Courthouse Clinics Body Limited

Courthouse Clinics Body Limited Wimpole St

Inspection report

30B Wimpole Street
London
W1G 8YB
Tel:02039078828
Website: Website: www.courthouseclinics.com

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Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
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. This service was not inspected before.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at, The Courthouse Clinics Body Limited Wimpole St. The service is registered with the Care Quality Commission to provide; Surgical Procedures, Diagnostics and Screening and Treatment of Disease, Disorder and Injury. Courthouse Clinics Body Limited Wimpole St provides a range of non-surgical cosmetic interventions, for example anti-aging aesthetic procedures and laser hair removal

Summary of findings

which are not within CQC scope of registration. Therefore, we did report on these services. We were told by the managers on site that, Fat Freezing, skin tightening, Vitamin IV Infusions were no longer being provided from the clinic. The provider Courthouse Clinics Body Limited has seven other locations nationally registered with CQC providing a range of face, non- medicinal weight loss, body and skin treatments privately.

One of the directors 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 people. 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. The clinic manager 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 patient feedback on the service through nine CQC comment cards. All were positive about the service they received and were very complimentary about the staff and the convenience of the services offered.

Our key findings were:

•Staff dealt with patients with kindness and respect and involved them in decisions about their care.

•The clinic did not provide care in a way that kept patients safe and protected them from avoidable harm.

•There was no defibrillator for use on site and no risk assessment had had undertaken to mitigate the lack of a defibrillator.

•The way the clinic was led and managed did not promote the delivery of high-quality, person-centred care.

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

•Ensure 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.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Courthouse Clinics Body Limited Wimpole St

Detailed findings

Background to this inspection

Courthouse Clinics Body Limited Wimpole Street is located at;

30B Wimpole Street

London

W1G 8YB

The provider is registered with CQC to provide the following activities:

- Diagnostic and Screening procedures
- Treatment of Disease, Disorder, Injury (TDDI)
- Surgical procedures

The clinic provides a range of services including the delivery of non-medicinal weight loss under the supervision of a qualified doctor. According to the provider only twenty five percent of services delivered are regulated by the Care Quality Commission, which is the non-medicinal weight loss. Therefore, this inspection report only covers on this aspect of the service.

The clinic does not provide services to patients below 18 years of age.

The clinic is based in central London. The service is provided across two floors. The service is open from 9am to 20:30pm Monday to Thursday with the exception of Fridays and Saturdays when the service is open between 9am to 5pm and 9am to 16:30pm respectively.

Patients can access appointments by telephone or in person. The clinic uses the services of visiting doctors. There is a clinic manager and administrative staff on site. The service uses a call centre located at one of the providers locations to answer calls and carry out other administrative duties across the providers other locations.

During our visit we talked to staff, observed the premises and reviewed documents.

How we inspected this service

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

Requires improvement

Are services safe?

Our findings

We rated safe as Requires improvement because:

- The provider had not thoroughly considered the risks of not having a defibrillator and was not undertaking identity checks on patients to ensure they were over the age of 18.
- The system for ensuring that oxygen was in good working order was not being followed. However, the safety concerns that were identified were rectified soon after our inspection. The provider sent us risk assessments that were undertaken or updated. Therefore, the likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor (see full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- The provider did not conduct a range of safety risk assessments. Staff received safety information from the service as part of their induction and refresher training. However, the clinic did not have a system to safeguard children from abuse. The service was not undertaking ID checks and there was no system in place to determine if a potential patient was under 18 years. On the day of the inspection, staff we spoke with including the clinic managers advised that ID checks would only be requested if a patient looked younger than 18. The service had not completed a risk assessment for not undertaking ID checks to prevent children from using the service. Following our inspection, we received communication from the provider advising that they had completed a risk assessment for completing ID checks. This outlined the processes that were now in place to verify the age of patients using the service to ensure they did not offer them to children.
- The provider carried out staff checks at the time of recruitment and on an on-going basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS 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).
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. However not all clinical staff had undertaken child safeguarding to level three. The manager explained that, this was because services were not offered to children.
- 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 no 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 at the service had not received training on the identification of acutely unwell patients and deteriorating patients including sepsis. The provider advised us that acutely unwell patients did not use the services they offered. However, it was our view that staff would benefit from receiving training that enabled them to identify unwell patients. Some emergency medicines were held at the clinic which included an anaphylaxis kit and oxygen. However, we saw no evidence that the oxygen was checked regularly to ensure it was in good working order. We checked the oxygen while on inspection and found that it was working well. Following our inspection, we received information from the provider outlining that it was policy to check the oxygen on a regular basis. However, this policy was not being followed at the time of our inspection and action had been taken to ensure this is monitored going forward.
- The emergency medicines were stored securely but accessible if needed and staff new of their location. The clinic had decided to store some emergency medicines but not all. We were advised after our inspection by the provider that the clinic's responsible officer had

Requires improvement

Are services safe?

undertaken a risk assessment outlining the medicines required in emergencies. These were a small number due to the reduced risks associated with the non-medicinal weight loss.

