The Broadgate Spine and Joint Clinic Limited

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 18 September 2018, 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 not 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.

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 not providing well-led care in accordance with the relevant regulations.

The service was last inspected in February 2014, by the Care Quality Commission's Hospitals Directorate, when it was found to be compliant with the relevant regulations. 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.

The service provides private general practice appointments, including blood tests; dietary advice; psychiatric support; flu vaccinations; travel clinic, providing travel vaccinations; sexual health, such as pregnancy and sexually transmitted disease testing; and health screening including cervical and breast cancer screening. Services are provided only to adults, aged over 18 years.

Summary of findings

We received feedback from 52 patients using the service. The feedback was consistently positive regarding easy access to the service, their involvement in decisions about their care and confirming staff treated patients with dignity and respect.

Our key findings were:

- At the time of the inspection, the provider did not have in place policies relating to safeguarding and infection prevention and control.
- Not all staff had received up to date safeguarding training and no guidance or training had been given to identify the signs of sepsis and to inform them of appropriate action to take in cases where sepsis was suspected.
- The provider had not carried out risk assessments in respect of general health and safety at the premises, staff workstations and emergency medicines.
- An infection prevention and control (IPC) review, carried out shortly before our inspection had not identified various issues that needed to be addressed. For example, there being no IPC protocols in place, premises deep cleaning and cleaning of medical equipment was not recorded, and there was no written guidance on sharps injuries.
- There were not effective systems and processes in place to assess monitor and improve the quality and safety of the services provided or to or to identify and mitigate risks to people's health, safety and welfare.
- Administrative staff had not had appraisals for several years.
- The provider had not established a full range of written governance policies, or consistently reviewed and updated where necessary its existing policies.
- The provider recognised that the were some areas of practice that required improvement. Consultants had been appointed before our inspection was announced to review clinical and business practices to bring about improvement.
- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

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.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

You can see full details of the regulations not being met at the end of this report.

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

- Review how patients are informed of the availability of chaperones.
- Review the process of providing locums with information about the service and its policies and procedures.
- Review arrangements for carrying out clinical audits to drive improvement.
- Review procedures for conducting and recording staff meetings.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Broadgate Spine & Joint Clinic Limited

Detailed findings

Background to this inspection

The Broadgate Spine and Joint Clinic Ltd (the provider) operates at 65 London Wall, London EC2M 5TU. It is registered by the Care Quality Commission to provide the regulated activities Diagnostic and screening procedures and Treatment of disease, disorder or injury. The provider began operating in 2003 offering services relating to spine and joint conditions. It later introduced a general practice service which now predominates, accounting for 90% of the business. The services provided include: blood tests; dietary advice; psychiatric support; flu vaccinations; travel clinic, providing travel vaccinations; sexual health, such as pregnancy and sexually transmitted disease testing; and health screening including cervical and breast cancer screening. Services are provided only to adults, aged over 18 years.

The service operates between 8.00 am and 6.30 pm from Monday to Thursday and from 8.00 am to 5.30 pm on Fridays. Standard appointments, 15 minutes long, are available throughout the day. In addition, patients may attend on a walk-in basis, but may be required to wait for the next available slot. At the date of the inspection, an average of 400 patient appointments were provided per month. There is a single full-time doctor, with occasional cover of planned absence provided by locums. The administrative staff consists of a practice manager and three receptionists.

We carried out this announced inspection of the practice on 18 September 2018. Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a nurse specialist adviser.

Before the inspection, the provider at our request sent us information regarding the service and we reviewed information we held. During the inspection, we interviewed the registered manager, the doctor, the practice manager and administrative staff. We reviewed the provider's governance documentation and looked at a number of patients' healthcare records. We spoke with two patients and reviewed 50 Care Quality Commission patient comment cards.

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. The current registered manager is a chiropractor, who was responsible for establishing the service in 2003. We were told that the doctor will be applying to take over as registered manager.

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.

Are services safe?

Our findings

We found that this service was not providing safe care in accordance with the relevant regulations.

- At the time of the inspection, the provider did not have in place policies relating to safeguarding and infection prevention and control.
- Not all staff had received up to date safeguarding training and no guidance or training had been given to identify the signs of sepsis and to inform them of appropriate action to take in cases where sepsis was suspected.
- The provider had not carried out risk assessments in respect of general health and safety at the premises, staff workstations and emergency medicines.
- An infection prevention and control (IPC) review, carried out shortly before our inspection had not identified various issues that needed to be addressed. For example, there being no IPC protocols in place, premises deep cleaning and cleaning of medical equipment was not recorded, and there was no written guidance on sharps injuries.

