Poland Medical LLP

Poland Medical

Inspection report

364A Whitton Avenue East
Greenford
London
UB6 0JP
Tel: 0208 903 4874
Website: www.polskaprzychodnia.co.uk

Date of inspection visit: 29 August 2017
Date of publication: 22/11/2017

Overall summary

We carried out an announced inspection on 29 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check on concerns we had received and whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the requirement notice section at the end of this report).

Are services effective?

We found that this service was providing not effective care in accordance with the relevant regulations (see full details of this action in the requirement notice section 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 not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the requirement notice section at the end of this report).

Background

Poland Medical is an independent provider of medical services and treats both adults and children in the London Borough of Ealing. Services are provided primarily to Polish people. Services are available to people on a pre-bookable appointment basis. The clinic employs doctors on a sessional basis most of whom are specialists providing a range of services from gynaecology to psychiatry. Medical consultations and diagnostic tests are provided by the clinic however no surgical procedures are carried out.

The clinic also provides dental services. A copy of the full report of the dental service is available on our website:

http://www.cqc.org.uk/search/services/doctors-dentists

The property is leased by the provider and consists of a patient waiting room & reception area, one dental surgery and three medical consultation rooms which are all located on the ground floor of the property.

Summary of findings

Poland Medical is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

The clinic is owned by an organisation and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Poland Medical is the owner of the service.

The clinic employs 13 doctors all of whom are registered with the General Medical Council (GMC) with a licence to practice. The doctors work across both the West London and Coventry locations. Other staff include the registered manager and a team of reception staff. Poland medical is a designated body (an organisation that provides regular appraisals and support for revalidation of doctors) with one of the specialist doctors as a responsible officer (individuals within designated bodies who have overall responsibility for helping with revalidation). The doctor is also medical advisor to the clinic.

The clinic is open Monday to Friday from 8am to 8pm, Saturday from 8am to 5pm and Sunday from 11am to 6pm. The provider does not offer an out of hours service or emergency care. Patients who require emergency medical assistance or out of hours services are requested to contact NHS direct or attend the local accident and emergency department.

Our key findings were:

- Systems and processes were in place to keep patients safe. However, we identified some shortfalls in relation to safeguarding children, staff recruitment, infection control and the management of prescription pads.
- There was some evidence that staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Some quality improvement was evident however it was limited particularly in relation to clinical audit. There were no medicine audits carried out to monitor the effectiveness of prescribing.
- Information about the services and how to complain was available. Complaints were dealt with in a timely way.
- Governance arrangements were in place however there was no program of continuous clinical and internal audit and no structured meetings that allowed for the sharing of learning from complaints and significant events with all staff.
- There were no multi-disciplinary meetings.
- We did not see any evidence of clinical supervision.
- There was no system for the reconciliation of pathology test results.

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

- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Introduce formal supervision and support for clinical staff.

In addition the provider should:

- Review how prescription pads are managed.
- Develop the vision for the clinic and implement a strategy to deliver it.
- Update policies and procedures to include review dates.
- Review the system of managing communication with a patient's NHS doctor.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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 not providing safe care in accordance with the relevant regulations.

- Systems and processes were in place to keep patients safe. However, we identified some shortfalls in relation to safeguarding children, staff recruitment, infection control and the management of prescription pads.
- There was a system in place for the reporting and investigation of incidents and significant events. However, we could not assess its effectiveness as no incidents had been reported.
- There was no system to ensure that patient information was recorded in patient care records in line with the 'Records Management Code of Practice for Health and Social Care 2016'. Patients' medical records were handwritten, often illegible and of a variable standard.
- The clinic had adequate arrangements in place to respond to emergencies and major incidents.
- There was no system for the reconciliation of pathology test results.

Are services effective?

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

- There was some evidence that staff were aware of current evidence based guidance.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Some quality improvement was evident however it was limited particularly in relation to clinical audit.
- There were formal processes in place to ensure all members of staff received an appraisal.
- Staff had received training appropriate to their roles, including training in infection control, fire safety awareness, basic life support and chaperoning.
- There was no evidence of formal clinical supervision, mentorship or support.

Are services caring?

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

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.

Are services responsive to people's needs?

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

- Information about the services and how to complain was available. Complaints were dealt with in a timely way.
- Appointments were available seven days a week.
- Information was available in both Polish and English which was appropriate for the people using the service.

