Messina Clinic Limited

# Messina Clinic Limited

## Inspection report

14-16 Dowgate Hill
London
EC4R 2SU
Tel: 020 3053 6709
Website: www.messinaclinic.co.uk

Date of inspection visit: 7 February 2018
Date of publication: 18/04/2018

## Overall summary

We carried out an announced comprehensive inspection on 7 February 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 not 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.

**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.

The Messina Clinic Limited is an independent provider of medical services and was founded in 2008 to provide the Brazilian community with medical services from its location at 14-16 Dowgate Hill London EC4R 2SU in the London Borough of City and Hackney. The doctor provides private general practice, and cosmetic treatments which are available to any fee paying patient. The service saw children aged 12 and over, however most patients were adults.

The service is open Monday to Friday from 9am to 6pm and Saturday 9am to 1pm. The service does not offer out of hours services.

The service is located on the lower ground floor which had an accessible via a lift. The property is leased by the provider there is a lift available and the premises consist of a patient reception area, and two consulting rooms. There are two toilets on the lower ground floor and four toilets including an accessible toilet in the building's main reception area.

The service is operated by three doctors (not on the GP register) including one director, supported by a service

# Summary of findings

manager and two reception staff. Two of the doctors are responsible for the private service and one doctor is responsible for cosmetics treatments which are not registerable..

The lead doctor is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is registered with the Care Quality Commission (CQC) to provide the regulated activity of treatment of disease, disorder or injury The service also provided cosmetic treatments which is not part of our remit.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were all extremely positive about the standard of care received, across the services offered. Comments included that staff, were kind, caring, polite, friendly, helpful and patients said they were treated with dignity and respect. Comments about the service included that the clinic was clean and hygienic. We spoke with three patients during the inspection who said they were very satisfied with the care they received and told us that appointments ran on time that they were not rushed, that they were involved in their care and treatment and that the provider provided an excellent level of service.

**Our key findings were:**

- There were limited arrangements in place to keep patients safe. The service was not able to demonstrate that it was providing safe services in relation to responding to medical emergencies, safeguarding, infection control, staff recruitment, training and policies.
- There was limited evidence of quality improvement. For example, the service had not undertaken any clinical audits.
- Information on how to complain was available. The service had not received any complaints in the last 12 months.
- There were limited governance arrangements in place. The policies and procedures were lacking in detail.
- There was some evidence that staff were aware of current evidence based guidance. Not all staff had been trained to provide them with skills and knowledge to deliver effective care and treatment.
- There were systems and processes in place for reporting and recording significant events and sharing lessons to make sure action could be taken to improve safety in the practice.
- The service did not have adequate arrangements to respond to emergencies and major incidents such as power failure.
- There was a clear leadership structure and staff felt supported by management.
- The service had systems in place to collect and analyse feedback from patients.

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.

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 with hearing impairments are supported.
- Review the process for sharing learning from complaints.

**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.

We have told the provider to take action (see full details of this action in the Warning Notices at the end of this report).

- There was an incident reporting form and a communication book in reception, used to record incidents and significant events. The service informed us that they had not had any significant events or incidents in the last 12 months.
- The service did not have clearly defined and embedded systems, processes and practices to minimise risks to patient safety. There was no infection control audit, sharps bins were not signed or dated. There was no cleaning schedule. There was no evidence of a Legionella risk assessment.
- The service did not have arrangements in place to respond to emergencies and major incidents such as power failure. There was no emergency medicine or equipment, and no risk assessment for not having these. Staff had not undertaken basic life support training.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. However doctors were only trained to level 2. After the inspection the service provided us with certificates to show all doctors were trained to level 3.

**Are services effective?**

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

- There was no evidence of quality improvement. The service had not undertaken any clinical audits.
- The service did not have an induction programme for newly appointed staff. They had last recruited a member of staff in December 2017.
- The service could not demonstrate that staff had undertaken role specific training, specifically basic life support training, infection control, safeguarding adults, information governance, fire and mental capacity training.
- There were no formal processes in place to ensure all members of staff received an appraisal, the service manager had not had an appraisal for two years.
- Staff were aware of current evidence based guidance relevant to their area of expertise.
- Staff had the skills and knowledge to deliver effective care and treatment.

**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.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- We spoke with three patients, they told us they were satisfied with the care provided by the service and said their dignity and privacy was respected.
- All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the provider offered an excellent service and staff were helpful, caring and treated them with dignity and respect.
- Patients' medical records were all stored electronically, only doctors could access their records.
- The service did not provide a hearing induction loop.

