JDoc Medical Limited

JDoc Medical - Wellington Diagnostic Centre

Inspection report

Roman House
296 Golders Green Road
London
NW11 9PY
Tel: 0800 043 1492
Website: http://www.jdoc365.co.uk/jdoc365/

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Overall summary

We carried out a focussed, desk based inspection at JDoc Medical - Wellington Diagnostic Centre on 13 December 2018. We found the service was providing well-led care in accordance with the relevant regulations.

We had previously conducted an announced, comprehensive inspection of the service on 16 August 2018 at which time we found the care being provided was safe, caring, effective and responsive but that it was not being provided in accordance with the relevant regulations relating to well led care. We found the provider had breached Regulation 17 (1) (Good governance) of the Health and Social Care Act 2008 due to governance arrangements not always working effectively. The service wrote to us to tell us what they would do to make improvements and meet the legal requirements.

We undertook this focussed, desk based follow up inspection to check the service had followed their plan and to confirm they had met the legal requirements.

This report only covers our findings in relation to those areas where requirements had not been met. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for JDoc Medical - Wellington Diagnostic Centre on our website at www.cqc.org.uk/location/1-1697990494.

Our key findings across all the areas we inspected were as follows:

• The service had acted to ensure that effective governance systems and processes were in place, clearly set out and understood.

Professor Steve Field

CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Are services well-led?

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

Our findings

When we inspected in August 2018, governance arrangements did not always operate effectively. For example, although staff safely managed medicines, the written protocols governing this activity were either out of date, not specific to the service or not in place. The service also lacked a written patient safety alert protocol and its governance arrangements had failed to identify that service specific phlebotomy training had not taken place. We asked the provider to take action.

At this inspection we noted the service had introduced a medicines management protocol governing the continued safe management of medicines. For example, the protocol now included a service specific procedure to cover ordering, receipt and administration of Controlled Drugs. Written instructions were also now in place regarding how to dispense Controlled Drugs.

We also noted the service had introduced a written protocol for disseminating patient safety alerts to all members of the team. This included protocols for ensuring documentation was retained in instances where patient safety alerts required action to be taken.

In addition, the provider's new pathology test protocol noted that only GPs with full practicing privileges were approved to undertake phlebotomy, which therefore negated the need for governance oversight of the training of the health care assistant who had previously undertaken this role.