Are services well-led?

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

Summary of findings

- Governance arrangements were in place however there was no program of continuous clinical and internal audit and no structured meetings that allowed for the sharing of learning from complaints and significant events with all staff.
- There was no clinical leadership in place to drive quality improvement.
- There was no evidence of formal clinical supervision, mentorship or support.
- Patient record keeping was of an inconsistent standard.
- The clinic had a system in place to gather feedback from patients. The results were collated and displayed on the website.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, a health and safety risk assessment had been completed.

Poland Medical

Detailed findings

Background to this inspection

We carried out an announced inspection on 29 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check on concerns we had received and whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by a CQC Lead Inspector and was supported by a Clinical Specialist Advisor. A dental inspector and a Dental Specialist Advisor were also present to inspect the dental services of the organisation. The teams were also supported by two Polish translators.

A dental report has been published separately.

During our visit we spoke with the reception staff, registered manager and one specialist doctor Reviewed four personal care or treatment records of patients and also staff records.

As the inspection was announced at short notice the clinic was not provided with CQC comment cards prior to our inspection. Due to the nature of the appointments we did not speak to any patients on the day of the inspection.

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.

Reporting, learning and improvement from incidents

- There was an incident reporting policy for staff to follow and there were procedures in place for the reporting of incidents and significant events. However, we could not assess its effectiveness as no incidents had been reported.
- The registered manager demonstrated an understanding of which incidents were notifiable under the duty of candour. (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).

Reliable safety systems and processes (including safeguarding)

The clinic had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety. However, there we did identify some shortfalls:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patients welfare. There was a lead member of staff for safeguarding. Safeguarding referral protocols were displayed in the consultation rooms.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults. All clinical and non-clinical staff were trained to child protection or child safeguarding level two. However, it is a requirement set out in the Intercollegiate Guidelines (ICG) for clinical staff working with children to be trained to child protection level three.
- There was no process in place to alert clinical staff of any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability.The clinic did not have a system in place of identifying vulnerable adults and children. Multi-disciplinary meetings to discuss safeguarding cases did not take place.
- The clinic had a chaperone policy in place. A notice was displayed in the waiting room to advise patients that chaperones were available if required.We saw records of patients being offered a chaperone during consultations including intimate examinations. Reception staff acted as chaperones, they had received chaperone training, understood the role, and they had received a Disclosure and Barring Service (DBS) check. (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).
- There was no system of reconciliation for pathology results. Blood and urine samples were sent to an external laboratory for analysis. Interpretation of test results was an additional service and patients could choose whether to have their results interpreted by the clinic or elsewhere. We were told that results were sent directly to the patient. There was no procedure to check whether the results had been received or by whom or whether any follow up treatment was required.

Medical emergencies

The clinic had adequate arrangements in place to respond to emergencies and major incidents.

- The clinic had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- Emergency medicines were easily available to staff in a secure area of the practice and all staff knew of their location. All the medicines were in date, appropriate and stored securely.
- The clinic had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Staffing

Are services safe?

- All the doctors working at the Greenford location were appropriately registered with the General Medical Council (GMC) the medical professionals' regulatory body with a licence to practice.
- All the doctors had professional indemnity insurance that covered the scope of their practice.
- All the doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to clinic). All the doctors were following the required appraisal and revalidation processes.
- We reviewed the personnel files of all the clinical and non-clinical staff and found that most

Monitoring health & safety and responding to risks

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The clinic had an up to date fire risk assessment and a fire evacuation plan.
- The clinic had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Infection control

- We observed the premises to be clean and tidy and there were cleaning schedules in place.
- There were infection control policies in place and records confirmed that staff had received up to date training. A professional company was contracted to remove clinical waste.
- We saw no evidence that an infection control audit had been undertaken to monitor infection control risks. The registered manager confirmed that infection control audits had not been carried out.

Premises and equipment

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- PAT testing of portable electrical appliances was up to date.

Safe and effective use of medicines

During our inspection we looked at the systems in place for managing medicines.