# Summary of findings

**Are services responsive to people's needs?**

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

- The service had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain and provide feedback was available and there was evidence that systems were in place to respond appropriately and in a timely way to patient complaints and feedback. The service had received no complaints in the last 12 months.
- The service population was predominately Brazilian (a total of approximately 95%), all staff spoke Portuguese and English. The service website was also viewable in Portuguese.
- There was no service leaflet available for patients which explained the services offered by the provider, however this information was available via the service website.
- Treatment costs were explained in detail over the phone, when patients booked an appointment. They were not displayed in the service, however if a patient requested fees information there was a folder in reception that gave pricing information.
- Patients were able to request consultations by telephone, email, and via the service website or in person.
- There was timely access to appointments once requested. Appointments were available on a pre-bookable basis only.
- The service provided 30 minute consultations face to face.
- The service saw children aged 12 and over, however most patients were adults.
- All patients attending the clinic referred themselves for treatment; none were referred from NHS services. The service told us they referred patients to other services when appropriate.
- The service dispensed medicines to patients.
- The service used social media to monitor its service.

**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 Warning Notice at the end of this report).

- There were limited arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions.
- Policies and procedures had not been reviewed since 2013 and required updating.
- The service had no systems which ensured oversight of staff training.
- There was no business continuity plan in place.
- The service could not show that it had undertaken a legionella risk assessment.
- The service did not have access to either emergency medicines or equipment.
- There was no documented evidence of internal clinical meetings.
- No clinical audits had been conducted.

# Messina Clinic Limited

**Detailed findings**

## Background to this inspection

We carried out this comprehensive 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.

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser and an interpreter.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. During our visit we:

- Spoke with staff including the lead doctor, service manager and patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment in use.

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.

**Safety systems and processes**

The service did not have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and the service had processes in place to access relevant information for patient's local safeguarding teams where necessary. Policies were accessible to all staff however policies were generic and did not clearly outline who the service safeguarding lead was.
- Staff demonstrated they understood their responsibilities regarding safeguarding. All staff had received training on safeguarding children but not vulnerable adults. All doctors were trained to child safeguarding level two, non-clinical staff were trained to level one. After the inspection the service provided us with evidence to show all doctors were trained to level 3.
- The service informed us that they did not see any children under the age of six this was because of cultural reasons and staff feeling they were not adequately trained.
- There were no notices advising patients that chaperones were available if required. The service manager told us this was for cultural reasons as in Brazil, patients don't require chaperones. However the service manager told us if patients did request a chaperone she would chaperone. The service had someone who was available who could chaperone 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).
- We reviewed five personnel files which demonstrated
- There were adequate waste management systems in place.

The service did not have adequate arrangements in place to respond to emergencies and major incidents.

- The service did not hold stocks of
- There was no system in place to ensure non-clinical staff had received annual basic life support training. However non-clinical staff had conducted first aid training. After the inspection the service manager informed us that all staff has been booked to complete basic life support training.A certificate was also sent confirming that one doctor had conducted basic life support training in August 2016 and the certificate was valid until August 2020.
- The service did not have a business continuity plan in place for major incidents such as power failure or building damage.

**Risks to patients**

- A health & safety risk assessment had been conducted in January 2018.
- The lead doctor and non-clinical staff knew how to identify and manage patients with severe infections, for example, sepsis.
- We saw evidence that one doctor had professional indemnity insurance that covered the scope of their practice. No evidence of indemnity insurance was provided for the other doctor , however after the inspection we saw evidence that this was in place.
- There was a health and safety policy available and there was a system in place to liaise with the building owner to conduct and review health and safety premises risk assessments.
- The service ensured there was an up to date fire risk assessment and were involved in the regular fire drills carried out on the premises. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises, staff were able to explain what they would do during a fire evacuation drill.
- All electrical and clinical equipment was checked.
- The service told us the building management had conducted a legionella assessment, but we were not provided with evidence of this. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

# Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

**Information to deliver safe care and treatment**

- The service needed a more effective system in place because the service did not have a process in place for identifying patients with a NHS GP, neither did they have a process for passing on information if medicines had been prescribed. The service told us this was because most of their patients did not have a NHS GP. Following the inspection the service told us they would start asking patients if they had a NHS GP. The service identified patients by asking them to bring identification when they first registered. The service understood about good practice in terms of communication with other health professionals, for example by referring patients over to secondary care if required.

