Poland Medical

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 effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

Poland Medical provides an independent doctor service and is based in Greenford, outer West London. The service has a 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 carried out an announced comprehensive inspection at Poland Medical on 27 February 2023 as part of our inspection programme.

Our key findings were:

- Individual care records were not written in a way that kept patients safe. For example, our review of a selection of patient records highlighted an absence of examination findings or of evidence that patients had been advised on actions to take if their condition worsened changed or failed to improve. This presented a risk to patients in that records contained insufficient information to either support diagnoses or enable other health care professionals to understand and interpret clinical decision making.
- The provider had not ensured they had all the details of the patient's health from their NHS GP prior to starting treatment which meant there was a risk they were not aware of all relevant healthcare needs. We noted they did gain patient's consent to share details of treatment with their NHS GP.
- Patient records did not always include the necessary details of prescribed medication including frequency, duration and quantity.
- From November to December 2022 there had been three recorded incidents of prescription fraud. Although the service recorded significant incidents, staff did not carry out a root cause analysis, to support shared learning and minimise chance of recurrence. At the time of the inspection whilst prescription pads were being stored securely, individual prescriptions were not being monitored.
- Risks associated with infection prevention and control were not all being regularly checked (for example regarding a bacterium called Legionella which can proliferate in building water systems).
- Issues to do with patient safety, incidents and complaints were discussed at team meetings. However, most staff could not attend the meeting and relied on reading meeting minutes to identify learning. These minutes were very brief and did not contain sufficient detail.

- These concerns did not provide assurance that the service's internal audit systems were having a positive impact on quality governance.

Overall summary

- Governance arrangements did not always operate effectively (for example regarding systems for logging safety alerts and learning from significant incidents).

However:

- There were clearly defined and embedded systems and processes to keep patients safe and safeguarded from abuse.
- Access to appointments and services took account of people's language needs.
- Patients fed back they were treated with kindness, respect and compassion.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure patient records include all the necessary details including details of prescribed medication to deliver safe care and treatment (Regulation 17).
- Ensure the provider liaises with the patients NHS GP where applicable to obtain all necessary healthcare information to be able to deliver safe treatment (Regulation 12).
- Take the necessary steps to ensure the safe management of individual prescriptions (Regulation 12).
- Ensure individual incidents are fully investigated to look at the root cause to minimise the risk of recurrence and ensure learning (Regulation 12).
- Review and strengthen internal systems of assurance such as audits to deliver effective governance arrangements for the surgery (Regulation 17).

The areas where the provider **should** make improvements are:

- Ensure team meetings are properly recorded for staff who cannot attend in person.

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to Poland Medical

Background to Poland Medical

Poland Medical provides an independent doctor service and is located at 364A Whitton Avenue East, Greenford, UB6 0JP. The service is primarily aimed at the local Polish speaking community and is located on the ground floor of a converted residential property. The service is open Monday – Saturday 8:00am - 8:00pm and Sunday 10:00am – 6:00pm. Services are only available on a pre-bookable appointment basis. The clinic employs eleven doctors on a sessional basis all of whom are registered with the General Medical Council (GMC) with a license to practice. Most doctors are specialists providing a range of services which includes paediatrics, gynaecology, cardiology and orthopaedics. Administrative support is provided by a practice manager and a small team of reception staff.

Poland Medical is registered with the Care Quality Commission to carry out the regulated activities of Family Planning, Surgical Procedures, Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- Patient records did not always include the necessary details of prescribed medication including frequency, duration and quantity.
- From November to December 2022 there had been three recorded incidents of prescription fraud. Although the service recorded significant incidents, staff did not carry out root cause analyses, to support shared learning and minimise chance of recurrence. At the time of the inspection whilst prescription pads were being stored securely, individual prescriptions were not being monitored.
- Risks associated with infection prevention and control were not all being regularly checked (for example regarding a bacterium called Legionella which can proliferate in building water systems).
- Issues to do with patient safety, incidents and complaints were discussed at team meetings. However, most staff could not attend these meetings and relied on reading meeting minutes which we noted contained insufficient detail to support sharing learning.

However:

- There were clearly defined and embedded systems and processes to keep patients safe and safeguarded from abuse.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. The service had systems to safeguard children and vulnerable adults from abuse.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service had systems in place to enable it to work with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. These 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.
- The service had clear systems to keep people safe and safeguarded from abuse (including a designated Safeguarding Lead and readily accessible Local Authority safeguarding guidance).
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The staff member who acted as a chaperone was trained for the role and had received a DBS check.
- We looked at systems in place to manage infection prevention and control (IPC) risks and noted that an IPC audit had taken place with the previous 12 months.
- We noted that in 2014, an external contractor had been commissioned to assess risks associated with a bacterium called Legionella which can proliferate in building water systems within a certain temperature range.
- The risk was assessed as low and we noted that periodic water temperature monitoring had been taking place to manage this risk. We also noted that shortly after our inspection the service had commissioned a water sample analysis and updated its Legionella Management Policy.

