Poland Medical LLP

Poland Medical - Coventry

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 20 May 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.

The CQC inspected the service on 10 September 2017 and asked the provider to make improvements regarding safe care and treatment and good governance. We checked these areas as part of this comprehensive inspection and found that significant issues highlighted at the previous inspection had not been addressed. For example, the majority of the requirements of the Warning Notices issued after the previous inspection in September 2017 had not been met.

Poland Medical is an independent provider of medical services and treats both adults and children at their location in Coventry. Services are provided primarily to Polish people who live in the UK and who choose to access the services as an adjunct to the NHS services for which they are eligible to register.

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

We received feedback through 18 comment cards.

Our key findings were:

Summary of findings

- Clinical records were not always recorded in English and were not always legible. General Medical Council guidance on keeping records is that any documents that doctors use to formally record their work must be clear, accurate, legible and usable in a UK context.
- Information sharing with external providers and the patients' NHS GPs was inconsistent.
- There was minimal evidence of quality improvement activities.
- The range of emergency medicines had not been risk assessed.
- One doctor we spoke with showed no awareness of Fraser guidelines or Gillick competency.
- Doctors had completed safeguarding training to the appropriate level.
- There was a broad range of policies and procedures, but they were not always working policies.
- Information about services, fees and how to complain was available.
- There were structured meetings, which were held mainly at the West London clinic. Few doctors were able to attend, due to the sessional nature of their work.
- The doctors were supported by the designated responsible officer, who was also the Medical Advisor for the clinic.
- Risks to patients were assessed and monitored.
- Patients said that it was easy to make appointments and were complimentary about the standard of service delivery.
- The premises were visibly clean and tidy.

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

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

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

- Review the emergency medicines held to ensure that they are in line with the risks associated with the range of procedures carried out at the clinic.
- Review the system for providing clinical oversight.
- Review the system for embedding policies into working 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.

We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- Clinical records did not always show the rationale for the treatment or prescribing decisions. In some instances, we found that prescribing was not in line with best practice guidelines.
- Information sharing with other providers and the patient's NHS GP was not consistent.
- The range of emergency medicines stocked had not been risk assessed.
- There was limited awareness of Fraser guidelines or Gillick competency.

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

We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- There was limited evidence to show that clinical staff were aware of current evidence based guidance.
- There was minimal evidence of a quality improvement programme and no evidence of clinical audits.

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

Are services responsive to people's needs?
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 have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- There was not an effective system to check that medical records were legible, and of a standard commensurate with the doctor being registered with the General Medical Council.
- There was not an effective system for monitoring poor or variable performance.
- The communication system for sharing learning was not effective.
- The clinical leadership necessary to monitor the standard of care and to drive quality improvement needed strengthening.

Poland Medical - Coventry

Detailed findings

Background to this inspection

Poland Medical is registered with the Care Quality Commission (CQC) as an independent provider of medical services. Both adults and children are treated at the Coventry location. Poland Medical, Coventry, is registered with the CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Poland Medical provides non-urgent services to a population which is mainly Polish. Services are available to people on a pre-bookable appointment basis. The clinic employs doctors on a sessional basis most of whom are specialists who provide a range of services from gynaecology to psychiatry. Medical consultations and diagnostic tests are provided by the clinic. No surgical procedures are carried out.

The clinic employs 11 doctors all of whom are registered with the General Medical Council (GMC) with a licence to practise. The doctors work across both the West London and Coventry locations. Other staff include the registered manager, the practice manager in training and reception staff. Poland Medical is a designated body (an organisation that provides regular appraisals and support for revalidation of doctors) with one of the specialist doctors as the responsible officer (an individual within a designated body who has overall responsibility for helping with revalidation). The doctor is also the medical advisor to the clinic.

Poland Medical is open on Saturdays and Sundays from 10am until 6.30pm. A cardiologist and a gynaecologist offer appointments on a Thursday evening from 4pm until 7pm. Appointments may be arranged on other days by prior arrangement via the West London clinic. The provider is not required to offer an out of hours service or emergency care. Patients who require emergency medical assistance or out of hours services are requested to contact NHS Direct or attend the local accident and emergency department.

We carried out an announced inspection on 20 May 2018 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 clinic had carried out their plans to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 10 September 2017.

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor. The team was also supported by two Polish translators.

During our inspection we spoke with the registered manager, two specialist doctors, including the responsible officer, and reception staff. We reviewed the treatment records of 25 patients and received 18 comment cards. We also viewed procedures and policies used by the clinic.