**Safe and appropriate use of medicines**

The arrangements for managing medicines, required improvement including not having emergency medicines, to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The systems for managing medicines, including vaccines minimised risks. The service kept prescription stationery securely and monitored its use.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

**Track record on safety**

There was a system for reporting and recording significant events and incidents.

- Staff told us they would inform the service lead of any incidents and there was a recording form and communication book available. The incident recording form supported the recording of notifiable incidents under the duty of candour; however the service had not had any of these incidents. (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).
- Staff demonstrated an understanding of their responsibilities under the duty of candour including informing patients of the incident as soon as reasonably practicable, providing reasonable support, truthful information, a written apology and information about any actions to improve processes to prevent the same thing happening again. The service used a secure electronic system to store patients' records, this was backed up daily.

The service maintained appropriate standards of cleanliness and hygiene, however there were no cleaning schedules, and no infection control audit had been undertaken.

- We observed the premises to be clean and tidy, including the specific areas used by the service.
- Out of files checked we saw no evidence that staff members had undertaken infection control training. The service told us the lead doctor was the infection prevention and control (IPC) lead who monitored risks and issues, he understood his role and what he should be doing.

**Lessons learned and improvements made**

- We reviewed significant event and incident policies and procedures and saw that there were systems in place to identify and investigate. However the service had not undertaken any processes of incidents or significant events, because they had not identified any. The lead doctor and service manager had oversight of MHRA alerts.

# 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.

**Effective needs assessment, care and treatment**

The service doctor was aware of relevant and current evidence based guidance and standards, best practice and current legislation, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Guidelines were accessed through the service computer system and used to deliver care and treatment that met patients' needs.
- Compliance with guidelines was monitored through analysis of patient records.
- The service was not able to provide evidence of minuted clinical meetings.
- The service did not have organisational care pathways or protocols.
- Care plans were not used, advice was delivered to patients verbally. There were information leaflets that were provided to patients in their choice of language.
- If patients required a blood test, the service would send the sample off via an external company then contact patient with the results after.

**Monitoring care and treatment**

- There was limited evidence of quality improvement. The service had not undertaken any clinical audits.

**Effective staffing**

- The service did not have an induction programme for newly appointed staff.
- There were no formal processes in place to ensure all members of staff received an appraisal, the service manager had not received an appraisal for two years.
- The service could not demonstrate that staff had undertaken role-specific training and relevant updates. We reviewed the training files of five staff members and found that two non-clinical staff members had not completed basic life support training. We saw no evidence that all staff members had completed infection control, fire, safeguarding adults, and mental capacity training. All doctors had only conducted safeguarding children level 2 training. After the inspection the service provided us with evidence to show all doctors were subsequently trained to level 3.

**Coordinating patient care and information sharing**

- There was no evidence of written communication between the clinic and patients' NHS doctors'. The service told us the majority of their patients did not have a NHS GP.
- The lead doctor confirmed they referred patients to other services as required and we saw evidence to support this.

**Supporting patients to live healthier lives**

- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Advice was delivered to patients verbally. There were information leaflets that were provided to patients in their choice of language

**Consent to care and treatment**

- There was no formal mechanism for sharing information with patients' NHS GP if they had them. We were told the majority of patients in the service did not have a registered GP. Reception staff did not ask for details of registered NHS GPs. We were told the clinician would share information with a patient's GP when it was clinically relevant. After the inspection we were told receptionists would start to ask if patients had a registered GP.
- The lead doctor did not demonstrate understanding of 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 lead doctor informed us that they do not see any patients under the age of 12.

# 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 we spoke with were aware of their responsibility to respect people's diversity and human rights.
- We spoke with three patients who told us they were treated with dignity, kindness and respect.

**Involvement in decisions about care and treatment**

We saw evidence that the service gave patients clear information to help them make informed choices about the services offered. Information on fees was not displayed in reception, however there was a folder in reception which detailed the prices and patients were told about prices at the time of making their appointment.

**Privacy and Dignity**

- We observed a culture of doors being closed during consultations in the premises; conversations taking place in these rooms could not be overheard.
- Staff receiving patients knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients' medical records were securely stored electronically.