Requires Improvement

Are services safe?

- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Safe and appropriate use of medicines

We looked at arrangements for the appropriate and safe handling of medicines.

- Our review of ten patient records highlighted four instances of an absence of information regarding frequency, duration and quantity of the prescribed medication. Shortly after our inspection we were advised that internal audit arrangements were being reviewed.
- The provider was undertaking periodic checks of emergency medicines and equipment.
- We noted an appropriate range of emergency medicines.
- At the time of the inspection, prescription pads were being stored securely. However, our review of a selection of patient records highlighted that individual prescriptions were not being monitored.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence).
- There were effective protocols for verifying the identity of patients including children.

Track record on safety and incidents

We looked at the service's safety record.

- There were comprehensive risk assessments in relation to safety issues (for example regarding fire safety and health and safety).
- This helped the service to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

We looked at systems in place for ensuring learning and improvement took place when things went wrong.

- Three separate incidents of prescription fraud had been recorded between November 2022 and December 2022. Records confirmed that these incidents had been discussed at a clinical meeting (although it was unclear who had attended). We noted clinicians worked part time sessional hours which meant that convening a meeting attended by all clinical staff members was not feasible. The provider had introduced a clinical governance meetings summary document for clinicians unable to attend clinical meetings but we noted it did not reference or analyse significant incidents in detail. It was therefore unclear how it could be relied upon to share learning amongst clinical staff members. Records confirmed that significant incidents were discussed at clinical meetings (although it was unclear who had attended these meetings)"

Requires Improvement

Are services safe?

- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- We noted a new staff meeting minuting system had been introduced in January 2023, entailing production of a summary record of staff meetings held during the previous three months. We were told this had been introduced because the service's clinical staff were sessional and rarely worked at the same time. However, the brevity of the record of discussion of significant events, complaints and safety alerts meant it was unclear how the minutes supported the shared learning stipulated in the service's Significant Event Policy.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

We identified concerns with the governance arrangements for acting on patient safety alerts.

We noted the service's policy for acting on Central Alerting System (CAS) alerts required that an on line log be maintained of each actioned alert. Records confirmed that the service had circulated a December 2022 UK Health Security Agency (UKHSA) Urgent Public Health message regarding Invasive Group A Strep but we noted confirmation of clinicians' receipt of this alert was via email and SMS text. We therefore could not be assured that the on line log was being maintained.

Inadequate

Are services effective?

We rated effective as Inadequate because:

- Individual care records were not written in a way that kept patients safe. For example, our review of a selection of patient records highlighted an absence of examination findings or of evidence that patients had been advised on actions to take if their condition worsened changed or failed to improve. This presented a risk to patients in that records contained insufficient information to either support diagnoses or enable other health care professionals to understand and interpret clinical decision making.

- The provider had not ensured they had all the details of the patient's health from their NHS GP prior to starting treatment which meant there was a risk they may not be aware of all their relevant healthcare needs. They did get the patients consent to share details of treatment with their NHS GP. Shortly after our inspection we were told the service was revising its protocols, so as to enable collection of more detailed patient medical history.

Effective needs assessment, care and treatment

People's care and treatment did not reflect current evidence-based guidance, standards and practice.

- People's care and treatment did not reflect current evidence-based guidance, standards and practice. We could not be assured that individual care records were written and managed in a way that kept patients safe. We reviewed ten hand-written consultation notes with the service's Medical Director. Eight of the ten notes contained limited information regarding assessment and diagnosis; and were also not clearly written. In addition, we noted an absence of documented examination findings and observations; and also saw instances where medications were prescribed with no obvious indication. This presented a risk to patients in that records contained insufficient information to either support diagnoses or enable other health care professionals to understand and interpret clinical decision making.

- We also noted that none of the consultation notes confirmed that the patient had been advised on actions to take if their condition changed or failed to improve. This presented a risk to patients in that clinicians failed to advise when and how to access further advice if symptoms were unresolved or worsened.

- Shortly after our inspection, we were advised that the service's prescribing protocol had been amended so that a copy of each issued prescription was attached to the patient's record. We were also advised that a revised programme of internal audit checks would immediately be undertaken; entailing the Medical Director formally reviewing records of each of the service's doctors and then providing feedback on identified improvement areas.

- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

We looked at the service's quality improvement activity.

- The service used internal audit to improve quality. For example, the service's Medical Director had audited clinicians' prescribing against National Institute for Health and Care Excellence (NICE) guidance, so as to support safe prescribing.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Inadequate

Are services effective?

