Chear Ltd

Chear, Shepreth

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	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as requires improvement because :

- Staff were not up to date in training in key skills, such as training in infection protection and control (IPC), and health and safety.
- Staff had not completed training on recognising and responding to patients with a learning difficulty.
- Staff did not have up to date safeguarding training on how to recognise and report abuse.
- The service did not always assess risks and take measures to prevent such risks. The service did not have a fire risk assessment or Control of Substances Hazardous to Health (COSHH) risk assessments.
- The service did not manage clinical waste in line with the Health Technical Memorandum 07:01.
- The service did not always record consent in patient records or gain consent when sharing patient details with an independent body to investigate a complaint.
- The service did not always fully investigate incidents and identify learning opportunities from them.
- The service did not reference duty of candour in any of their policies and they were not always open, honest, and transparent when responding to patient complaints.
- Managers did not monitor the effectiveness of the service. The service did not have an audit programme. We did not see any evidence of clinical audits, which assessed, monitored and improved the quality of the service.
- The service did not document evidence of peer review or competency tests.
- Leaders did not run services well using reliable information systems. The service did not engage routinely with patients to seek feedback and identify improvements.
- Additional training and support was not given to the registered manager to support them in their role.

However:

- The service had enough staff to care for patients. Staff understood how to protect patients from abuse. Staff kept good care records.
- Staff provided good care and treatment. Key services were available to suit patients' needs.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Chear, Shepreth

Chear, Shepreth is operated by Chear (Children's Hearing Evaluation and Amplification Resource) Limited and is based in Royston, Hertfordshire. The service provides hearing assessments for babies, children and adults. The service is open between 9am and 5pm, Monday to Friday. The service saw 1340 patients in the year preceding our inspection; 672 of these patients were children. Patients aged over 19 are not in scope for registration with Care Quality Commission (CQC) and therefore not part of our inspection.

The service is registered with CQC to provide the regulated activity:

- Diagnostic and Screening Procedures.

The service has had a registered manager since it registered with CQC in 2013. The registered manager was the director of Chear, who is a clinical scientist in audiology. A new registered manager was appointed in December 2021. A registered manager is a person who has registered with the CQC to manage the service. They have legal responsibility for meeting the requirements set out in the Health and Social Care Act 2008.

The service was last inspected in June 2021, when it was rated Requires Improvement overall. The inspection team found a lack of formal processes and systems to maintain the overall governance of the service, including shared learning from incidents and complaints. There was also no formalised approach to identify and manage risks within the service. In addition, policies and guidelines were not reviewed and the service did not have audit processes to monitor the effectiveness of care and treatment. Mandatory training for staff was limited and staff did not manage clinical waste well. Equipment checks were not always documented.

We received information of concern in February 2023 which suggested that the service did not always have robust processes in place to ensure that clinical decisions and diagnoses were accurate. There were concerns that complaints were not always acted on openly and honestly, with learning identified and changes made to improve the service.

How we carried out this inspection

A short notice, focused inspection looked at aspects of the key questions under Safe and Well Led. During the inspection visit, the inspection team:

- Visited the Chear Shepreth clinic in Hertfordshire.
- Spoke with the registered manager, the director of the service and the second audiologist.
- Looked at 5 sets of patient records.
- Observed a range of policies and documents relating to the leadership, governance and running of the service.
- Looked at staff training records.

Following the inspection, the inspection team reviewed further policies and procedures relating to the running of the service and looked at patient feedback of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The director of the service was committed to research and innovation. They had been awarded an innovation fund award (IFA), as part of a team who were developing a new method of hearing assessment for young children who were not responsive to simple sounds traditionally used in behavioural hearing assessment.

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:

- The service must ensure that duty of candour is followed, acting in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying out a regulated activity. (Regulation 20).
- The service must ensure that learning, development and required training is closely monitored and appropriate action taken quickly when training requirements are not met. (Regulation 18(2)(a)).
- The service must ensure they 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 activity. This includes having appropriate fire risk assessments and Control of Substances Hazardous to Health (COSHH) risk assessments. (Regulation 17(2)(b)).
- The service must have systems and processes in place to monitor patient outcomes, to ensure that outcomes are positive and consistent. This includes the use of clinical audits and peer review. (Regulation 17(2)(a)).
- The service must ensure that the most recent CQC rating is displayed at the service's principal place of business and on its website. (Regulation 20A).
- The service must ensure that the registered manager has the support, qualifications and skills which are necessary for their role. (Regulation 19(2)).

