and staff whose role included patient contact had received checks through the Disclosure and Barring Service (DBS). (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). Where possible clinical staff were used as chaperones. Non-clinical staff who may act as chaperones had received chaperone training. All non-clinical staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The provider did not provide evidence that they monitored training records for employed GPs on the day of inspection but have since provided evidence of training records for employed GPs.

The service carried out some staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. All clinical staff were up to date with their professional revalidations. Since our inspection in March 2018 the provider had revised their recruitment policy. This policy stated that two references were required, however when we reviewed three staff files we found that two GPs only had one reference recorded and one GP had no reference recorded. Since the inspection the service has provided evidence of two references for each employed GP. The service did not keep records to demonstrate staff vaccination was maintained in line with current Public Health England guidance.

On the day of the inspection the copies of the professional indemnity arrangements for all clinical staff held by the provider showed that they had expired, but since the inspection the service has provided evidence of current professional indemnity arrangements for all clinical staff.

There was an effective system to manage infection prevention and control, including Legionella risk assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The service had completed an internal fire risk assessment and health and safety risk assessment.

Risks to patients

All staff received annual basic life support training and there were emergency medicines available on site.

The service had a defibrillator and oxygen with adult and children's masks available on site. However, the service did not record checks completed to ensure these were working or contained sufficient oxygen. A first aid kit and accident book were available. We noted that there was no signage to identify the room that the oxygen cylinder was stored in.

Emergency medicines were accessible to staff in a secure area of the service and all staff knew of their location. All the emergency medicines we checked were in date and stored securely.

We noted that there was a mercury sphygmomanometer in one of the clinical rooms but there was no mercury risk assessment or mercury spill kit available on site.

We also noted that there was equipment within the clinical rooms that was not suitable for use, such as nebulisers with no corresponding medicines, and an ear syringe that was not properly maintained. The principal GP told us that these pieces of equipment were either not in use or belonged to visiting consultants.

Safe and appropriate use of medicines

The service did not have reliable systems for managing medicines. We found medicines, such as partly used boxes of antibiotics that were prescribed to specific patients who had not attended the service for over six months, and some medicines that were out of date.

Are services well-led?

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

Our findings

At our inspection in March 2018 we found that this service was not providing well-led care in accordance with the relevant regulations. We found that improvements should be made relating to the governance arrangements. This was because there were gaps in recording of risk assessments and staff training, a lack of written policies and protocols and a lack of effective recruitment procedures.

At this inspection, January 2019, we found that improvements had been made however in some areas they were not sufficient.There was not an effective system for monitoring medicines within the service.

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

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. The service had some structures, processes and systems to support governance, however we noted that some were not operating as well as intended. Since our inspection in March 2018 the provider had reviewed their policies, for example, the recruitment policy, however on the day of inspection the provider was unable to demonstrate that they were complying with their own policy which required two references for clinical staff. Also since our March 2018 inspection the service had developed a new system for monitoring non-clinical staff training. However, on the day of inspection the provider did not demonstrate that they had maintained records of training for employed GPs. Since the inspection the provider has provided evidence to demonstrate that they were complying with their recruitment policy and that they had records of training for employed GPs.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however these were not always sufficient. There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. There was not an effective process for monitoring medicines within the service.

Leaders had oversight of safety alerts, incidents, and complaints.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** There was not proper and safe management of medicines. In particular: • Patient prescribed medicines were held within the service without a plan for when they were going to be collected or used. Some of these medicines were found to be out of date. • No evidence that medicines stored within the service were monitored to ensure appropriate stock levels. . • There was not system for monitoring the expiry dates of medicines stored within the service and some were found to be out of date. The equipment being used to care for and treat service users was not used in a safe way. In particular: • A mercury sphygmomanometer with no mercury risk assessment or mercury spill kit. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.