- Records seen showed that staff had undertaken basic life support and first aid training. However, the service did not have a defibrillator on site and they had not risk assessed the reason for not having one. Staff had been provided with a map of a service nearby which was 0.4 miles away or 10-minute walk where they could go and request for a defibrillator. The clinic manager confirmed this arrangement when we spoke to them. However, it was clear that theprovider had not thoroughly thought this through as no formal agreement was in place with other provider who had the defibrillator, and this had not been risk assessed. Following our inspection, the provider sent us a risk assessment that they reported to have had in place prior to our inspection. This risk assessment outlined the steps staff were to follow during an emergency. Other information in the risk assessment were the need for staff to have training, ensure the Oxygen was checked and in good working order. The risk assessment further outlined that a defibrillator was to be found at nearby sites and this information was to be provided at emergency check points within the clinic. However, we have still judged that improvements are required based on the fact that; Oxygen that is vital in an emergencywas not being checked. Secondly, the risk assessment relating to the defibrillator, still needs improvement as it does not contain all the specifics details relating to the location of the nearest defibrillator and the arrangements the provider has made to ensure that this equipment will besafe to use.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was not available to relevant staff in an accessible way. Records viewed showed that patient information was not obtained in full. We viewed three records. However only one record related to a patient receiving care for the services we were inspecting.
- The service did not have systems for sharing information with other agencies to enable them to deliver safe care and treatment. For example, from the care record we viewed, the patients GP details had not been documented. It was not clear if the patient had been asked this information and had refused to provide it. We also saw an example where patient records had been transferred from one of the provider's other locations as the patient had moved to London. These records had been scanned and emailed across. The patients name had been removed from the record, and an ID number was in place. The clinic managers could not demonstrate how these records would be matched to the right patient.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- We were told by the clinic managers that the doctors prescribed antibiotics to patients when required. However, we were not shown the protocols that the doctors worked to. Following our inspection, the provider wrote to us to, reporting that this was incorrect as it was not relevant to their line of work.
- We found that the fridge used to store medicines was not working well. The thermometer was showing a maximum of 27.2 degree Celsius. Furthermore, the fridge did not have a second thermometer as required for the safe keeping of vaccines and medicines. However, at the time of our inspection there were no medicines stored in the fridge related to the regulated activities we were inspecting. Following our inspection, the provider wrote to us to report that they had ordered new fridge thermometers. However, they reported that the fridge was used to store medicines related to services we did not regulate.
- No medicines were used in the provision of the weight loss programme.

Track record on safety and incidents

Requires improvement

Are services safe?

- There were comprehensive risk assessments in relation to safety issues relating to staff recruitment and premises.

Lessons learned, and improvements made

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. However, on the day of the inspection we saw no evidence of how these were shared. Following our inspection, the provider wrote to us explaining, that the system used for sharing SEAs was the same across all of the providers locations and this was a centralised system. However, on the day of the inspection the managers we spoke with were not fully aware of the process.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents. They further explained that significant event analysis was completed quarterly at MAC meetings and the information was circulated to all team members. Moving forward they were planning to ensure that these minutes were signed by all staff for reference.

  When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Requires improvement because: We saw no evidence of completed audits, the system of seeking patient consent was not being followed with records not being documented appropriately.

Effective needs assessment, care and treatment

- During our inspection there were no clinicians who delivered the services we were inspecting. Therefore, we were unable to confirm if patients care and treatment needs were assessed and planned in line with guidelines.

Monitoring care and treatment

- We saw no evidence of the use of completed audits in improving patient quality. The clinic manager advised that each clinician completed audits relating to the care they were delivering. Following our inspection, the provider advised that audits were completed quarterly in readiness for MAC meetings to identify trends in treatments, results and incidents and appropriate actions implemented. The provider also sent to us an audit relating to Sclerotherapy, a procedure to treat blood vessels or blood vessel malformation. However, this was not a completed audit cycle and it was not clear if this related to the care being provided at the clinic. Following our inspection, the provider wrote to us and explained that; all clinicians were provided with regular clinical training relevant to their skills and practice at least three times per year. They also reported that the medical director, disseminated any relevant information related to practice and reviewed policies and protocols to ensure they were current and in line with legislation.