# 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**

- Access to the premises were suitable for wheelchair users, those with poor mobility and pushchairs and there were accessible facilities available.
- The service did not have provision for other patients with additional needs such as those with hearing impairment.
- The majority of patients were Brazilian and spoke Portuguese or Spanish the doctors were bilingual and able to speak to patients in their native language. Patient information leaflets were available in the patient's choice of language were available and provided when needed.
- The service website could be viewed in Portuguese as well as English.

**Timely access to the service**

The service was open Monday to Friday from 9am to 6pm and Saturday 9am to 1pm. The service did not offer out of hours services.

**Listening and learning from concerns and complaints**

The service did not have an effective system in place for handling complaints and concerns.

- There was a designated responsible person who handled all complaints.
- A complaints leaflet was available to help patients understand the complaints system.
- Verbal complaints were not logged or recorded.
- Patients left feedback on the services social media page. No formal written complaints were shared.

# 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.

**Responding to and meeting people's needs**

- Access to the premises were suitable for wheelchair users, those with poor mobility and pushchairs and there were accessible facilities available.
- The service did not have provision for other patients with additional needs such as those with hearing impairment.
- The majority of patients were Brazilian and spoke Portuguese or Spanish the doctors were bilingual and able to speak to patients in their native language. Patient information leaflets were available in the patient's choice of language were available and provided when needed.
- The service website could be viewed in Portuguese as well as English.

**Timely access to the service**

The service was open Monday to Friday from 9am to 6pm and Saturday 9am to 5pm. The service did not offer out of hours services.

**Listening and learning from concerns and complaints**

The service did not have an effective system in place for handling complaints and concerns.

- There was a designated responsible person who handled all complaints.
- A complaints leaflet was available to help patients understand the complaints system.
- Verbal complaints were not logged or recorded.
- Patients left feedback on the services social media page. No formal written complaints were shared.

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.

**Leadership capacity and capability;**

- There was no formal clinical leadership and oversight, there was no monitoring of the service provided.
- Staff told us that there was an open culture within the service and felt they could raise any issues with the lead doctor.
- The service manager said they felt respected, valued and supported by the lead doctor.

**Vision and strategy**

- The service 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 a mission statement available and staff were aware of it.

**Governance arrangements**

The service had limited governance arrangements in place to support the delivery of good care.

- The was no oversight for emergency medicines or equipment, there was a lack of consideration for how to deal with medical emergencies.
- Not all prescriptions issued had the prescriber's name printed or the prescriber's GMC number.
- Generic policies were used and, which had not been updated since 2013. The policies and procedures folder did not define any organisation specific protocols.
- There were no references for two doctors, although the service did say they had obtained a verbal references however this was not recorded.
- There was no formal process of sharing information with patients' GP if there was a registered NHS GP.
- There was no programme of quality improvement in place to monitor quality and to make improvements. The service had not performed any clinical audits or infection control audits.
- There were no medicine audits to monitor the quality of prescribing.
- There was no monitoring guidance no sampling of records, no peer review of clinical referrals or medical referrals.

**Culture**

The service had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the service.

# Are services well-led?

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

- The serviced focused on the needs of patients.
- 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 positive relationships between the service manager and the lead doctor.

**Managing risks, issues and performance**

There were not clear and effective processes for managing risks, issues and performance of staff. The service manager had not had an appraisal for two years.

- The lead doctor and service manager had oversight of MHRA alerts, incidents, and complaints.
- There had been no clinical audits.
- The service did not have plans in place and had not trained staff for major incidents.

**Engagement with patients, the public, staff and external partners**

- The service had a system in place to gather feedback from patients and staff.
- The service had received seven comment cards, all were positive.
- The service used social media to monitor its service.

**Continuous improvement and innovation**

- There was no evidence of continuous improvement.

This section is primarily information for the provider

# Enforcement actions

## 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 |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**Warning notice**<br><br>**How the regulation was not being met:**<br><br>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had not assessed risks associated with legionella, infection control, having emergency medicines, or equipment, basic life support training for all staff.<br><br>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Warning notice**<br><br>**How the regulation was not being met:**<br><br>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use the services. There was a lack of oversight in having effective policies, procedures and governance to enable effective management of risks associated with no emergency medicine and equipment, infection control no audit or cleaning schedule, omission of business continuity plan. Ineffective systems in place to monitor staff training and appraisals. Lack of effective systems to monitor and improve patient outcomes. There was no system for recording clinical meetings. |

This section is primarily information for the provider

# Enforcement actions

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