Skintique Clinic

Inspection report

342 Welford Road
Leicester
LE2 6EH
Tel: 07720463080

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive at Skintique Clinic on 14 June 2022. This is the first time this service has been inspected by the Care Quality Commission (CQC) following its registration as a new service in June 2020.

The service provides, phlebotomy, some beauty treatments, some of which are in scope of CQQ regulations such as, treatments for headaches and migraines, administration of Semaglutide (Ozempic) and liraglutide injections (Saxenda) for weight management, treatments for hyperhidrosis (common condition in which a person sweats excessively) and Bruxism (a problem in which you unconsciously grind or clench your teeth). Some treatments carried out by the service are out of scope of CQC regulations, for example, beauty treatments, laser hair removal.

There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We only inspected and reported on the services which are within the scope of registration with the CQC. The only staff who were associated with the delivery of regulated activities were the nominated individual, two registered managers and a nurse. There were other staff on the premises who provided the non-regulated activities

Due to the current pandemic we were unable to obtain comments from patients via our normal process of asking the provider to place comment cards within the service location. We saw from reviews on the provider's website and from google reviews that patients were consistently positive about the service, describing staff as professional and helpful. We did not speak with patients on the day, as there were none attending for regulated activities

A director and a business manager at the location are the CQC registered manager's. A registered manager is a person who is registered with the CQC 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.

Our key findings were:

- We found that the service was caring and compassionate towards patients and we observed many positive comments received from those who had used the service.
- There was a lack of good governance in some areas.
- The service could not demonstrate they had reliable systems in place for the appropriate and safe handling of medicines.
- Prescribing was not audited or reviewed to identify areas for improvement.

Overall summary

- Clinical records reviewed did not always contain the required relevant information to ensure patient safety.
- The process for patient safety alerts was not effective.
- The service involved patients in decisions about the care and treatment.
- Appointments were pre-bookable by phone or in person.
- Information on how to complain was readily available.

The areas where the provide **must** make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Develop the training matrix so that training records of staff training are documented as completed and all staff immunisations are all recorded.
- Demonstrate that actions from risk assessments and infection control audits are documented when completed.
- Review the process for staff meetings with a view to a set agenda.
- Look to provide leaflets in different languages.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection was led by a CQC inspector and a GP Specialist Advisor.

Background to Skintique Clinic

Skintique Clinic are located at 342 Welford Road, Leicester. LE2 6EH and is registered with the CQC to provide the regulated activities of diagnostic and screening procedures, family planning and treatment of disease, disorder or injury. The service was first registered with the CQC in 2020 and this is the first inspection of the service.

Skintique Clinic is an independent organisation which offers consultations, treatment and advice to private patients. We only inspected the treatments provided by this service that fall under the CQC regulated activities, for example, some aspects of weight management, headaches and migraines, phlebotomy and the treatment for hyperhidrosis (common condition in which a person sweats excessively) and Bruxism (a problem in which a person unconsciously grinds or clenches their teeth).

There are two directors, one of whom is the clinician, a business manager and a registered nurse who are supported by a team of beauty therapists whose activities do not fall under the CQC scope of registration.

The location is a two storey building but does not have disabled access. It has a range of treatment rooms on the ground and first floor along with an office and staff kitchen.

The Service is open Monday 9:00am to 4:00pm, Tuesday 10:00am to 8:00pm, Wednesday 10:00am to 6:30pm,Thursday 10:00am to 8:00pm, Friday 9:00am to 6:30pm and Saturday 9:00am to 3:00pm.

How we inspected this service

This inspection was carried out both remotely and by visiting the providers location.

This included:

- Visiting the providers location.
- Reviewing information provided to us before our site visit.
- Reviewing patient feedback.

The provider is not required to offer an out-of-hours service. Patients who need urgent medical assistance out of the service opening hours are requested to seek assistance from alternative services such as their own GP, the NHS 111 telephone service or accident and emergency.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- The service did not have reliable systems in place for appropriate and safe handling of medicines.
- There were processes in place to ensure that risks to patients were assessed but not all were well managed.
- Information needed to deliver safe care and treatment was not always available to staff in a timely manner.