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 previous inspection on 10 September 2017 we found that the service was not providing safe care in accordance with the relevant regulations:

- Medical records were not always accurate, complete, contemporaneous or legible.
- The clinic had not ensured that information was shared or transferred in a timely manner.
- There was an ineffective system for monitoring emergency medicines.
- Doctors did not have a clear understanding of the principles of Fraser guidelines or Gillick comptency.
- There were no infection control audits.
- Staff had not received safeguarding training to the level appropriate to their role.

At this inspection on 20 May 2018, we found that some areas had been addressed, but areas of concern remained.

Safety systems and processes

- The clinic had appropriate systems to safeguard children and vulnerable adults from abuse. All staff had received safeguarding training appropriate to their role. Staff we spoke with were able to explain how they would identify and report concerns and they shared an example of when this had been done. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Services (DBS) check. It was the clinic's policy that all staff had a DBS check.
- The responsible officer supported doctors with the requirements of professional revalidation.
- There was an effective system to manage infection prevention and control.
- The clinic had arrangements to ensure that facilities and equipment were safe and in good working order. Staff carried out actions to manage risks associated with legionella in the premises (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

- The clinic was equipped to deal with most medical emergencies and staff were trained in emergency procedures. We saw that there was a flowchart for the management of medical emergencies, which included doses of emergency medicines. The clinic had not risk assessed the range of emergency medicines that they had decided to stock, so the reasons for the decisions regarding the choice of emergency medicines were not recorded.
- Staff understood their responsibilities to manage emergencies at the clinic. Doctors knew how to identify and manage patients with severe infections including sepsis.

Information to deliver safe care and treatment

- Clinical records were not always recorded in English and were not always legible. General Medical Council guidance on keeping records is that any documents that doctors use to formally record their work must be clear, accurate, legible and usable in a UK context.
- We noted that the system for managing test results had improved since our last inspection. Test results were now sent to the patient and to the clinic, although we were told that only cervical cytology test results were routinely reviewed by a doctor. Abnormal results were reviewed.
- There was a policy for sharing information with other agencies, including the patient's NHS GP, but doctors did not consistently adhere to this policy and medical records we reviewed demonstrated that information was not routinely shared with the patients' NHS GPs even when consent had been given. Consent to share was not always recorded in the patient's medical record.
- Referrals documented in clinical records were not always followed through with letters to the appropriate organisation. For example, there was a reference to a referral in a patient's medical record, but there was no evidence that a letter recommending a referral had been sent to the patient's NHS GP.

Safe and appropriate use of medicines

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks.
- There were no audits of prescribing methods to check whether doctors were prescribing medicines in line with current guidelines. In some instances, we found that prescribing was not in line with best practice guidelines

and there was no rationale for the prescribing decisions. For example, we saw that in one case prescriptions did not match the working diagnosis and in another that the prescription did not align with antibiotic guidelines.

Track record on safety

There were comprehensive risk assessments in relation to safety issues, apart from emergency medicines.

Lessons learned and improvements made

- Staff we spoke with showed that they understood how to raise concerns and report incidents and near misses. We were told that incidents were usually reported to the registered manager for recording.
- The service was aware of and complied with the requirements of the Duty of Candour. A culture of openness and honesty was encouraged. The service had systems in place for knowing about notifiable safety incidents.
- There were adequate systems for reviewing and investigating when things went wrong. Incidents were discussed at clinical governance meetings and the meeting minutes were emailed to all doctors, so that they were informed of the outcome of the discussions and any associated learning.
- When there were unexpected or unintended safety incidents, the service offered support, information and an apology to those affected. Copies were kept of all correspondence.
- The clinic acted on patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 September 2017 we found that the service was not providing effective care in accordance with the relevant regulations:

- There was no evidence of a quality improvement programme or clinical audits.
- There was no evidence of effective support, training, professional development or supervision for doctors.

At this inspection on 20 May 2018, we found that some areas had been addressed, but areas of concern remained.

Effective needs assessment, care and treatment

The clinic was able to provide some evidence that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards. For example, the doctors we spoke with explained how they followed National Institute for Health and Care Excellence (NICE) best practice guidelines for the care and treatment they provided.

Monitoring care and treatment

At the last inspection in September 2017, we were told that a quality improvement manager had been recruited in order to introduce a quality improvement programme which would include comprehensive audits, but we saw limited evidence of this. The responsible officer had carried out patient health record audits for each doctor, but these did not include monitoring whether the prescribing or treatment was in line with the patient's symptoms or current guidelines. No separate clinical audits had been carried out to monitor the quality of prescribing.

Effective staffing

The registered manager kept a training matrix for all staff, which included details of statutory training updates for clinical staff. We also saw that annual appraisals were carried out for all clinical and non-clinical staff. We were told that personnel records were kept at the West London location, so we could not check details of continuing professional development for clinical staff.

