Med-Pol Ltd

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection at Med-Pol Medical Centre on 14 December 2017 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We have told the provider to take action (see full details of this action in the Requirement Notice at the end of this report).

Are services caring?

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

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Med-Pol Ltd is a private medical clinic, which provides services in the following areas: gynaecology and maternity services, surgery, dermatology, urology and general practice. All doctors working in the clinic are Polish and the service is mainly accessed by the Polish community.

The service is registered with the Care Quality Commission to provide the regulated activities of:

Diagnostic and screening, Surgical procedures, Family Planning and Treatment of disease, disorder and injury.

We received 31 completed comment cards all of which were very positive about the service and indicated that patients were treated with kindness and respect. Staff were described as helpful, caring, thorough and professional.

Our key findings were:

Summary of findings

- There was evidence in place to support that the service carried out assessments and treatment in line with relevant and current evidence based guidance and standards.
- Systems were in place to deal with medical emergencies and staff were trained in basic life support.
- The information needed to plan and deliver care and treatment was available to staff in a timely and accessible way.
- There was evidence to demonstrate that the service operated a safe and timely referral process.
- The provider operated safe and effective recruitment procedures to ensure staff were suitable for their role.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring that high quality care was delivered by the service.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- CQC comment cards completed by patients were very positive about the standard of care they received.
- Systems were in place to protect personal information about patients.
- Although most risks to patients were assessed and monitored, the service had not ensured those associated with legionella were suitably assessed.
- There was no evidence the service undertook any clinical improvement activity such as audit.
- The service had policies and procedures to govern activity, but some of those we reviewed needed updating as they contained out-dated information.
- The service had a complaints policy in place and information about how to make a complaint was available for patients, however we found that complaints were dealt with informally and not in line with the policy.

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

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

- Review all risks associated with the service's premises and ensure formal risk assessments are carried out at regular intervals to reduce risks to patients and staff, for example, legionella.
- Review and maintain records of fire drills as outlined in the fire risk assessment.
- Strengthen the service's governance arrangements, in particular, complaints handling, meetings, practice policies and risk management.
- Review how patients who are fully reliant on a wheelchair can access the service.
- Review and update the business continuity plan to include emergency contact number for all staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations. We found areas where improvements should be made relating to the safe provision of treatment. This was because the provider did not have a legionella risk assessment at the time of our inspection and record of fire drills were not maintained.

- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguard them from abuse.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- We reviewed personnel files for all members of staff and found the service undertook
- Most risks to patients were assessed and managed, regular fire drills and they had not undertaken a legionella risk assessment.
- The service had a business continuity plan, however it did not include emergency contact number for staff.
- The provider was aware of the requirements of the Duty of Candour. Staff told us the provider encouraged a culture of openness and honesty.
- The service had systems in place to monitor the usage and movement of blank prescription forms.
- Procedures were in place to ensure appropriate standards of hygiene were maintained and to prevent the spread of infection.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care.

- Patients' needs were assessed and care was planned and delivered in line with best practice guidance.
- Systems were in place to ensure appropriate record keeping and the security of patient records.
- Staff were aware of most current evidence based guidance.
- The practice had systems to keep all clinical staff up to date.
- There was no evidence the service undertook any clinical improvement activity such as audit
- The service had arrangements in place to share information appropriately for example, when patients were referred to other services.
- There was evidence of appraisals and personal development plans for all staff.

Are services caring?

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

- CQC comment cards completed by patients were very positive about the standard of care they received.
- The service provided facilities to help patients be involved in decisions about their care.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- The services latest customer satisfaction survey results indicated that patients felt their dignity was respected during examinations with the doctor.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

Summary of findings

- The premises were suitable for the service provided. There were facilities in place for people with disabilities and for people with mobility difficulties.
- Translation and interpreting services were available for those who did not have Polish as a first language.
- Appointments could be booked over the telephone, face to face and online.
- Patients had a choice of time and day when booking their appointment.
- The service had a complaints policy in place and information about how to make a complaint was available for patients, however we found that complaints were dealt with informally and not in line with the policy.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The service had a vision and that was to provide professional diagnostics and treatment in accordance with the principles of medical ethics and respect for patients' rights.
- The service had policies and procedures to govern activity, but some of those we sampled needed updating.
- The service had systems in place which ensured patients' data remained confidential and secured at all times.
- The service proactively sought feedback from patients.
- There was a focus on learning and development; clinical staff attended various medical conferences and training sessions as part of their personal and continuing professional development.

