The Doctors Laboratory Limited

The Doctors Laboratory

Inspection report

Patient Reception
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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?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We have not rated this service before. We rated it as requires improvement because:

- The service did not make sure that staff were up to date with their mandatory training. Not all staff had up to date training on how to recognise abuse or knew how to escalate safeguarding concerns.
- The service did not control infection risk well.
- The service did not manage waste well.
- Not all staff were trained in basic life support.
- The medicines refrigerator was not checked regularly.
- Staff showed limited understanding of how to report an incident.
- Managers did not appraise staff's work performance regularly.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, the service did not clearly display information about how to give feedback or raise a concern or complain in patient areas. The service did not routinely collect patient feedback.
- There was limited visibility of senior leaders and executives from the company. Leaders only operated some effective governance processes throughout the service. Staff meetings were not held regularly.
- There was limited engagement from leaders with staff and patients.
- Leaders had limited oversight of all the risks and performance issues.

However,

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff kept relevant records of patients' care. The service used systems and processes to safely administer local anaesthetics.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff managed pain well. Staff monitored the effectiveness of care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The service planned and provided care in a way that met the needs of patients. Staff made reasonable adjustments to help patients access services. They coordinated care with referring doctors. People could access the service when they needed it.
- 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
Outpatients	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to The Doctors Laboratory

The Doctors Laboratory, patient reception at Wimpole street is operated by The Doctors Laboratory Limited. The service registered in September 2015, providing blood (phlebotomy) and other sample collection services. It is a private outpatient service in London. The service does not provide services to NHS-funded patients.

The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

At the time of this inspection, there were a registered manager and a nominated individual. The service employed 31 phlebotomists, 10 reception staff and one administrative staff member.

We have not previously inspected this service.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 11 November 2021. We did not give staff any notice that we were coming to inspect. During the inspection, we visited the whole department, including the reception, waiting area and phlebotomy cubicles. We spoke with 11 staff including phlebotomists, reception staff, administration staff and the registered manager. We spoke with seven patients and reviewed four sets of patient records.

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.

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 to have effective systems in place to control infection risk well. (Regulation 12(1))
- The service must ensure that all furniture is well-maintained. (Regulation 12(1))
- The service must audit relevant infection prevention and controls (IPC) practices, including hand hygiene and being bare below the elbow. (Regulation 12(1))
- The service must ensure that staff take appropriate steps when using personal protective equipment (PPE). (Regulation 12(1))
- The service must ensure they are following the Control of Substances Hazardous to Health (COSHH) Regulations 2002. (Regulation 12(1))
- The service must ensure that staff always implement the Aseptic Non-Touch Technique (ANTT) when doing venepuncture. (Regulation 12(1))

Summary of this inspection

- The service must have effective systems and processes for cleaning in line with the 2021 National Standards of Healthcare Cleanliness. (Regulation 12(1))
- The service must have effective systems to manage waste well. (Regulation 12(1))
- The service must ensure that paper sheet rolls used for phlebotomy chairs are stored in line with good IPC practice. (Regulation 12(1))

Action the service SHOULD take to improve:

- The service should ensure staff are up to date with their mandatory training.
- The service should ensure staff are up to date with their safeguarding training and know how to escalate safeguarding concerns.
- The service should consider displaying information regarding needle stick injury (NSI), so staff know what to do in the event of an NSI.
- The service should ensure health and safety audits include all aspects of IPC practice.
- The service should ensure all staff are trained in basic life support.
- The service should ensure the medicines refrigerator is checked regularly.
- The service should ensure staff have good understanding of how to report an incident.
- The service should ensure staff are fully aware of what the term 'duty of candour' (DoC) means.
- The service should appraise staff's work performance regularly.
- The service should consider introducing annual training updates related to venepuncture and Aseptic Non-Touch Technique (ANTT).
- The service should make it easy for patients to give feedback or raise concerns by giving information to them or by displaying the information within the department.
- The service should consider the availability of hearing loops at the reception.
- The provider should improve the visibility of the company's leaders and executive members.
- The service should improve the effectiveness of their governance processes in relation to IPC and staff training compliance monitoring.
- The service should have regular staff meetings.
- The service should improve oversight of all risks and performance issues.
- The service should improve staff engagement and staff feedback mechanisms.