Action the service SHOULD take to improve:

- The service should ensure that consent for treatment and recording of treatment for teaching purposes is recorded in patient records, detailing all risks and benefits of treatment options. (Regulation 11).
- The service should ensure they seek and act on patient feedback from relevant persons on the service provided in the carrying on of the regulated activity on a regular basis. (Regulation 17).
- The service should ensure there are appropriate processes in place to record and document the processes involved in cleaning and testing equipment, to ensure a consistent approach. (Regulation 17).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Requires Improvement

Requires Improvement

Diagnostic and screening services

Safe	Requires Improvement
Well-led	Inadequate

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to staff, but did not make sure everyone completed it.

Staff did not keep up-to-date with all of their mandatory training. Mandatory training is compulsory training that is determined essential by an organisation to enable the safe and efficient delivery of services. Statutory training is required by law and is required because of a specific legislation, for example the Health and Safety at Work Act.

Staff had accessed mandatory training in fire safety, equality, diversity and inclusion, data protection and lone working. Only 1 staff member had completed training in first aid.

Training in Level 2 Health and Safety in the Workplace had lapsed 14 months before our inspection for the registered manager. Two out of 3 staff members were not up to date in training for infection prevention and control (IPC). The service provided evidence that IPC training had been completed immediately after our inspection.

While staff had completed training on recognising and responding to patients with autism, they had not received training on recognising and responding to patients with learning disabilities. Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training, but they did not ensure it had been completed in a reasonable time.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not have up to date training on how to recognise and report abuse.

Staff did not have up to date training specific for their role on how to recognise and report abuse. Level 3 safeguarding training is recommended for individuals who have a central role in any safeguarding situation and are the first point of call for staff or individuals who have a safeguarding concern. Level 3 safeguarding training for the safeguarding lead had lapsed 3 months prior to the inspection.

The director of the service had received safeguarding training to level 2. This training had lapsed 2 months prior to our inspection. The registered manager had received safeguarding training to level 1.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding policy referenced the appropriate local authority safeguarding team.

The service did not have any processes in place to ensure that the primary care givers were in attendance and consenting to treatment for the child.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean but cleaning records were not up to date.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained, but cleaning records were not up-to-date to demonstrate that all areas were cleaned regularly. Staff told us that cleaners attended the service once a week, but they did not keep a log of what cleaning had taken place. The service implemented a cleaning log immediately after our inspection.

Staff cleaned equipment after patient contact. All surfaces and children's toys within the audiology room were wiped down with disinfectant wipes at the start of the day, after each patient and at the end of the day.

Single use audiology instruments were disposed of after use within clinical waste bins. Instruments that were re-usable were cleaned within an ultrasonic bath. An ultrasonic bath is a cleaning method which uses high frequency waves to create microscopic bubbles that implode and generate a powerful cleaning action. Dissolvable cleaning tablets containing chlorine were used in the ultrasonic bath. Cleaning the instruments was the responsibility of the second audiologist.

The service did not have any standard operating procedures (SOPs), which is a set of step-by-step instructions to help staff carry out routine operations. The registered manager told us that the service director and the second audiologist would take their holidays at the same time. It was not clear on who would perform these cleaning duties if the second audiologist was not able to work.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff used hand gel in between each patient. Hand washing facilities were available within the staff kitchen and communal toilet. Staff told us they would wear face masks when treating vulnerable patients. PPE was not routinely used and not necessary for the type of treatment delivered. Staff were bare below the elbow which aids in preventing the spread of infections and allows for effective hand washing.

The service did not conduct any audits to give assurance of IPC effectiveness, such as hand washing audits or audits of the cleanliness of the service. Immediately following our inspection, the service implemented the use of a handwashing observation form.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The service did not manage clinical waste according to national guidance.

Staff carried out daily safety checks of specialist equipment. We saw evidence of daily checks of the audiometer, music audiometer and screen checks.

Requires Improvement

Diagnostic and screening services

Equipment was serviced and calibrated yearly by an external company. Calibration ensures the equipment is maintaining accuracy, standardisation and repeatability. We saw servicing records for 7 different types of audiology equipment. The director of the service told us that some equipment had been calibrated more frequently as they were participating in research work.