Med-Pol Ltd

Detailed findings

Background to this inspection

Med-Pol Limited is a private medical clinic located on the first floor of a three storey building in a busy and popular area close to Central London. It is well served by local buses and London Underground. The service is registered with the Care Quality Commission to provide the following regulated activities from 94a Whitechapel High Street, London, E1 7RA.

- Diagnostic and screening
- Surgical procedures
- Family Planning
- Treatment of disease, disorder and injury.

Med-pol has been providing services from their present location for over eight years and is accessed mainly by Polish speaking patients. General practice, urology, dermatology, and gynaecology services are provided by two female and two male doctors. Administrative support is provided by one female reception staff. The service sees 120 patients on average each month and maintained comprehensive medical records for all patients. Patients who require further investigations or any additional support are referred on to other services such as their NHS GP or an alternative health provider.

The service's opening hours are Friday 3pm to 9pm and Saturday 9am to 4pm, however earlier and later appointments are available on request. The service also offers online and telephone advice to their regular patients.

A registered manager is in place. 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.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector and included a GP Specialist Advisor . Interpreting and translation was carried out by a CQC certified Interpreter/ translator. Before visiting, we reviewed a range of information we hold about the service.

During our visit we:

- Looked at the systems in place for the running of the service.
- Explored how clinical decisions were made.
- Viewed a sample of key policies and procedures.
- Spoke with two doctors, one of whom was the registered manager.
- Viewed anonymised patient records.
- Made observations of the environment and infection control measures.
- Reviewed 31 CQC comment cards including those which were in Polish.

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?

Detailed findings

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff electronically and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a flow chart at the end of the policy which outlined who to contact for further guidance, for example if staff had safeguarding concerns, however this was not on display at the time of inspection. The registered manager led on safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. All four doctors employed by the service were trained to child protection or child safeguarding level three and receptionist to level one.
- There was a chaperone policy and a notice in the waiting room advised patients that chaperones were available if required. The receptionist had received formal chaperone training, but had not received a Disclosure and Barring Service (DBS) check. We saw evidence an application had been submitted for this member of staff. (DBS
- We reviewed personnel files for all members of staff and found the service undertook
- We observed the premises to be visibly clean and tidy and we saw that cleaning schedules were maintained. Clinical waste was disposed of in a suitable manner and those awaiting collection were stored in a lockable cupboard. Staff had access to personal protective equipment (PPE) such as disposable gloves and aprons.
- The registered manager was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and all staff had received up to date training. There was some evidence infection control audits were undertaken, for example we saw that the service completed a clinical waste audit in March 2016 and we saw evidence that action was taken to address any improvements identified. We noted at the time of our inspection that the service had not undertaken an audit in 2017.

Risks to patients

- There was a health and safety policy available and all staff had received health and safety training.
- The service undertook a fire risk assessment in December 2017 and we received evidence that action was taken to address any improvements identified as a result. From conversations had with a member of staff, we were told fire drills were carried out by the landlord, however records were not maintained to demonstrate this was done. We did see evidence that fire alarms were tested weekly to ensure they were in good working order. There were designated fire marshals within the practice who had received appropriate training. There was a fire evacuation plan which identified how staff could support patients with mobility problems to evacuatethe premises. The building itself was not accessible for wheelchair-bound individuals, despite a lift installed (the lift was too small to permit transporting a wheelchair). Staff members were suitably trained to offer reasonable arrangements for means of escape for persons with other disabilities.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as electrical installation testing and inspection. We noted that the practice had not carried out a Legionella risk assessment and there was no evidence the risks associated with legionella were monitored. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Following the inspection, the service told us that a risk assessment for legionella had been carried out, however they were awaiting test results from the Legionella Water analysis.
- There were enough staff to meet the demands of the service.
- The practice had adequate arrangements to respond to emergencies and major incidents. During our visit we saw that the service had a defibrillator and oxygen with

adult masks on site; all staff had received training on how to use these equipment. all staff had received annual basic life support training. There was a comprehensive business continuity plan for major incidents such as power failure or building damage, however the plan did not include emergency contact numbers for staff.

Information to deliver safe care and treatment

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system. This included investigation and test results, health assessment reports and advice and treatment plans.
- We saw some evidence national safety alerts were disseminated by doctors, for example, one alert we reviewed related to "good practice in prescribing and managing medicines and devices." This was discussed amongst the four doctors in their bi-monthly meeting. The service had a Medicine and Healthcare products Regulatory Agency (MHRA) policy as well as an incoming alert log sheet.