The service should improve patient engagement and proactively seek patient feedback to learn from themes.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Outpatients safe?

Requires Improvement

We have not rated safe before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff were up to date with their training.

Staff received mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training required to be undertaken by all those who worked for the service included: fire safety, environmental awareness, fraud and bribery awareness, good clinical practice, manual handling and display screen equipment. There was a log kept with a record of who had completed this training. However, managers did not make sure that staff were up to date with their training. At the time of inspection, staff compliance with fraud and bribery awareness training was 45%, compliance with fire safety was 55% and compliance with information governance was 35%. A staff member we spoke with was not aware that information governance training has been added to their required learning. We raised this issue with the provider. Following this inspection, data submitted to us showed some improvement in training compliance. Staff compliance with fraud and bribery awareness training improved to 72%, compliance with fire safety improved to 73% and compliance with information governance was 79%.

Safeguarding

Staff understood how to protect patients from abuse. Staff. However, not all staff had training on how to recognise abuse or knew how to escalate safeguarding concerns.

All staff were required to complete safeguarding adults and children training (level two) as part of their mandatory training. At the time of inspection, staff training compliance with safeguarding adults training was 63% and safeguarding children training was 61%. The registered manager and a senior phlebotomist had completed level three adult and children safeguarding training and were the nominated safeguarding lead and deputy lead, respectively. There was an up-to-date safeguarding adult and children policy. All staff we spoke with demonstrated awareness of potential safeguarding issues. However, not all staff knew how to escalate safeguarding concerns. For example, staff told us that they would escalate concerns to the service manager but were not aware that the service manager was also the safeguarding lead, or that another senior phlebotomist was a deputy safeguarding lead.

Requires Improvement

Outpatients

Cleanliness, infection control and hygiene

The service did not control infection risk well.

All areas had suitable furnishings, however not all furniture was well-maintained. Specifically, two patients' chairs in the phlebotomy cubicles had rips in them and were covered with tape. Senior leaders informed that new chairs have been ordered but there has been a delay due to COVID-19.

Reception staff and phlebotomists had a unified dress code and wore their uniforms correctly. However, staff not required to wear uniform were not all bare below the elbow (BBE). For example, the managers and administration staff working within the clinical setting wore full sleeves and some wore watches. The service did not do any BBE audits.

We observed staff washed their hands regularly and between patients, However, the hand hygiene posters were not consistently displayed to promote the seven stage hand washing technique and the 'five Moments for Hand Hygiene'. The service did not conduct hand hygiene audits. We observed that not all staff used appropriate steps when doffing off the personal protective equipment (PPE). For example, not all staff took gloves off first when removing PPE.

We observed that Aseptic Non-Touch Technique (ANTT) was not always implemented when doing venepuncture (a procedure to withdraw blood sample). We observed on two occasions, staff re-palpated the puncture site after disinfecting. There were no posters displayed regarding needle stick injury (NSI), so staff would know what to do in the event of an NSI.

Infection prevention and controls (IPC) training was part of mandatory training programme. At the time of inspection, staff compliance with IPC training was 70%.

The environment appeared clean and there was no clutter visible. Staff said that they would clean the room and equipment at the start of their shift and clean in between patients. The general cleaning service was provided by an external company. We found that no colour coding for cleaning equipment was in place. The domestic cupboard was very cluttered and items were on the floor. There was no national colour coding poster displayed. The cleaning staff showed limited understanding of the cleanliness colour coding system and were not aware of the '2021 National Standards of Healthcare Cleanliness' guidance. Cleaning schedules on the back of door were one week old.

We observed that paper sheets were available in each phlebotomy cubicle to be used to cover the phlebotomy chair. However, the sheet rolls were on a stand on the floor which meant that one side of the roll touched the floor. This was not in line with good infection prevention and controls (IPC) practice.