- We saw the training matrix which listed training for such areas as safeguarding, basic life support, confidentiality, chaperoning and equality and diversity. Training was complete and in date. We were told that such training was completed via a combination of online modules and face to face sessions.
- The system for supporting and managing staff when their performance was poor or variable was ineffective. For example, a specific doctor's standard of record keeping had not improved sufficiently since our previous inspection in September 2017.
- A receptionist had been appointed as practice manager in training in order to provide daily supervision at the Coventry location when the registered manager was not on site. The registered manager told us that additional training had been given to the receptionist in order to enable them to perform effectively in the new role, but that the duties were mainly supervisory. Further training would be provided as required.

Coordinating patient care and information sharing

- The patient's registration form gave them the option of consenting to copies of notes of their consultation and treatment being forwarded to their NHS GP.
- We were told that patient information was only shared on request. Letters for the patient's NHS GP were handed to the patient. There was a policy on information sharing, but this was not consistently followed. We saw little evidence of regular communication with other agencies or primary care providers. We saw examples of where a patient's consent to share information had been given, but the information was not shared and where the need for a referral was noted, but there was no record of a referral letter having been sent.

Supporting patients to live healthier lives

- The clinic identified patients who may be in need of extra support and directed them to relevant services. For example, Alcoholics Anonymous and family behavioural therapy.
- Staff discussed treatment options with patients as necessary.

Consent to care and treatment

The clinic obtained consent to care and treatment in line with legislation and guidance.

- Doctors understood the requirements of legislation and guidance when considering consent and decision

Are services effective?

(for example, treatment is effective)

making. However, one doctor we spoke with showed no awareness of Fraser guidelines or Gillick competency, despite the topics having been circulated as a result of discussions at a clinical staff meeting in May 2018. (Gillick competence is used to decide whether a child (16 years or younger) is able to consent to his or her own treatment, without the need for parental permission or knowledge. Fraser guidelines relate specifically to contraception and sexual health advice and treatment.)

- Doctors supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from comment cards was very positive about the standard of care shown by clinical and non-clinical staff. Staff were said to be very kind, helpful and friendly.
- Staff had a good understanding of patients' personal, cultural, social and religious needs.

Involvement in decisions about care and treatment

- Staff helped patients to be involved in decisions about their care and treatment options.
- Information on the clinic's website included details of the specialist doctors, the scope of services offered and the schedule of fees.

Privacy and Dignity

- We observed that reception staff treated patients with respect and dignity.
- Curtains were provided in consulting rooms to maintain patients' privacy during examinations, investigations and treatments.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.
- Patients' medical records were stored in lockable cabinets which were located in a secure area of the premises.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The clinic organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The facilities and premises were appropriate for the services delivered.
- The premises were not suitable for patients with disabilities, because there was a step leading up to the main entrance and there was no disabled toilet. Patients with access problems were advised to contact the clinic in advance, so that they could be directed to an alternative local NHS or private clinic where there were facilities for disabled patients**.**
- We were told that all patients who attended the clinic spoke either English or Polish. All staff spoke both languages, so there was no need for a translation service.
- Information on the clinic's website could be downloaded in Polish or English.
- Baby changing facilities were available and there were play tables for children in the reception area.
- A hearing loop was provided for patients who were hard of hearing.

Timely access to the service

Patients were able to access care and treatment from the clinic within an acceptable timescale for their needs.

- Patients had timely access to initial assessments. Patients were able to book appointments on alternative days by prior arrangement via the West London clinic. All appointments were pre-bookable and no urgent appointments were provided.
- Patients said that the appointment system was easy to use. Appointments could be booked either in person or by telephone.
- The clinic had increased the opening days in response to demand. It now opened on Saturdays as well as Sundays. It was also possible to book an appointment with a cardiologist or gynaecologist on Thursday evenings.

Listening and learning from concerns and complaints

The clinic took complaints and concerns seriously and responded to them appropriately.

- Information about how to raise a complaint was available in the reception area.
- The registered manager was the designated lead for handling complaints.
- We viewed two complaints and noted that they were thoroughly investigated in line with the complaints policy and changes were made as appropriate. For example, as a result of a patient complaint about a late appointment, doctors were allocated additional time during their lunch break in order to give them time to catch up with appointments.

Are services well-led?

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

Our findings

At our previous inspection on 10 September 2017 we found that the service was not providing well-led care in accordance with the relevant regulations :

- There was no evidence of any governance to ensure that quality improvement activities, including clinical audits, were carried out.
- There was no system to ensure that infection control audits were carried out.
- The system for communicating and sharing learning from patient safety alerts, incidents or complaints was ineffective.
- Systems were not in place to ensure that accurate, complete and contemporaneous records were maintained for each service user.
- Management and oversight arrangements were not in place on a daily basis.
- There was no formal meeting structure for multi-disciplinary or full practice meetings.