Effective staffing

- The provider had an induction programme for all newly appointed staff.
- Relevant medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation. We were advised that all records were monitored and kept centrally.

Coordinating patient care and information sharing

- We were told that all patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. However, an example of records we viewed had not been fully completed. From the documentation it was not clear if the patient had been asked and then declined sharing information with their GP.

Supporting patients to live healthier lives

- Where appropriate, staff gave people advice, so they could self-care. Staff explained that patients were seen on a weekly basis for on- going support while on the weight loss programme.

Consent to care and treatment

The service did not obtain consent to care and treatment in line with legislation and guidance.

Records viewed demonstrated that consent had not been sought and discussed with the patients' no clinical staff were on duty, hence we were unable to speak with them further to verify the processes that was in place when seeking patients consent.

Good

Are services caring?

Our findings

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Patients told us through comment cards, that they felt listened to and supported by staff.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated responsive as Good because:

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- However, we saw no evidence that reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was no hearing loop or step free access. Staff we spoke with advised that patients were referred to a more suitable branch if they had reasonable adjustments.

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 reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. On the day of the inspection, we were not able to confirm how the clinic learned from complaints. However, the provider sent us information after the inspection advising that all complaints were centrally reviewed with outcomes communicated to staff at MAC meetings.

Are services well-led?

Requires improvement

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

Our findings

We rated well-led as Requires improvement because:

They were concerns regarding the governance of the clinic. We found that checks for areas such as oxygen were not being carried out and the management had failed to identify this prior to our inspection. Other risk assessments relating to ID check requirements and risk assessments relating to lack of some emergency equipment were not thoroughly completed.

Leadership capacity and capability;

- On the day of the inspection the clinic managers we spoke with did not appear to be knowledgeable about issues and priorities relating to the quality and future of the clinic.

Vision and strategy

The service had a vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

- Staff felt respected, supported and valued. They were proud to work for the service.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance arrangements

There was no clear responsibilities, roles and systems of accountability to support good governance and management.

The service had an overarching governance framework in place to support the delivery of good care. However, there were gaps in some areas of governance:

- On the day of the inspection, they were concerns regarding the governance of the clinic. Risk assessments relating to ID check requirements and risk assessments relating to lack of some emergency equipment had not been carried out.
- The provider had policies for most key areas. However, these polices were not being followed to
- Following the inspection, the provider with responsibility for governance wrote to us. They explained that the governance systems used by the services were the similar to all their locations and were monitored centrally. However, they had failed to identify the concerns we found at this particular location and therefore we are concerned about the lack of monitoring at the clinic we visited.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There were no effective, processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the service had failed to identify the risks associated with the lack of ID checks to ensure patients under 18 did not access the service. This was rectified after our inspection but had not been assessed as a risk prior, with measures put in place to support staff to ensure only age appropriate patients were registered with the service.
- We could not evidence a system in place that ensured the performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. For example, a patient record viewed was incomplete. The patient's personal details had not been fully completed.
- We saw no evidence of clinical audit and the impact on quality of care and outcomes for patients. The provider did write to us to state that they undertook audits of SEAs and Complaints. However, there was no specific evidence of clinical audits being completed as these were undertaken by each individual clinician. After our inspection the provider sent to us, a one cycle clinical audit. We were not clear if this was related to the work being offered at the clinic. However, they also explained to us that they had plans to undertake other audits in the near future.

Are services well-led?

Requires improvement

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

Appropriate and accurate information

- On the inspection day, we found no evidence that quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Following our inspection, the provider wrote to us and explained that meetings were held, and information was shared centrally. However, they were planning to improve the system in place to ensure all staff are aware.

Engagement with patients, the public, staff and external partners

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

- The public's, patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Regular patient surveys were carried out with appropriate action being taken following such feedback.
- Staff could describe to us the systems in place to give feedback.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems and processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. The system in place for checking that emergency equipment such as oxygen was in good working order was not being followed. The provider had not thoroughly carried out a risk assessment to mitigate lack of a defibrillator. The provider had not assessed the risk of not undertaking ID checks, to ensure care was not provided to children. Systems in place for quality monitoring had not identified poor record keeping and the lack of consent monitoring. There was no consistent system for sharing learning significant events. Governance arrangements relating to the leadership of the service were lacking at the clinic. This is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.