The service displayed some evidence of COVID-19 safety measures to be undertaken to ensure transmission was minimised and staff and patients remained safe. For example, social distancing and one-way systems, face coverings, hand sanitisation units and seating separation. Information related to COVID-19 signs and symptoms was available for patients on the provider website. However, upon arrival, the reception staff did not ask patients if they were experiencing any COVID-19 symptoms or if they had been in close contact with someone who was experiencing symptoms of COVID 19.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, the service did not manage waste well.

Requires Improvement

Outpatients

The department had nine phlebotomy cubicles, a reception at the entrance and a separate billing reception at the exit. Except for the paediatric phlebotomy room, all cubicles were in the basement. Patients checked in at the main reception and would be directed to the waiting area in the department. Toilets were available in the department. There was seating available in the waiting rooms for patients waiting for appointments.

Due to the nature of the service, there was no resuscitation trolley. Instead, a fully-equipped first aid kit, portable oxygen cylinders and a portable defibrillator were available. The first aid equipment was checked monthly and we saw records of this.

A central log of equipment service and portable appliance testing was kept and all equipment was in date.

The provider's central health and safety team performed monthly environmental audits and provided regular reports related to any non-conformity identified by these audits. They monitored them regularly.

Staff had access to personal protective equipment such as gloves and aprons. These were available in each of the phlebotomy cubicles. Staff told us that there was enough equipment in the department. The provider had a maintenance team that staff could contact if required.

On the day of inspection, we found some cleaning products and a flammable canister of WD-40 stored unlocked in the emergency spill kit cupboard. These were not covered by the Control of Substances Hazardous to Health (COSHH) risk assessments viewed on the day of inspection, meaning there were insufficient control measures in place to prevent or reduce exposure to these hazardous substances.

The provider did not manage the general and clinical waste correctly. For example; for general waste, the provider used waste bins that were not pedal operated. Waste bins within the phlebotomy cubicles did not have signage indicating the type of waste to be disposed of in them. The provider did not use correct colour-coded waste bags as per agreed IPC standards, i.e. black coloured sacks for household waste rather than white bags. We observed that staff disposed of aprons (clinical waste) in the general waste bin which was under the administration staff desk. All the sharp bins we checked were labelled correctly. Though the sharp bins we checked were not full, staff did not use the temporary closure mechanism on most of the sharp bins. The provider conducted an annual clinical waste audit. Any lapse in practice was identified and actions were taken to rectify these. For example, as an action from October 2021 audit, clinical waste bins were placed in each phlebotomy room so sample tubes were correctly disposed of.

Assessing and responding to patient risk

Staff knew how to escalate and manage any patients at risk of deterioration. However, not all staff were trained in basic life support.

Staff responded promptly to any sudden deterioration in a patient's health. On the day of inspection, we saw staff taking appropriate actions to manage a situation where a parent fainted after their child had a blood test. There was a managing a deteriorating patient policy. Staff informed that in the event of an emergency they would call emergency services using 999.

Nine staff members had basic life support training (BLS) and five first aiders had first aid at work and paediatric basic life support training. One staff member who was a level three first aider. The practice service manager told us that they were in the process of booking all staff onto a life support training course.

Requires Improvement

Outpatients

Staff doing venepuncture were courteous and performed this practice with care and dedication, quoting aspects of policy they had been trained to follow. Staff shared key information to keep patients safe when handing over the test samples to the laboratory or liaising with the referring doctor.

All paediatric patients were attended by two phlebotomists trained to carry out paediatric venepuncture.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave bank, agency staff a full induction.

The service had enough phlebotomists and support staff to keep patients safe. Managers accurately calculated and reviewed the number of staff needed for each shift. At the time of the inspection, the service had no vacancies. The service had low turnover rates (4.76%) and sickness rates (7.95%).

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Records

Staff kept relevant records of patients' care. Records were clear, up to date, stored securely and easily available to all staff providing care.

Due to the nature of the service, limited but relevant patient information was kept and all staff could access this easily.

Patients attended the department with a test request form, which was scanned and linked to an electronic bar code system to record the patient journey in the service. The paper forms were then sent to the main laboratory along with the test samples.