Safety systems and processes

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

- The service had systems in place to safeguard vulnerable adults and children from abuse, which included safeguarding policies. The policies outlined who to go to for further guidance, and there was an identified safeguarding lead within the service.
- Most employed staff at the service had received up-to-date safeguarding training appropriate to their role. We found that the two clinical staff had Level three adult safeguarding training but had only completed Level two child safeguarding training. Since the inspection both clinicians had completed thier level three child safeguarding training.
- Staff we spoke with knew how to identify and report any safeguarding concerns.
- The provider carried out recruitment checks on new staff and maintained evidence of this. We reviewed one staff file who had joined the service at the beginning of 2022 and found that most pre-employment checks had been completed. 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). However we found, and we were told by the management team that they did not seek references, although two names had been given, but had completed a risk assessment instead. Since the inspection, the service had updated its recruitment policy and would seek references going forward. The records of staff immunisations needed to be updated so that the management team were assured that the staff who carried out regulated activities were up to date with vaccinations relevant to their role.
- All staff who carried out the role of chaperone had received the appropriate training but we did not see any chaperone posters in the treatment rooms we looked at. Since the inspection the service has sent us evidence that a chaperone poster was now in place in the reception area.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- There was a system in place to manage infection prevention and control. The building was visibly clean and free from dust. Cleaning schedules were in place and identified what cleaning had been undertaken and how. We found that the clinical waste bin was locked but not secured to the fence outside and the Control of Substances Hazardous to Health (COSHH) cupboard was not locked but was in a locked staff only room. Since the inspection the service has sent us evidence that the cupboard and the clinical waste bin now had locks in place.
- We were told that the lead for infection control had not undertaken specific lead infection control training to provide guidance and support to staff. However,they had completed online level one and two infection control training. We discussed this with the management team who had just reallocated this role to a member of the clinical team and specific training would be sourced for them to attend. They had carried out an infection control audit in January 2022. Actions for improvement had been discussed and target dates for completion had been set but these were not due until July, August and September 2022.
- The management of sharps was appropriate with sharps bins in place which were signed, dated and not over filled.
- There was information available to staff to support them when using hazardous substances. This was in line with legislation.

Requires Improvement

Are services safe?

- We saw a legionella risk assessment had been carried out on 21 September 2021. We saw that it had recommended that a full legionella risk assessment needed to be carried out but this had not taken place by the day of the inspection. Since the inspection the management team have advised the CQC that this had now been booked and would be completed within two weeks. Water monitoring testing was carried out.
- We saw a fire risk assessment had been carried out on 21 September 2021. We saw that there were evidence of six actions identified three medium and three low. We were told by the management team and we saw that most actions had been taken to mitigate the risks identified on the risk assessment but they had not recorded that the actions had been completed. They had not started the checking of emergency lighting monthly as recommended in the risk assessment but the management team told us they would commence this going forward. A fire drill had taken place on 8th February 2022 and we saw meeting minutes where this had been discussed with staff.
- The provider carried out appropriate environmental risk assessments which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There were some systems in place to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system for staff tailored to their role.
- We saw evidence that staff had undertaken "Emergency First Aid at Work" training and Basic Life support awareness.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place
- There were some suitable medicines and equipment to deal with medical emergencies which were stored appropriately. We saw evidence that the equipment and medicines were checked and a checklist was in place.

Information to deliver safe care and treatment

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

- Individual care records we reviewed were not always written and managed in a way that kept patients safe. We looked at six care records which showed that in most cases limited information was recorded. For example, whilst the service did not do any activity that would necessitate the sending of samples for histology (study of cells and tissues, which is typically aided by the use of a light microscope), they were sending off blood samples for pathology analysis. We saw a patient record where there was no past medical history, not all required blood tests had been taken or external results recorded, identification was not checked or advice on counselling and goal setting. We were not able to identify if the blood pathology results had reviewed. Since the inspection the provider has reviewed and updated the pre-treatment questionnaire to ensure that all the information required would ensure that patients are kept safe. There was no process or policy in place for the reviewing of those results pertaining to weight management for patients. Since the inspection the provider has sent us a repeat prescription policy which will be reviewed in detail at the next inspection'
- The service did not have systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, a patient's GP practice.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

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

Requires Improvement

Are services safe?