In addition, we found areas where the provider should make improvements:

- Patients were not informed of the availability of chaperones.
- Although locums were used infrequently, there was no written information, such as a locum pack, to provide them with information about the service and its policies and procedures.

Safety systems and processes

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

- The registered manager was the nominated safeguarding lead, but the provider did not have appropriate policies in place relating to safeguarding vulnerable adults and child protection. Staff had not received suitable safeguarding training. However, the provider subsequently sent us policies it had drawn up after our inspection. The policies were made accessible to all staff. They set out the necessary actions to take if abuse was suspected, including contact numbers for the local safeguarding authorities, and who to go to for further guidance. The policies stated that they would be reviewed on an annual basis. The provider also sent us evidence that two staff members had completed safeguarding training appropriate to their role since our inspection and that training had been booked for the remaining members of staff.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. 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.
- The doctor was registered with a licence to practice by the General Medical Council. Their last appraisal was in June 2018, conducted by the Independent Doctors Federation, and they were due for revalidation in December 2020.
- The provider had a policy relating to the provision of chaperones, which stated that staff would be trained for the role. However, their availability was not advertised in the waiting area, in the consultation rooms or on the practice website. One member of the administrative staff had been trained and had received a DBS check. They told us they had performed chaperone duties only twice in seven years. There was no provision for cover should they be absent from the service when a chaperone was requested.
- The provider did not have an effective system to manage infection prevention and control (IPC). There was no written IPC policy, but we were sent one after our inspection. The provider had carried out an IPC review shortly before our inspection was announced. However, this was not sufficiently detailed to be considered an audit and we noted various issues that it had not highlighted. General cleaning was carried out by a contractor, in accordance with an agreed schedule, but we saw evidence from the cleaner's communications book listing concerns raised by the provider over performance. Most areas appeared clean on the day of the inspection, but we noted there was a carpet in one of the consultation rooms, which was not mentioned in the cleaning schedule, to state how frequently a deep clean was required. The provider used an ear irrigator and we were told this was cleaned after use, but no records were maintained to confirm this. Nor were there cleaning records regarding the spirometer, although it appeared clean at our inspection. Hand

washing gel was available and handwashing guidance was posted in the consultation rooms. The provider did not have a sharps injury policy and no guidance was available in the consultation rooms. There were arrangements in place for the management and collection of clinical waste. The provider used only single-use disposable instruments. All staff had received IPC refresher training shortly before our inspection. The provider had a spills kit available and a sufficient supply of personal protective equipment. A risk assessment in respect of Legionella – a bacterium which can infect water systems in buildings – had been carried out by the premises landlord in December 2017. A management plan was operated, which included regular water temperature testing and sample analysis.

Risks to patients

There were not effective systems to assess, monitor and manage risks to patient safety.

- Staff were up to date with training in basic life support. Reception staff would inform the doctor on duty, if a patient was taken ill in the waiting area. Staff we spoke with told us that in the event of a medical emergency an ambulance would be called. The provider had an up to date protocol for dealing with medical emergencies. However, we found that there was no guidance to assist staff to recognise and appropriately deal with patients presenting with sepsis (blood poisoning or septicaemia) and no training had been provided.
- The provider had a defibrillator (a device for re-starting someone's heart) and an emergency oxygen supply, which we checked and found in working order. It also had a supply of emergency medicines, but had not carried out of formal risk assessment of the emergency medicines that should be maintained. For example, the practice did not keep a supply of the following medicines: buccal midazolam/rectal diazepam/ intravenous diazepam to treat patients having an epileptic seizures; chlorphenamine for anaphylaxis or acute angio-oedema; furosemide or bumetanide for left ventricle failure; glyceryl trinitrate for chest pain due to possible cardiac origin; or hydrocortisone for severe asthma or anaphylaxis. However, the practice sent us evidence after the inspection that a supply of these medicines had been obtained. The provider had systems in place to monitor the emergency equipment and medicines on a weekly basis.
- There was a single doctor, with occasional cover provided by locums for planned absence, such as holidays. Staff told us that when a locum was to be used, a day would be spent with them discussing the provider's systems, but there was no locum handbook, which locums could refer to for guidance. Should the doctor be absent in unforeseen circumstances, for example due to illness, patients' appointments were re-arranged. The was no business continuity plan in place. Staff told us that patients records could be accessed remotely, to review urgent test results, for example, if the premises could not be accessed.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Staff maintained patients' individual care records, which were 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 available to relevant staff in an accessible way. Patients' records were maintained securely on an electronic system with two-layer password protection. The provider had a system in place to retain medical records in line with Department of Health and Social Care guidance.
- There were systems for sharing information with other agencies to enable them to deliver safe care and treatment. This included effective systems for managing and reviewing pathology test results, etc.
- The provider made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. All prescriptions were generated from the electronic record. Prescription stationery was kept securely and its use was monitored.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The provider had an up to date prescribing policy.