- All staff were appropriately qualified. Doctors were registered with the General Medical Council (GMC).
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

Coordinating patient care and information sharing

We looked at how staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Our review of a selection of patient records highlighted that clinicians did not always ensure they had adequate knowledge of the patient's health before providing treatment. Shortly after our inspection we were told the service was revising its protocols, so as to enable collection of more detailed patient medical history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their NHS GP.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

- There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Feedback from patients was positive about the way staff treated them.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. For example, a 2022 patient highlighted that 29 out of 30 patients (96%) rated reception staff as either 'very good' or 'good'.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Staff sought to ensure that patients felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- All 30 patient survey respondents fed back that they were treated with dignity and respect.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The service was planned and delivered in a way that met the needs of its patients. The importance of flexibility, choice and continuity of care was reflected in how care was delivered.
- Patients could access the right care at the right time. Access to appointments and services was managed to take account of people's needs, including those with urgent needs.
- The service had systems in place to respond appropriately to complaints.

Responding to and meeting people's needs

The provider organised and delivered services to meet the healthcare needs of its patients and took account of their needs and preferences.

- The provider understood the preferences and needs of their patients and strove to provide patient centred and flexible services.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

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

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Arrangements were in place to allow patients to make contact outside the service's opening times. Patients were advised they could call at any time if they experienced an emergency.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs. For example, the 2022 patient highlighted that 26 out of 30 patients (87%) found it either 'very easy or 'fairly easy' to make an appointment.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and had systems in place to respond to them appropriately to improve the quality of care.

- The service had a complaints policy and procedures in place.
- Information about how to make a complaint was available on the premises.
- The service had received two complaints in the previous 12 months.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- Governance arrangements including internal audits did not always operate effectively (for example systems to ensure comprehensive patient records, for supporting shared learning, and recording safety alerts).

However:

- The practice leaders promoted a culture where patients felt able to give feedback and staff felt involved and supported in the operation of the service.

Leadership capacity and capability

We looked at Leaders' capacity and skills to deliver high-quality, sustainable care.

- The Medical Director was knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. These included the challenge of sharing information effectively with a team of sessional clinical staff.
- The Medical Director was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

We looked at the service's vision for delivering high quality, patient centred care.

- The Medical Director had the experience, capacity and capability to ensure that this vision was delivered.
- Staff were aware of and understood the vision and values of the service; and their role in delivering patient centred care.

Culture

We looked at the culture of the service.

- Staff felt respected, supported and valued. They were proud to work for the service.
- Systems were in place to ensure openness, honesty and transparency were demonstrated when responding to complaints.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There was a strong emphasis on the safety and well-being of all staff.

Governance arrangements

Governance arrangements did not always operate effectively.

Governance arrangements did not always support the delivery of high-quality person-centred care. For example:

Requires Improvement

Are services well-led?

- Although the service had an internal audit system in place, this had failed to identify and take appropriate action in relation to improving the quality of consultation records. This presented a risk to patients in that records contained either inaccurate or missing information regarding care and treatment provided to the service user or decisions taken in relation to this care and treatment. We were therefore not assured that internal audit arrangements were having a positive impact on quality governance or patient safety.
- The service's clinical governance summary document lacked sufficient detail to support shared learning and quality improvement.
- However, the service used performance information which was reported and monitored and management and staff were held to account.
- The service also submitted data or notifications to external organisations as required.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- We saw evidence of processes to identify, understand, monitor and address current and future risks. For example, Infection Prevention & Control audits and Fire Safety risk assessments had recently taken place. The provider also had plans in place for major incidents.
- We noted that in 2014, an external contractor had been commissioned to assess risks associated with a bacterium called Legionella which can proliferate in building water systems within a certain temperature range.
- The risk was assessed as low and we noted that periodic water temperature monitoring had been taking place to manage this risk. We also noted that shortly after our inspection the service had commissioned a water sample analysis and updated its Legionella Management Policy.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support high-quality sustainable services.

- The service routinely undertook patient surveys and considered survey findings.
- Staff were proud of the organisation as a place to work and spoke highly of the service's listening culture.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

We looked at systems and processes for learning, continuous improvement and innovation.

- We saw evidence of continuous learning and improvement. For example, the service's Medical Director had audited clinicians' prescribing against National Institute for Health And Care excellence (NICE) guidance, so as to support safe prescribing.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) HSCA (RA) Regulations 2014 The proper and safe management of medicines How the regulation was not being met: • The provider failed to ensure that prescription security arrangements were sufficiently robust and in line with current legislation and guidance. • The provider failed to include all necessary details including details of prescribed medication to deliver safe care and treatment. • The provider failed to liaise with the patient's NHS GP where applicable to obtain all necessary healthcare information to be able to deliver safe treatment. • The provider failed to ensure that individual incidents were fully investigated so as to ensure learning and minimise the risk of recurrence.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. How the regulation was not being met: • The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.