At this inspection on 20 May 2018, we found that some areas had been addressed, but areas of concern remained.

Leadership capacity and capability;

The responsible officer (RO) and manager could articulate the issues and priorities relating to the quality of the services. They had a broad understanding of the challenges and were trying to address them with limited evidence of progress. Significant issues highlighted at the previous inspection had not been addressed. For example, the majority of the requirements of the Warning Notices issued after the previous inspection in September 2017 had not been met.

The manager was not present at the Coventry location every day, so a receptionist had been assigned the role of practice manager in training in order to provide daily supervision. We were told that it was easy to contact the manager even when they were not on site.

Vision and strategy

The registered manager and RO worked to develop and evolve a strategy to meet the changing demands of their patient base. For example, the clinic now opened on Saturdays as well as Sundays.

Culture

- The culture of the service encouraged candour, openness and honesty. We saw that incidents and complaints were handled in a timely manner with honesty and transparency.
- Staff told us that they felt respected, supported and valued.
- Staff said that they could raise issues at any time with the manager.
- It was clear that the clinic focused on the needs of patients and adapted their services accordingly.
- Staff received annual appraisals which included career development conversations. Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- The clinic actively promoted equality and diversity. We saw that staff had received training in equality and diversity.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support governance and management, but they were not always effective.

- The RO had introduced an audit system for each doctor in order to encourage better record keeping, but this had met with limited success. For example, we noted insufficient improvement in the standard of record keeping for a specific doctor whose work we had discussed with the RO after our inspection in September.
- We saw that the need for patients' medical records to be completed in English was raised at a clinical staff meeting in April 2018, but the issue was carried forward for further discussion.
- The RO was also the Medical Advisor for the clinic, so guidance was available, but the clinical oversight arrangements for the doctors were not conducted in an effective manner and needed to be strengthened.
- We noted that there were regular structured meetings, but they were mainly held at the West London clinic. Minutes were kept, so that there was a record of discussions, decisions and learning points. The Minutes

Are services well-led?

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

were emailed to doctors, but this system of communication was not effective. For example, Fraser guidelines and Gillick competency were discussed at the staff clinical meeting, which was held in May 2018, but one doctor we spoke with showed no awareness of either.

- Staff were clear on their roles and accountabilities in respect of safeguarding and infection prevention and control.
- A broad range of policies and procedures had been introduced to ensure safety, but they were not always working policies. For example, doctors did not consistently adhere to the information sharing policy.

Managing risks, issues and performance

There were appropriate arrangements for identifying, recording and managing risks.

- There was limited evidence of quality improvement activities or continuous clinical and internal audits to monitor quality and to drive improvements. For example, no clinical audits had been carried out to monitor the quality of prescribing or check that it was in line with current guidelines.
- We noted that two infection control audits had been carried out since the previous inspection in September 2017. Issues highlighted during the first audit had been addressed by the time that the second audit was carried out. For example, the audit carried out in January 2018 highlighted the fact that sterile packs were stored on the floor. This had been corrected by the time of the repeat audit in April 2018.

Appropriate and accurate information

Poland Medical was an independent medical provider, so performance information from external sources was not available.

The RO carried out internal audits to monitor the performance of individual doctors, but these audits did not include a review of the appropriateness of clinical diagnosis and treatment.

Engagement with patients, the public, staff and external partners

Patients' views were obtained via comment cards, which were left in the reception area. A patient survey was conducted each year and the findings were uploaded to the Poland Medical website.

There were formal staff meetings, where staff could raise concerns, but the meetings were mainly held at the West London clinic. The practice manager in training at Coventry attended the meetings when possible.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning and continuous improvement.

- We saw that incidents and complaints were discussed at formal meetings and that learning was shared by email for the benefit of those doctors who could not attend.
- We saw limited evidence of continuing professional development. We were told that a receptionist had been appointed as practice manager in training in order to provide daily supervision when the registered manager was not 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 Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** • The registered person had systems and processes that were operating ineffectively in that they failed to enable the registered person to ensure that accurate and legible records were maintained of all clinical care decisions and treatments. • Where responsibility for the care and treatment of service users was shared with, or transferred to other persons, the registered person had not ensured that information was shared or transferred to ensure that timely care planning took place to ensure the health, safety and welfare of service users. • There was limited awareness of Fraser guidelines and Gillick competency. These matters are in breach of regulation 12 (1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

- There was minimal evidence of quality improvement monitoring including continuous clinical and internal audit. There were no medicine audits to monitor the quality of the prescribing.
- The registered person had not ensured that systems were in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided.

These matters are in breach of regulation 17 (1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.