For paediatric patients, additional information was recorded on the referral forms. For example, any known allergies, weight and maximum collection volume, any blood tests done in the last four weeks, consent given by the child/parent and if the patient required any local anaesthetic.

Medicines

The service used systems and processes to safely administer local anaesthetics. However, the medicines refrigerator was not checked regularly.

Due to the nature of the service, the department only used local anaesthetic cream and spray. Staff told us that these were mainly used for paediatric patients. Staff stored and managed local anaesthetics safely.

Local anaesthetics stored in a refrigerator seen during the inspection were found to be in date. However, refrigerator checks were not completed daily as required on the temperature logs. For example, no checks were completed for three days in September, nine days in October and one day in November 2021.

Incidents

Staff showed limited understanding of how to report an incident.

Requires Improvement

Outpatients

Staff had a clear understanding of what an incident was but showed limited understanding of how to report it. Staff told us that they would inform the manager and email the administrator to log it on the electronic system. However, none of the staff were familiar with the incident form used.

Between January 20201 and November 2021, three incidents had been reported. Actions were taken to reduce the risk of re-occurrence of a similar type of incident. The service had no never events and no serious incident reported since it became operational.

The service monitored and kept a daily log of any phlebotomy errors. Between January 2021 and October 2021, 106 errors were reported. Out of these 106 errors, 79 were related to missing samples, 24 were related to wrong samples being collected and three were related to mislabelling of samples. We saw that actions were taken to reduce these errors. For example, most errors were due to coding so more experienced staff were assigned to coding duties.

Were things to go wrong, staff told us they would apologise and give patients honest information and suitable support. The provider had a duty of candour policy. However, not all staff were fully aware of what the term 'duty of candour' (DoC) meant and they did not receive any training. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The provider had a process to ensure actions from patient safety alerts were implemented and monitored.

Are Outpatients effective?

Inspected but not rated

We don't rate effective in outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were available and accessible through the company's electronic systems. Policies viewed as part of our inspection were found to be in date. Staff in the service had access to policies such as incident reporting, safeguarding and venepuncture, amongst others. All staff were required to sign once they had read the policies and a log of this was kept by the managers.

The service had a programme of repeated audits to check improvement over time. There were action plans and non-conformities were monitored. Results of these audits and any learning were shared with staff in meetings, via staff communication form and were available on a shared drive.

Nutrition and hydration

Staff made sure patients had access to drinks.

Water dispensers were available throughout the department.

Requires Improvement

Outpatients

Pain relief

Staff managed pain well.

Due to the nature of the service, pain relief was not generally provided. Local anaesthetic cream and spray was provided for paediatric or anxious patients. All patients we spoke with told us that the bloods were taken with minimum pain and staff were considerate of this while performing the procedure.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations. The service monitored and kept a daily error log of any phlebotomy appointments that required a follow-up rebleed or follow-up home visits. Between January 2021 and October 2021, phlebotomy errors that required follow-up rebleed ranged between 2% and 16%. In the same reporting period, phlebotomy errors that required follow-up home visit ranged between 0% and 9%. Managers and staff used the results to improve patients' outcomes. Patients were offered free of charge follow-up appointments or home visits for any rebleed due to an error.

Competent staff

The service made sure staff were competent for their roles. However, managers did not appraise staff's work performance regularly.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All phlebotomy staff had certificates of competency in phlebotomy and some of the phlebotomy staff were also registered nurses. Managers gave all new staff a full induction tailored to their role before they started work. All phlebotomists were required to complete a training programme which was observed by a phlebotomy trainer before they could deal with patients independently.

As part of their annual appraisal, all phlebotomists were required to complete competency checks. At the time of inspection, we were informed that none of the phlebotomy staff had their appraisal or competency checked in 2021. Managers informed us that there had been a delay in completing all appraisals this year due to the absence of the main appraisee. Following the inspection, data submitted to us showed that 75% of staff had their appraisal, with the remaining 25% either new starters or on leave.

Along with the central training and development department, the phlebotomy trainer supported the learning and development needs of clinical staff. However, the service had no recognised annual training update identified for venepuncture. Aseptic Non-Touch Technique (ANTT) training was not an annual mandated training module for clinical staff.