Portable Appliance Testing (PAT) of electrical equipment had been performed within the year preceding the inspection.

The service had suitable facilities to meet the needs of patients' families. The service had disabled access with a ramp. The clinic was on 1 level and consisted of a reception area, kitchen and storage area, toilet facilities and an audiology room. Baby change facilities were available within the toilet facilities. The audiology room was specifically designed for an audiology service and was sound proofed. Children could access toys as assessments were based on play and the service's main goal was to help make children and their families feel at ease.

The service had enough suitable equipment to help them to safely care for patients.

Fire extinguishers were accessible and were serviced yearly. Fire exits were clearly displayed, with meeting points displayed on the notice board. However, the service had not conducted a fire risk assessment in accordance with The Fire Safety Order. Following feedback from the CQC inspection team, the service immediately booked a fire risk assessment.

The service had not carried out Control of Substances Hazardous to Health (COSHH) risk assessments and cleaning products and chlorine tablets were stored in unlocked cupboards. COSHH risk assessments were carried out following our inspection.

It was not clear if the service disposed of clinical waste safely. Single use equipment was disposed of in clinical waste bins, which was collected by a clinical waste company when required. The service did not have a formal contract with the clinical waste company or keep any records of collection. Health Technical Memorandum 07-01: Safe Management of Healthcare Waste states it is the producer's responsibility to ensure the transport and destination are correctly authorised when waste is transferred and a written description providing an accurate description of the type and quantity of waste, is provided for transfer of the waste as it is moved from point of production to point of final disposal.

Assessing and responding to patient risk

Staff completed some risk assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a first aid box which was appropriate for the service. As only 1 staff member had received this training, if they were absent from work no other staff members were trained to administer first aid. Staff would call for an ambulance if required.

Staff knew about and dealt with any specific risk issues. The service had identified a risk to children who may bang their heads on the desk within the audiology room. Staff placed a foam edging around the desk when treating children to minimise this risk.

The audiology room was soundproofed. If there was an emergency inside this room the registered manager would not hear a call for help. The service installed bells within the audiology room, toilet and reception area, so staff could be alerted in an emergency.

Requires Improvement

Diagnostic and screening services

Staffing

The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment. Not all staff had completed continued professional development or received appraisals or peer review.

The service had enough staff to keep patients safe. This was a small service. The director of the service was a clinical scientist in audiology and registered hearing aid dispenser. A second audiologist and assisted the director with hearing assessments. The registered manager was also the office manager, and managed appointments, reports and payments alongside the duties expected of a registered manager.

The service did not use bank or agency staff. The service had a lone working policy. Staff rarely worked alone, as the registered manager would be present.

The registered manager and the second audiologist received yearly appraisals, which evaluated their work and provided feedback on their performance. We did not see any evidence of appraisal or peer review for the service director. We saw that the second audiologist had completed 10 hours of continued professional development (CPD) in the year preceding the inspection. We did not see evidence of CPD for the service director. The British Academy of Audiology – Quality Standards in Paediatric Audiology guidance states 'there should be a record of appropriate training accessed with at least biennial updates on advances in paediatric audiology, hearing aid technology and assistive devices'.

Records

Staff kept detailed records of patients' care and treatment, but did not always record patient consent. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Patient records were paper based. They included details about a patient's medical history, family history and speech development. Details of what testing had been carried out and the results of those tests were included in the records. The director of the service documented the conclusions and management plan in the records. The service did not conduct any audits of patient records.

The record proformas included a section to indicate that patients or their carers, consented to receiving the report by email. Certain procedures, such as ear wax removal, carried some risks including post operative infection and perforation of the ear drum. The director of the service told us that treatment options were explained, with the risks and benefits discussed, but no consent form was used. We looked at 5 patient records and we did not see evidence of recorded consent. Following feedback after the inspection, the service implemented the use of a consent form for ear wax removal, according to best practice.

When patients transferred to a new team, there were no delays in staff accessing their records. The registered manager produced a report which was sent to the patient within a week. The report could be shared with the patient's general practitioner (GP) or an ear, nose and throat (ENT) doctor if a referral was recommended.

Records were stored securely in locked cabinets.

Incidents

Although, the service had a process to report patient safety incidents, staff did not always recognise incidents and near misses and report them appropriately. Managers did not always investigate incidents appropriately. When things went wrong, staff did not always apologise and give patients honest information and suitable support.