Safe and appropriate use of medicines

There were no medicines held on the premises, with the exception of emergency medicines for use in a medical emergency; these were all stored securely in a lockable cupboard. The service had systems in place which ensured blank prescription forms were managed and secured appropriately.

Track record on safety

A system was in place for recording, reporting and investigating serious events. Although there had been no serious events recorded over the past 12 months, both doctors we spoke with told us they would feel confident to raise any events or concerns. The service had ensured staff had access to this policy and an incident reporting template was also available.

Lessons learned and improvements made

The service had a Duty of Candour policy and the doctors we spoke with on the day of inspection were aware of and complied with this. The doctors told us they encouraged a culture of openness and honesty. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The service had a notifiable safety incident policy which detailed the process for reporting patient safety incidents to the National Reporting and Learning System (NRLS).

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

- There was evidence in place to support that the service carried out assessments and treatment in line with relevant and current evidence based guidance and standards. Doctors assessed patients' needs and delivered care in line with National Institute for Health and Care Excellence. We saw evidence that the four doctors met bi-monthly where various clinical topics were discussed; this included topics such as bacterial resistance, superbug amongst others.

Monitoring care and treatment

- There was no evidence of clinical quality improvement activity and the service could not demonstrate how they monitored patient outcomes. Clinical audit is a methodical processthat seeks to identify and promotes good practice, leads to improvements in patient care and provides information about the effectiveness of the service. At the time of our inspection, the service did not meet this standard and there was no evidence of any other clinical quality improvement activity.
- The service monitored adherence to best practice for infection control standards, maintenance of staff recruitment records and staff training; this helped to ensure that recruitment standards and training needs were effectively managed as part of a continuous monitoring process.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The service had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, COSHH, fire safety, health and safety and confidentiality.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff.For example, for specialist doctors in gynaecology, urology and dermatology.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included coaching and mentoring, clinical supervision and facilitation and support for revalidating doctors. Doctors appraisal were up to date and all had been revalidated by the General Medical Council (GMC).

Coordinating patient care and information sharing

When a patient used the service they were asked if the details of their consultation could be shared with their registered GP and we saw that patient consent was sought and documented in line with the General medical Council's (GMC) guidelines. We reviewed anonymised referrals made to other services and found that these were detailed and done in a timely manner. Patients were informed of test results by telephone and or letter depending on their preferred communication method. During the inspection we were satisfied that the service had effective systems in place for coordinating patient care and sharing information as and when required.

Consent to care and treatment

The practice had a policy for obtaining consent from patients before any care or treatment was provided. In addition, clinicians had access to a consent checklist which purpose was to reduce mistakes and ensure consistency in how the service obtained consent. There was clear information available in English and Polish with regards to the services provided and the cost of these. As part of our visit we reviewed a random selection of consultation records of patients who used the service. We were satisfied there was sufficient evidence to show that doctors practicing in the clinics provided patients with appropriate information and support in choosing their treatment. Staff sought patients' consent to care and treatment in line with legislation and guidance. The doctors we interviewed on the day understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring?

Our findings

Kindness, respect and compassion

Staff we spoke with told us patients were treated with dignity, respect and compassion at all times. We observed treatment rooms to be spacious, clean and curtains were provided. Doctors told us treatment rooms were kept closed to ensure conversations taking place remained private. This was reflective in feedback we received from patients about the service. We received 31 completed comment cards (26 completed in English and six in Polish) all of which were very positive and indicated that patients were treated with kindness and respect. Staff were described as helpful, caring, thorough and professional. In addition, comment cards described the environment as hygienic and safe.

Involvement in decisions about care and treatment

The service gathered patient feedback through customer satisfaction surveys, online feedback via social media, comment slips and by word-of-mouth feedback provided during appointments. Results of the services 2016/2017 satisfaction survey highlighted patients were happy with the care they received from the service. We saw that the 45 patients surveyed answered positively to questions when they were asked to choose from good, very good, satisfactory, unsatisfactory, poor, does not apply and no answer: For example:

- All patients (100%) said the doctors were either "very good or good" at listening to them.
- All patients (100%) said the doctors were very good or good at assessing their medical condition.
- All patients (100%) stated that the doctors were either very good or good at explaining their condition and treatment.
- All patients (100%) said that they felt involved in decisions about their treatment.

The service provided facilities to help patients be involved in decisions about their care. Staff told us that interpretation services were available for patients who did not have Polish as a first language. Although there were no notices of this in the waiting area, we did review a copy of the service's translation and interpreting services agreement. The service also told us they were in the process of discussing alternative communication methods for patients who had difficulty hearing, visual impaired and those with a learning disability.