We saw an induction checklist for couriers that included guidance on how to transport medical samples.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Clinical and non-clinical staff worked together as a team to benefit patients. They supported each other to provide good care. Staff told us there were positive working relationships between all individuals.

Requires Improvement

Outpatients

Seven-day services

Key services were available to support timely patient care

The service was available 7am to 7pm Monday to Friday, and 7am to 1pm on Saturday.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to give samples was based on all the information available. Staff could describe gaining verbal consent from parents of paediatric patients. A system was in place to remind staff to seek verbal consent from parents. For example, a sticker was placed on all paediatric test request forms by reception staff for phlebotomists to complete once the verbal consent was sought.

Written consent was taken for DNA testing only. The completed consent form was sent to the main laboratory along with the test sample.

Are Outpatients caring?

Good

We have not rated caring before. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff followed local policy to keep patient care and treatment confidential. Staff were friendly, approachable and introduced themselves to patients. Patient feedback regarding care and treatment during the inspection was positive. Patient comments indicated the staff were "friendly and welcoming", treated them well and with kindness and their experience was "excellent".

Privacy and dignity were maintained in the areas we visited by ensuring doors were closed as required. We observed that the reception staff took extra care to ensure patients could speak without being overheard at the reception desk. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff were able to describe how they would provide reassurance and support for nervous and anxious patients. For paediatric patients, various reward items were given to them. For example, colouring pencils and books, reward stickers and soft toys (in sealed packs).

Requires Improvement

Outpatients

We spoke with six patients after their venepuncture, and they told us that they had received a good service and they commended the staff for their care and professionalism. We observed one patient who requested to see the same phlebotomist and this request was accommodated.

Understanding and involvement of patients and those close to them

Staff supported patients to understand the tests and make decisions about their care and treatment. However, the service did not routinely collect patient feedback.

Staff made sure patients understood their tests. Staff talked with patients, families and carers in a way they could understand.

The services did not routinely collect patient feedback. During the COVID-19 pandemic, the service stopped using the patient feedback cards. Patients were able to provide feedback via email, and we saw various examples of positive feedback from patients in this format. However, no information on how to give feedback was given to patients or displayed within the department and feedback was not collated to learn from any themes.

Are Outpatients responsive?

Good

We have not rated responsive before. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of patients.

Leaders described the way they planned and managed services across the department. Staff across the department worked with the main laboratory and referring doctors to meet the needs of people attending the service. Capacity and demand were managed by the department's leadership team.

Facilities and premises were appropriate for the services being delivered. No appointment was required for routine tests. For specialist tests, there was a choice of appointments available to patients and appointment times varied depending on the needs of the patients.

The service's location was close to public transport links.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with referring doctors.

The service had a ramp and lift available, enabling disabled access. There were various sample collection information leaflets available on the company website, on topics such as urine collection for children, lactose tolerance tests and glucose tolerance tests. There was signage directing patients and visitors to the various parts of the department.

Translation and Interpreter services were available and accessible as required. The provider made reasonable adjustments to meet the needs of people with learning difficulties. However, we found that there was no hearing loop available at the reception.

Requires Improvement

Outpatients

Access and flow

People could access the service when they needed it.

Patients could arrange an appointment by telephone or via the company's website for special/extended tests, such as glucose tolerance tests. Appointments could be made for a home visit for any tests.

Managers monitored waiting times and made sure patients could access services when needed.

The department audited the turnaround time between when patients were booked at the reception until they were seen by a phlebotomist. Between January 2021 and October 2021, between 90% and 95% of patients were seen within five minutes. Managers used information from the audits to improve care and treatment.

A non-clinical staff member had been introduced to escort patients from the waiting area to the phlebotomy cubicles and back to the patient reception area. This was to improve patient flow and implement a one-way patient flow system around the premises, improving compliance with the social distancing and IPC guidelines in response to the COVID-19 pandemic.

Learning from complaints and concerns

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, no information was available for people to give feedback and raise concerns about care they received.

Patients knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Leaders told us they would try and resolve complaints informally if appropriate, but the complaint would be addressed formally if required. Between January 2021 and November 2021, there had been three formal complaints. Managers investigated these complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. However, the service did not clearly display information about how to raise a concern or complain in patient areas.