Requires Improvement

Diagnostic and screening services

Staff did not always know what incidents to report and how to report them. Incidents were logged in an incident reporting book. One incident was logged in the year preceding the inspection, which detailed what measures had been taken after a child had fallen over. However, we were aware of a complaint which was not classed and recorded as an incident.

The service had received 1 complaint in the year preceding the inspection, and 3 complaints in total over 9 years. A recent complaint was recorded within a complaints log, with a timeline of the correspondence relating to the complaint. However, we did not see any evidence that the service had considered the complaint to be a notifiable safety incident. A notifiable safety incident is defined as any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity, that in the reasonable opinion of a health care professional appears to have resulted in an impairment of the sensory, motor or intellectual functions of the service user which lasted for a continuous period of at least 28 days, or resulted in the service user experiencing prolonged pain or psychological harm. On review of the complaint, CQC had considered it to be a potential notifiable safety incident.

It was not clear if staff fully understood the duty of candour. They were not always open and transparent and did not give a full explanation following an incident. There was no reference to duty of candour in any of the service's policies. The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them. To fulfil the duty of candour, an apology should be given for any harm caused, regardless of fault, as well as being open and transparent about what has happened. We did not see evidence of duty of candour in response to a recent complaint.

The service had modified its complaint's policy in March 2023, shortly after receiving a complaint relating to a potential notifiable safety incident. The modified complaints policy specified that an independent professional would review and investigate complaints, documents and results available. We saw evidence that the professional who gave a review of the complaint was not completely independent to the service.

We did not see evidence that opportunities had been explored to make changes as a result of feedback. The British Academy of Audiology – Quality Standards in Paediatric Audiology guidance states, 'when a case of mis-identified hearing loss occurs, the opportunity is used to review the case in an open and transparent way. Duty of candour to the family should be explored. A senior professional should over-see this process to review the factors around the cause of the error, to prioritise and amend the patient-management pathway. A documented procedure and training opportunity is applied to make this error less likely to happen in future'. While a senior professional reviewed this incident, we did not see evidence of any learning identified following this complaint.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

The registered manager did not have all the skills and abilities to run the service. They understood and managed some of the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Requires Improvement

Diagnostic and screening services

At the last CQC inspection in 2021, the service director was the registered manager. We did not find assurance that their skills were sufficient to provide leadership and governance within the service.

The service appointed a new registered manager in December 2021. Although some improvements had been made, we did not receive assurances that the new registered manager had sufficient knowledge and oversight to identify, review and act on risks to the service. This was evident in the lack of COSHH and fire risk assessments. The registered manager was unaware if the service carried out any clinical audits to assess, monitor and improve the quality and safety of the service.

We did not see any evidence of any recruitment process when the service provider appointed the registered manager. We did not see any evidence of additional training or support given to the registered manager to support them in their new role and in the relation to the governance of the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service provided us with an updated vision and strategy immediately following our inspection. The updated vision reflected the feedback given after the inspection and included reference to duty of candour. The service's vision was to provide and support the professional dispensing of hearing aids to both paediatric and adult patients seeking an independent opinion. They aimed to listen to individual concerns, gain measures of the hearing and provide solutions through the fitting of appropriate hearing technology. They aimed to apply a duty of candour with all families. Their vision recognised that family-centred care involved collaboration across hearing and communication professionals around the needs of each child and family.

Their strategy to fulfil their vision included:

- Providing a full evaluation of hearing ability and listening skills, to provide advice and to support communication needs to all clients.
- Using clear communication skills to explain and report test results, diagnoses and proposed treatments, so families clearly understood the options that were offered to them.
- To show compassion and empathy to all children and their families.
- To keep up to date with changing hearing technology and liaising with manufacturers.
- To provide staff with ongoing training, support and opportunities for shared learning.
- To build collaborative working relationships with NHS audiology services and other agencies in the field.
- Offer training in practical aspects of children's hearing assessment, through university establishments and professional bodies such as the British Academy of Audiology (BAA).
- Being actively involved in research and innovations in hearing assessment and development of new techniques including for speech understanding and music.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Requires Improvement

Diagnostic and screening services

This was a small service but the 3 staff members worked together cohesively as a team. There was a sense of pride in the service provided.

The service had a whistleblowing policy, and staff could access a charity to speak about any concerns. The complaints policy was accessible on the service's website.