Privacy and Dignity

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We were told consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Results from the 2016/2017 survey highlighted that patients responded positively to questions relating to confidentiality.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The premises were suitable for the service provided. There were facilities in place for people with mobility difficulties, however the lift was not big enough to accommodate a standard wheelchair.
- Translation and interpreting services were available for patients who did not have Polish as a first language.
- Appointments could be booked over the telephone, face to face and online. Patients had a choice of time and day (Friday or Saturday) when booking their appointment; they also had a choice of male and female doctors.
- Patients were also able to book the same clinical staff member for continuity of care; the 2016/2017 survey highlighted patients tended to see the same doctor.
- The service had a website; patients could register online.
- The service used their online social networking sites as a tool for health promotion.
- Unanswered telephone calls to the service's landline were diverted to a mobile number.
- Patients undergoing treatment could contact a doctor for advice.
- The provider made it clear to the patient what services were offered and the limitations of the service.

Timely access to the service

The service's opening hours were Friday 3pm to 9pm and Saturday 9am to 4pm, however earlier and later appointments could be requested. The service also offered online and telephone advice to their regular patients. On average the service saw around 120 patients on a monthly basis.

Listening and learning from concerns and complaints

- There was a lead member of staff for managing complaints.
- The service had a complaints policy in place and information about how to make a complaint was available for patients. The complaints information detailed that complainants could refer their complaint to the Independent Health Care Advisory Service or General Medical Council (GMC) if they were not happy with how their complaint had been managed or with the outcome of their complaint.
- The service told us two verbal complaints had been made during the last 12 months, however these were not recorded and there was little evidence these had been thoroughly investigated in line with practice policy. The service's complaints policy stated that all verbal complaints or concerns received would be recorded using the complaints log. The service told us that the complaints were not recorded as both patients concerns were resolved satisfactorily on the day. They told us that lessons were learnt from both complaints and action was taken to improve care. For example, one complaint related to a specific doctor who was running late. The service told us they apologised to the patient and spoke to the doctor regarding this.

Are services well-led?

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

Our findings

Leadership capacity and capability;

The organisation was owned and managed by two of the four doctors who worked at the service. There was a leadership and staffing structure and staff were aware of their roles and responsibilities and the limitations of these. Processes were in place to check on the suitability of and capability of staff in all roles.

Vision and strategy

- The service had a vision and that was to provide professional diagnostics and treatment in accordance with the principles of medical ethics and respect for patients' rights.
- The practice had a mission statement, it was not displayed in the waiting areas but this was displayed on the services' social media's pages.
- The practice told us they had a strategy, however we did not see evidence of this or supporting business plans.

Culture

- The service had an open and transparent culture. Doctors told us they felt confident to report concerns or incidents and felt they would be supported through the process. The provider had a whistleblowing policy in place and staff had been provided with training in whistleblowing. A whistle blower is someone who can raise concerns about the service or staff within the organisation.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements.

Governance arrangements

- There was an organisational structure and most staff were aware of their roles and responsibilities.
- There was a range of service specific policies that were available to all staff, however some policies were in need of reviewing as they contained out-of-date or incorrect information.
- The service carried out patient surveys to monitor the quality of the service.
- The service held bi-monthly peer like meetings where different clinical topics were discussed.
- The service could not demonstrate meetings were held to discuss significant events and complaints. We did not see any evidence these were recorded, investigated and shared with all members of staff.

Managing risks, issues and performance

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, however fire drills were not recorded and the service had not carried out a legionella risk assessment. This meant that the registered person did not ensure people using the service were protected from the risks associated with legionella. The service took steps immediately after the inspection to address these issues. Other completed risk assessments we reviewed were fit for purpose and were updated at the recommended intervals.

Appropriate and accurate information

- The service had systems in place which ensured patient's data remained confidential and secured at all times. Anonymised patient consultation records reviewed during our inspection were comprehensive and current for example, patients were asked to complete a new medical history questionnaire at each visit; this was then stored in their files for future reference.
- Staff had received Caldicott Protocols training which included information governance, data protection, handling patient information and record keeping.

Engagement with patients, the public, staff and external partners

The service encouraged feedback from patients. It sought patients' feedback and engaged patients in the delivery of the service and told us this was used to improve the service they offered. We noted that the most recent patient survey indicated that patients were satisfied with the service.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations: Good Governance.** **How the regulation was not being met:** **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • The service did not have a process of quality improvement activity, for example completed clinical audits. **This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**