Are Outpatients well-led?

Requires Improvement

We have not rated well-led before. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. However, there was limited visibility of senior leaders and executives from the wider parent company.

There was a clear leadership structure in place across the service. There was a patient service manager and a deputy service manager, who were supported by administration staff. Both the managers were trained phlebotomists. The patient service manager reported to the director of business development and service.

Requires Improvement

Outpatients

Local managers had an open-door policy and were visible in the service. Staff told us that local managers were approachable and supportive. However, there was limited visibility of senior leaders and executive teams from the wider parent company.

Leaders described the challenges and planned improvements to the service, which included additional rooms to be added in the service to cope with the demand.

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.

There was a clear strategy in place for the service and this could be described by the senior leadership team. The company's values were on display in the department. There was also a company strategy and leaders told us the local strategy aligned with the overall company's strategy. Leaders told us the current plans were focused on expanding the service. The registered manager and management staff understood and knew how to apply those plans in practice and monitor progress.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development.

Staff we met were welcoming, friendly and helpful. Staff felt positive about working in the service. There was a culture centred on the needs and experience of people who used the service. The culture encouraged staff to be open and honest with each other and the people who used the service. There were systems in place which allowed staff to access career development opportunities. Staff described their working relationship with colleagues to be positive and we found there to be a positive culture of teamwork.

Governance

Leaders operated some effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities. However, local teams did not have regular opportunities to meet, discuss and learn from the performance of the service.

There were governance processes in place across the department and leaders could describe these processes. Quality management meetings were held every three months with the company's quality manager to discuss incidents, policies, audits, equipment and staff training. We saw minutes from three previous meetings, which were of limited effectiveness. These meetings did not identify cleaning and IPC issues or low appraisal rate as areas of concern. Managers informed us that due to the unavailability of key staff and annual leave, the department had been unable to carry out full staff meetings this year. Only one meeting had been held in October 2021. Instead, staff communication was sent out each month and all staff were required to read and sign this.

An audit programme was in place to monitor the quality of services being provided.

We saw that policies were in place for key governance topics such as risk management, safeguarding and management of complaints and incidents.

Management of risk, issues and performance

Leaders and teams had limited oversight of all the risks and performance issues.

The company had an up-to-date risk management framework. There was a company risk register that was reviewed regularly. Leaders could describe current risks mitigation around each risk. Leaders informed us that there was no separate local risk register and there were no risks on the company risk register which related to the location we inspected. The company's central health and safety team undertook various risk assessments in conjunction with service leads. We saw risk assessments for fire safety, health and safety, COVID-19 and legionella. However, infection prevention and control issues, low staff compliance with mandatory training and lack of appraisal were not on the service's risk register. This indicates that senior leaders at the company had limited oversight of all the issues faced by the service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, and to make decisions and improvements. The information systems were integrated and secure.

Leaders had access to information relating to performance. There was access to electronic information systems such as the incident reporting systems and error logs.

There were notice boards and information boards on display in the department to provide information to staff.

Policies and procedures seen during the inspection were in date.

Engagement

There was limited engagement from leaders with staff and patients.

The service kept records of the minutes of the staff meetings which focused on operational issues, service developments and learning and improvement. However, there had been only one staff meeting this year. A monthly 'staff communication form' was distributed to all staff to share information and highlight operational changes. The provider completed annual staff surveys to enable staff feedback. However, most staff we spoke with were not aware of this.

The service had an easily accessible website and patients were able to leave feedback and contact the service. This showed patients were able to engage with the service online and verbally. The department also reviewed any comments or reviews left online. Senior leaders informed us that due to COVID-19 they stopped using comment cards and asked patients to give feedback via email. However, the service did not proactively seek patient feedback or carry out any formal patient survey.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The department had considered improvements to the service and department as part of the overall company's strategy. The department used audits to assess and monitor the performance of the department and to make improvements where required.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12 (1) (2)(h) – assessing the risk of, and preventing, detecting and controlling the spread of, infection, including those that are health care associated.