- There was a medicines management policy in place.
- The clinic had signed up to receive healthcareand medicines alert. The registered manager showed us a file of alerts that had been distributed to the appropriate staff, acted on and stored for future reference. The doctor we spoke to told us of a medicines alert he had recently acted on relating to valproate (a medicine primarily used to treat epilepsy and bipolar disorder and to prevent migraine headaches).
- All prescriptions were issued on a private basis. Prescription pads were stored securely in a locked cabinet located behind the reception however, the keys were not restricted to one responsible staff member.
- The clinic did not carry out audits of medicines to monitor the quality prescribing.
- The doctor we spoke to followed National Institute for Health and Care Excellence (NICE) and British National Formulary (BNF) guidance for prescribing.
- Individual doctors were responsible for monitoring any patients on high risk medicines. For example, the doctor we spoke to had one patient on lithium (a medicine used in the treatment of mental health disorders) and we found this patient was being monitored appropriately.

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.

Assessment and treatment

- The clinic provided some evidence that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards. For example, the doctor we interviewed provided evidence that they followed National Institute for Health and Care Excellence (NICE) best practice guidelines for care and treatment he provided.

Monitoring and improving outcomes for patients

- There was limited evidence of quality improvement including effective clinical audit. There had been one clinical audit undertaken. The audit was carried out in May 2017 to assess whether NICE guidelines were being followed for hypertension in adults. The results of the audit were analysed and recommendations made to improve adherence to the guidelines. However, since the initial audit there had been no second cycle to check for improvement. The manager told us that they had recently appointed a staff member to lead on and develop quality improvement activity within the clinic. This was confirmed by the minutes from a clinical governance meeting where the new role had been discussed. However, it was not clear if the appointed person had any clinical training.

Staff training and experience

- The clinic had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The clinic could demonstrate role-specific training and updating for relevant staff. We saw evidence of Continual Professional Development (CPD) for all the doctors.
- The learning needs of staff were identified through a system of appraisals. All staff had received an appraisal in the last 12 months.
- Staff received training that included: safeguarding, basic life support, fire safety awareness, chaperoning, consent, confidentiality and equality and diversity.
- There was no evidence of formal clinical supervision, mentorship or support.

Working with other services

- It was unclear how doctors communicated with the patients' NHS GPs. (Details of the patients' NHS GPs were not always recorded on their registration forms, because it was optional and the question about permission to share information with the NHS GP was only asked at the initial visit.)
- The manager confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

Consent to care and treatment

- The clinic had a consent policy in place and the doctors had received training on consent. We saw documented examples of where consent had been sought for example for gynaecological services.
- The doctor we spoke to understood the concept of Gillick competence in respect of the care and treatment of children under 16. (Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).
- The doctor we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. All the doctors had received training in the mental capacity act.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.
- Standard information about fees was detailed on the clinic website and information leaflets provided at the clinic.

Are services caring?

Our findings

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

Respect, dignity, compassion & empathy

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- We were unable to speak to patients at our inspection. However, we noted that staff treated patients respectfully, appropriately and kindly and were friendly towards patients over the telephone.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.
- Patients medical records were stored in locked cabinets located behind the reception desk to maintain confidentiality.

Involvement in decisions about care and treatment

- The clinic gave patients clear information to help them make informed choices including information on the clinics website. The information included details of the specialist doctors and the scope of services offered and information on fees.

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 patients' needs

- Access to the clinic was not suitable for disabled persons or those with prams and pushchairs as there were steps leading up to the main entrance. The registered manager told us that the property owner did not permit any modifications to the building and therefore patients with access problems were referred to alternative local private clinics.
- Baby changing facilities were available and a hearing loop for those patients who were hard of hearing.
- Staff told us that all patients attending the clinic were either Polish or English speaking and therefore translation services were not used.
- There was a clinic leaflet which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also services available.
- Information was also available on the clinic website in both Polish and English.
- All patients attending the clinic referred themselves for treatment; none were referred from NHS services. The clinic told us they referred patients to NHS services when appropriate.

Tackling inequity and promoting equality

- The clinic offered appointments primarily to Polish patients or anyone who requested one (and had viable finance available) and did not discriminate against any nationality.
- The clinics website was available in both Polish and English languages.

Access to the service

- The clinic was open Monday to Friday from 8am to 8pm, Saturday from 8am to 5pm and Sunday from 11am to 6pm. Appointments were available on a pre-bookable basis. Generally, patients could access the service in a timely way by making their appointment either in person or over the telephone. The manager told us when treatment was urgent patients would be referred to other local private services as they did not provide urgent appointments.