The service acted following feedback from the CQC inspection team, implementing measures to encourage patient feedback, completing mandatory training, and arranging a fire risk assessment immediately after our inspection.

Governance

Leaders did not always operate effective governance processes. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service held monthly staff meetings. We saw meeting minutes for the 6 months preceding our inspection.

The second audiologist was the designated safeguarding lead, first aider and completed cleaning of the equipment.

The registered manager reviewed and updated service policies on a yearly basis. We saw policies were dated and reviewed yearly. However, the health and safety policy only included a statement page and did not outline the practical arrangements in place required to fulfil the health and safety aims, for example, risk assessments, training, or safety signs. The health and safety policy and information governance policy did not refer to national guidance.

Not all staff had completed all mandatory training and some training was out of date. Only 1 member of staff had training in first aid, and 2 staff members did not have up to date safeguarding training at a level suitable for their role.

A complaint which referenced a potential notifiable safety incident was not managed well. We did not have assurances that there were robust processes in place to identify learning and implement changes to drive improvement following an incident.

The British Academy of Audiology – Quality Standards in Paediatric Audiology guidance states, 'Services should monitor their quality management on an ongoing basis. A robust audit and clinical assurance timetable and strategy should be in place including where any serious incidents are reviewed annually as information for sharing and training updates.' While the service director had completed an audit for research purposes, we did not see any evidence of any audit or clinical assurance timetable for the year preceding the inspection. The service did not conduct any audits on patient records.

Management of risk, issues and performance

Leaders identified and escalated some of the relevant risks and issues and identified actions to reduce their impact. They did not have plans to cope with unexpected events.

The service had a general risk register, which outlined some potential hazards and control measures to mitigate these risks. One of the risks listed was staff sickness. The control measure in place to mitigate this risk was to arrange cover for that staff member. However, the service did not have any documented standard operating procedures (SOPs) which

could be followed to ensure consistency if a staff member was absent from work. As the service had not identified any of the risks that were highlighted during our inspection, such as the lack of a fire risk assessment, lack of audits and not all staff having up to date and relevant mandatory training, it was not clear if managers had a good understanding and oversight of the risks to the service.

The service also had a risk assessment specifically for the risks involved with the assessment of children with social and communication delays (SCDs). Children with SCD are more at risk of harm and distress in the hearing assessment environment. This risk assessment had a comprehensive list of potential risks to these children and control measures listed to reduce these risks. An example was that parents may observe that a child responds to some sounds at low levels, which may be missed by the audiologist. A control measure for this risk was to send a questionnaire to parents after the appointment to gain feedback on satisfaction on the information and testing. However, we saw that feedback questionnaires were not routinely sent out to patients.

We did not see evidence that the service had robust processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. The service had not conducted a fire risk assessment which is required by law. The service had not conducted a Control of Substances Hazardous to Health (COSHH) r isk assessment and no staff members had received COSHH training. The service provided evidence immediately following the inspection that showed fire and COSHH risk assessments had been arranged.

The service did not have a business continuity plan.

Information Management

The service did not always collect reliable data and analyse it. The information systems were integrated and secure.

We did not see evidence that the service collected information to improve the performance of the service. Patient feedback was not routinely collected, and the service did not conduct any audits to assess patient outcomes.

Patient records were paper based and were stored securely. The service had a back-up system for their information technology (IT) systems, which was maintained by an external IT company. Patient reports were encrypted before circulating to other organisations.

Engagement

Leaders and staff did not actively and openly engage with patients on a routine basis to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service sent feedback questionnaires to a small cohort of patients for 1 month of the year between 2022 and 2023 and 1 month of the year between 2021 and 2022. We were told the service felt it was important to request feedback once service users had a chance to consider whether the appointment had fulfilled their expectations, and not immediately after the appointment. Therefore, the feedback questionnaire was sent within an email containing the patient report.

The service had seen a total of 1340 patients and received feedback for 11 of those patients in the year preceding the inspection. Although the sample size was small, feedback was complementary with responses such as, ‘fantastic service from start to finish, my son enjoyed the process so much he didn’t want to leave’ and ‘the approach to dealing with nervous children is great and much appreciated.’ We saw thank you cards displayed within the reception area, which were also very complementary on the service.