Are services safe?

- Processes were in place for checking medicines kept on the premises and staff kept accurate records of this. The vaccines fridge temperature was monitored and recorded. No controlled drugs were prescribed and none were kept at the premises.
- We were shown evidence that systems were in place for the provider to receive and act on safety alerts, for example those issued by the Medicines and Healthcare products Regulatory Agency (MHRA), received via the Independent Doctors Federation. We saw a recent example relating to testing strips for blood glucose monitoring.
- An serious incident involving medicines prescribed by a locum GP was being investigated by the Coroner and reviewed at the time of the inspection.

Track record on safety

- Although the provider had up to date policies relating to general health and safety and fire safety, it had not carried out any general health and safety risk assessments, relating to the premises, staff's work stations, etc.
- The premises landlord had carried out a fire risk assessment and had recently updated the fire emergency plan. Firefighting equipment had been inspected in June 2018 and fire escape routes were checked weekly. Fire drills were carried out every six months. The provider's staff had received annual fire safety awareness training. The provider's electrical equipment had been PAT tested in September 2018.
- The provider's emergency oxygen supply and defibrillator was monitored and logged. Medical equipment had been inspected and calibrated in July 2018.

Lessons learned and improvements made

The provider learned from and made improvements when things went wrong.

- There was a system for recording and acting on significant events and we saw a formal policy had recently been introduced. Staff understood their duty to raise concerns and report incidents and near misses and they were supported to do so.
- There were systems for reviewing and investigating when things went wrong. The provider learned from incidents, shared lessons and took action to improve safety. There had been one significant event in the past 12 months, which at the date of the inspection was in the process of being reviewed both within the service and externally.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

When there were unexpected or unintended safety incidents:

- The provider gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.
- The provider acted on and learned from external safety events as well as patient and medicine safety alerts. The provider had an effective mechanism in place to disseminate alerts to all staff.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective care in accordance with the relevant regulations.

- The provider carried out limited quality improvement activity. For example, no clinical audits to drive improvement had been carried out in the previous 12 months.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

- We saw evidence that the provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the NICE best practice guidelines. The provider received these guidelines and updates via the Independent Doctors Federation. We saw an example relating to co-amoxiclav, an anti-biotic medicine.
- Patients' immediate and ongoing needs were assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. A consultant psychiatrist worked with the provider under practicing privileges and patients could access this specialist service, which included counselling, on a same day basis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The provider carried out some quality improvement activity, for example by monitoring and acting upon guidance received via the Independent Doctors Federation. It had introduced the use of an improved HIV testing system, providing fast results. However, it did not actively undertake clinical audits to drive improvement.

Effective staffing

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

- The doctor was registered with the General Medical Council (GMC) and was up to date with revalidation.
- The provider had an induction programme for all newly appointed staff.
- Up to date records of skills, qualifications and training were maintained. Some staff were overdue safeguarding training at the date of the inspection, but we saw evidence this was provided shortly afterwards. Reception staff had not been trained to identify signs of sepsis.
- Staff whose role included immunisation could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

The provider worked with other organisations to deliver effective care and treatment.

- Patients received coordinated and person-centred care. The provider referred patients to other services, such as secondary care providers, effectively.
- Before providing treatment, the provider ensured it had adequate knowledge of patients' health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable services to ensure safe care and treatment when this information was not available.
- 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. We saw examples of information sharing, where consent had been given.

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. The service provided dietary advice, which included producing dietary plans for patients, and offered health screening services, including sexual health and well-man and well-women clinics.
- Where patients' needs could not be met by the provider, staff redirected them to the appropriate service for their needs.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The provider had an up to date policy and obtained consent to care and treatment in line with legislation and guidance.

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

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was very positive about the way staff treated them.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The provider gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Staff told us that that an interpreting service was available for patients who did not have English as a first language, but that it had never been used.
- The service did not have an induction loop to assist patients with a hearing impairment, but we were sent evidence after the inspection that one had been ordered.
- We received feedback from 52 patients. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Privacy and Dignity

The provider 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The provider 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. It was focussing on providing general practice services, offering appointments between 8.00 am and 6.30 pm, Monday to Thursday and from 8.00 am until 6.00 pm on Friday. In addition, it operated a walk-in service, with slots being available between booked appointments throughout the day.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use. Patient feedback was very positive regarding access to the service.
- Referrals and transfers to other services were undertaken in a timely way. The provider had working arrangements with several local private hospitals for speedy referrals.