Concerns & complaints

The clinic had a system in place for handling complaints and concerns

- The practice had a complaints policy and there were procedures in place for handling complaints.
- There was a designated responsible person who handled all complaints in the clinic.
- A complaints leaflet was available to help patients understand the complaints system. There was information on how to complain on the clinic website.
- We reviewed five complaints that had been received within the last 12 months. For example, a patient had called the clinic requesting an urgent telephone consultation with a doctor. They were informed that telephone consultations were not provided by the clinic and they were signposted to NHS direct or the local hospital. The patient was unhappy about this and wrote a letter of complaint. The complaint was acknowledged and responded to in a timely way. The clinic reiterated that urgent care was not a service offered and they apologised that this had not been made clear enough to the patient.

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.

Vision and strategy

- The clinic had a vision to deliver high quality care and promote good outcomes for patients.
- There was no strategy or business plans in place to deliver the vision.
- There was no mission statement available.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The manager and the doctors had lead roles in key areas. For example, the manager was the safeguarding lead and one of the specialist doctors was the lead for appraisals.
- Practice specific policies were implemented and were available to all staff. However, these were not dated and therefore we could not establish when they were last reviewed.
- Clinical governance meetings were held quarterly and this was confirmed by the meeting minutes we reviewed. The meetings were attended by the board members. The boardconsisted of the registered manager, the medical advisor and a doctor who was an appraiser. However, structured practice meetings did not take place to allow lessons to be learned and shared with the whole team following significant events and complaints. The manager told us that it would not be practical to gather all staff members together for meetings, in particular the doctors who worked on a demand basis. However he accepted that meeting minutes could be distributed to those staff members who could not attend to share any necessary learning.
- There was no programme of quality improvement monitoring including continuous clinical and internal audit in place to monitor quality and to make improvements. Clinical audit was limited and infection control audits were not in place. There were no medicine audits to monitor the quality of prescribing.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, a health and safety risk assessment had been completed.
- Patient record keeping was not of a consistent standard. We reviewed four patients medical records. Two from the doctor we interviewed on the inspection day and two from a second doctor. The doctor we interviewed held computer records of his patients and we found the records of care and treatment were written in English, they were comprehensive and met recognised standards. The records of patients of the second doctor were on paper and written in Polish. The advising doctor and the translator on our inspection team were unable to read the records as they were indecipherable.
- Most patients records were on paper as there was no computerised clinical system.

Leadership, openness and transparency

- There was no formal clinical leadership and oversight. The registered manager of the clinic had a non-clinical background and therefore did not have an insight into the medical consulting part of the clinic. One of the specialist doctors was the medical advisor who advised the clinic on medical matters but he did not provide clinical leadership to drive quality improvement. The doctors provided a wide variety of specialist services on a sessional basis and the registered manager told us it would be impractical for them to work as a team to drive improvement in clinical outcomes for patients.
- Staff told us that there was an open culture within the practice and felt they could raise any issues with management.
- Staff said they felt respected, valued and supported by the registered manager of the clinic.

Learning and improvement

- The practice had no quality assurance processes in place to encourage learning and continuous improvement.

Are services well-led?

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

- There was no evidence of formal clinical supervision, mentorship or support.

Provider seeks and acts on feedback from its patients, the public and staff

- The clinic did not have a system in place to gather feedback from staff and there were no formal staff meetings structures in place to encourage discussion.
- The clinic had a system in place to gather feedback from patients. The results were collated and displayed on the website. This was done on an annual basis.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** The registered person had systems and processes in place that were operating ineffectively in that they failed to ensure all staff received safeguarding training at a suitable level for their role. This is in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulation was not being met:** The registered person did not provide effective support and supervision of clinical staff employed by the service. This is in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and social Care Act 2008 (Regulated Activities) Regulations 2014

How the regulation was not being met:

- 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. There was no programme of quality improvement monitoring including continuous clinical and internal audit in place to monitor quality and to make improvements. Clinical audit was limited and infection control audits were not in place. There were no medicine audits to monitor the quality of prescribing.
- There was no effective system for the reconciliation of pathology test results.
- There was no effective system for communicating or sharing learning from patient safety alerts, significant events, or complaints.
- There was no formal meeting structure in place for multi-disciplinary or full practice meetings.
- The registered person had systems and processes in place that were operating ineffectively in that they failed to enable the registered person to maintain accurate, complete and contemporaneous records of service users in respect of care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.

This is in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.