Requires Improvement

Diagnostic and screening services

We saw a poster within the reception area which informed service users on how to give feedback to CQC, but there was no information on how service users could give feedback directly to the service. Following feedback after our inspection, the service generated a Quick Response (QR) code which linked to a feedback questionnaire. This was to be displayed within the service and would give all service users the opportunity to give feedback on the service provided.

The service's complaints policy was accessible on the website. The service had received 1 complaint in the year preceding the inspection, and 3 complaints in total over 9 years. The service kept a log of complaints and we saw evidence that a recent complaint had been discussed within monthly staff meetings.

The service director was able to contact 2 heads of service at different organisations to discuss the management of different cases. We saw 2 email threads where the service director had discussed the difficulties they had with liaising with local services, and another which discussed waiting lists and advice on how to escalate the care for a patient under NHS audiology.

The service was experiencing an increased demand due to other local audiology services closing. The registered manager told us that they had adjusted appointment times from 1 hour to 45 minutes to accommodate the increase in demand. We saw meeting minutes which indicated that staff were looking for other ear wax removal audiologists in the Norfolk area who specialised in children and in May 2023, the registered manager was looking to open additional days to accommodate the patients on their waiting list.

Staff accessed an interpreter service if required but told us they had never needed to use it.

The service had not displayed their CQC rating from their last inspection either on the premises or on their website.

Learning, continuous improvement and innovation

The service director participated in innovation and research but could not provide evidence of continued professional development.

Chear Ltd was founded by the service director in 2001, who was a clinical scientist in audiology and a hearing aid dispenser. The service director had studied speech and language therapy prior to obtaining a masters' qualification in Audiology. They had spent 8 years as a research associate, working on research into new assessment techniques and digital hearing aid prescriptions for both adults and children.

The service director had been awarded an innovation fund award (IFA), as they were working as part of a team who were developing a new method of hearing assessment for young children who were not responsive to simple sounds traditionally used in behavioural hearing assessment.

The service's Staff Training and Development Policy was shared with CQC following the inspection. It stated that the service offered opportunities to support staff with their development. This document also stated that it was the responsibility of individual staff members to identify any training and development opportunities and to keep a record of their training. Although this policy was in date, we did not see this policy within the policy file on site and it had not been signed by any staff members to acknowledge receipt and compliance.

Requires Improvement

Diagnostic and screening services

The second audiologist had attended a conference around current developments and new directions in paediatric audiology in May 2023. The service director was invited to speak at this conference and presented on a new area of clinical audiology using remote online appointments for teenagers. In addition, the service director had carried out 10 hours of online presentation to university students on updates in behavioural testing for children being seen in NHS audiology departments.

While we saw evidence of continued professional development (CPD) for the second audiologist, in the form of a certificate of attendance at the conference, we did not see any evidence of CPD for the service director. The British Academy of Audiology – Quality Standards in Paediatric Audiology guidance states 'there should be a record of appropriate training, with at least biennial updates on advances in paediatric audiology, hearing aid technology and assistive devices. Staff should also keep an up-to-date, relevant CPD portfolio for their role and registration'.

The British Academy of Audiology – Quality Standards in Paediatric Audiology also states, 'competency of staff to perform clinical procedures should be verified by peer review or competency checks on both the use of equipment and the testing method at least every two years and this should be formally documented. If the service undertakes auditory brainstem response (ABR) testing, they should take an active part in an external ABR peer review scheme. If the service undertakes behavioural testing (conditioned play audiometry (CPA) and visual reinforcement audiometry (VRA) it should undertake peer-review of these procedures. There should be a service process for acting on peer review observations so that opportunities for retraining and upskilling are made available. Training should be available within teams through ongoing processes of assessment and appraisal in clinical practice.' The service director told us that they could access peer review with another audiologist who worked at another Chear service based in London. We did not see any record that the service director had received or participated in any peer review to ensure compliance with these guidelines.

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	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The service must ensure that duty of candour is followed, acting in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying out a regulated activity. (Regulation 20).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The service must ensure that the registered manager has the support, qualifications and skills which are necessary for their role. (Regulation 19(2)).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure they 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 activity. This includes having appropriate fire risk assessments and ensuring adherence to Control of Substances Hazardous to Health (COSHH) regulations. (Regulation 17(2)(b)).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments

The service must ensure that the most recent CQC rating is displayed at the service's principal place of business and on its website. (Regulation 20A).