Listening and learning from concerns and complaints

The provider 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 provider informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint, for example by referral to the Independent Doctors Federation.
- The provider had an up to date complaint policy and procedures in place. The provider learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. We saw the provider had received four complaints over the previous 12 months. In response to one, it had arranged a deep clean of the premises.

Are services well-led?

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

Our findings

We found that this service was not providing well-led care in accordance with the relevant regulations.

- There were not effective systems and processes in place to assess monitor and improve the quality and safety of the services provided or to or to identify and mitigate risks to people's health, safety and welfare.
- Administrative staff had not had appraisals for several years.
- The provider had not established a full range of written governance policies, or consistently reviewed and updated where necessary its existing policies.
- The was no business continuity plan in place.

In addition, we found areas where the provider should make improvements:

- Staff meetings were infrequent and those that were held were not recorded.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. However, the provider had identified the need to engage consultants to review clinical and business practices to bring about improvement.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The provider told us the doctor would shortly be applying to take over as registered manager.

Vision and strategy

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

- There was a clear vision and set of values. The provider had a realistic strategy to develop the service and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision and strategy and their role in achieving them

Culture

The service had an established culture of providing quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The provider focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were informal processes for providing all staff with the development they need. Staff told us they had not received an annual appraisal for several years. However, they said that managers were approachable and receptive.
- The provider actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.

Governance arrangements

Staff we spoke with were aware of responsibilities, roles and systems of accountability to support good governance and management. However, the provider recognised that the were some areas of practice that required improvement. The provider had engaged external consultants to assist and formalise the governance arrangements before our inspection was announced, but the work was ongoing and the registered manager told us it would take several months to complete. It had been identified that there was the need to establish a full range of written governance policies, together with reviewing and updating where necessary the existing policies. For example, the infection prevention and control and safeguarding policies were drawn up following our inspection.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not effective.

Are services well-led?

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

- Risk assessments relating emergency medicines, general health and safety at the premises and staff workstations had not been undertaken. An infection control audit carried out before our inspection had not been sufficiently thorough to identify all risks.
- There was no written business continuity plan.
- Although the provider's clinical governance policy, last reviewed in August 2017, stated that regular clinical audits would be conducted, we found that none had been carried out to drive improvement.
- Staff had not been trained or provided with written guidance to identify signs of sepsis.

Appropriate and accurate information

- The information used to monitor performance and the delivery of quality care was generally accurate and useful. However, although we were told there were staff meetings, these were not regular or recorded. They said that performance information, together with feedback from patients was reviewed and discussed.
- The induction of locum staff involved discussion with the doctor and introduction to policies and processes, but there was no written information for locums to follow, such as a locum pack.
- The practice had been made aware of a significant incident regarding prescribing by a locum doctor in early 2018. However, it had not formally notified the CQC until shortly before our inspection. At the time of the inspection, the matter was still being investigated.
- Clinical and business practices were in the process of review by a consultant so that plans could be made to address any identified weaknesses.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Staff had received recent training relating to the General Data Protection Regulation which came into force in May 2018.

Engagement with patients and staff

There was opportunity for engagement with patients and staff to support high-quality sustainable services.

- Patients' and staff members' views were sought. Feedback from patients was requested after each consultation and the provider carried out regular staff surveys. Patients could submit comments and suggestions in person, by forms in the waiting area and via the provider's website. Patients and staff were encouraged to raise concerns.
- Staff told us they could raise any concerns at meetings and with their manager. However, formal staff meetings were infrequent and those that were held were not minuted. Staff also told us that they had not had annual appraisals for several years.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. The provider had engaged external consultants to review clinical and business practice to identify where improvements were need and draw up suitable action plans. Work on this was ongoing at the time of the inspection.
- The provider made use of external sources such as the Independent Doctors Federation to improve services. Patient feedback and complaints were monitored and a significant incident was under review, so that learning points could be identified.
- There were systems to support improvement and innovation work. For example, the provider had introduced the use of a faster, more thorough HIV test procedure.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 - Care and treatment must be provided in a safe way for service users How the regulation was not being met: The registered person had not done all that was reasonably practicable to assess and mitigate risks to the health and safety of service users and staff. In particular: The registered person had not carried out risk assessments in respect of general health and safety at the premises, staff workstations and emergency medicines. There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: An infection prevention and control review, carried out shortly before our inspection had not identified various issues that needed to be addressed. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular: Not all staff had received up to date safeguarding training. No guidance or training had been given to staff to identify the signs of sepsis and to inform them of appropriate action to take in cases of suspected sepsis. Administrative staff had not had an annual appraisal for several years. Regulation 12 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 - Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards

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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

The registered person had not established a full range of written governance policies, or consistently reviewed and updated where necessary its existing policies. There was no business continuity plan in place.

Regulation 17 (1)