- Although the nominated individual was the only clinician prescribing medicines, they had not carried out any medicine audits to ensure prescribing was in line with best practice guidelines for safe prescribing. They prescribed, administered or supplied medicines to patients and gave advice on medicines which were not always in line with legal requirements. There was no past medical history documented to guide safe prescribing and follow up of the patient. The clinic had carried out blood sampling for the patient but there was a discrepancy between the results received and what was recorded in the GP letter. We saw limited information documented to reflect any weight management advice and counselling and no goal setting.
- We identified a safety concern in regard to weight management treatments.The day after the inspection the provider advised CQC that they would be suspending this service until they had put in effective governance measures and they could be assured that they had improved patient safety. So at present the likelihood of this happening again in the near future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care were minor
- We identified a safety concern in regard to treatment of patients who experienced headaches and migraines which was rectified on the day of inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care were minor. At the end of the inspection the nominated individual advised CQC that they would not be carrying out this treatment going forward.
- We were told on the day of the inspection that treatments that fell within the regulated activity of family planning had not been started and they did not envisage this commencing in the near future.
- Some of the medicines this service prescribed were not licensed for the treatment of obesity. This put patients higher risk than treating with licensed medicines, because such medicines may not have been assessed for safety, quality and efficacy for the indication they are being used for and doses used for licensed indications may well be different than those used for obesity. This was not an illegal practice but patients needed to be informed of the benefit and risks. We did not see any evidence that this had been discussed in the patient records we reviewed. The British National Formulary (BNF) states 'drug treatment should never be used as the sole element of treatment (for obesity) and should be used as part of an overall weight management plan. Since the inspection the provider had sent us information that The National Institute of Health and Care Excellence(NICE) were in the process of appraising the clinical and cost effectiveness of semaglutide for the management of people with obesity or overweight with risk factors but a launch date for later in 2022 had not yet been set.
- We saw evidence that medicines that required refrigeration were stored securely in a refrigerator. We were told and we saw that they had a system in place to record the temperatures electronically which were then stored on a cloud based computer system. This system alerted the registered manager if there had been any spikes or drops in temperature in line with their cold chain policy. However, when we reviewed the records for the 18th April 2022 we found that in the evening the fridge temperature had gone up to 12.22 but the registered manager had not received the alert and was not able to tell us what the issue, if any, had been with this refrigerator.
- There were protocols for verifying the identity of patients including children.

Track record on safety and incidents

The service had a good safety record.

- There were risk assessments in relation to safety issues. These included Fire, Legionella and Health and Safety.
- The electrical installation condition check of the premises had been carried out on 27 May 2020 and a gas safety check was carried out on 22 April 2022.
- We noted that the safety of electrical portable equipment was assessed at the premises to ensure they were safe to use.
- The service were not able to demonstrate that they monitored and reviewed activity to support them to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

Requires Improvement

Are services safe?

The service did not always learn from and make improvements when things went wrong.

- There were adequate systems for reviewing and investigating when things went wrong. We saw completed accident and incident forms (relating to non-regulated activities as we were told there had not been any incidents relating to regulated activities provided). We saw limited evidence that these had been discussed and learning shared in minutes of meetings we reviewed.
- The provider was aware of the duty of candour but only had some systems in place to ensure compliance with the CQC requirements". The provider encouraged a culture of openness and honesty.
- At this inspection we found the systems in place for actioning external safety alerts as well as patient and medicine safety alerts were not effective or embedded. Prior to the inspection the provider sent us a list of alerts since January 2022 that they had actioned, but the clinical alert log did not set out the names of the medicines or equipment apart from one on 31 May 2022 to demonstrate what alerts had been reviewed. There was no effective mechanism in place to disseminate alerts to members of the team that carried out the regulated activities.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

The service did not have systems in place to keep up to date with current evidence based practice.

The service was not actively involved in quality improvement activity.

There were no patient specific directions or standard operating procedures in place.

Effective needs assessment, care and treatment

The provider did not systems to keep clinicians up to date with current evidence based practice.

- The service was unable to evidence how they kept up to date with current evidence based guidance. For example, we saw that prescribing was not always in line with national guidance.
- From patient records we reviewed we were not assured that patients' immediate and ongoing needs were fully assessed.
- From records we reviewed clinicians did not always have enough information to make or confirm a diagnosis
- We did not see any evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service were actively involved in quality improvement activity.

- The service did not have an effective system in place to make improvements through quality improvement activity such as audits. Clinical audits included disability, clinical record keeping, disability access, patient satisfaction. These were first cycle audits. The clinical record audit which had been completed in March 2022 was in relation to patient records. It identified that it was a retrospective audit but it was a first cycle audit and in the main looked at records of treatments that were not within the CQC scope of registration.
- A disability access audit had been completed in May 2022 and actions had been identified but there was no timeframes for completion of these actions. They had acceptable access and facilities for patients with disabilities for those treatments provided on the ground floor. We spoke with the management team who told us that the actions, such as lowering the assistance call bell cord were being discussed and costings needed to be explored before further decisions were made.

Effective staffing

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

- All staff were appropriately qualified.
- The provider had an induction programme for all newly appointed staff.
- The nominated individual was appropriately qualified.
- Relevant professionals (medical and nursing) were registered with the Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

Coordinating patient care and information sharing

Requires Improvement

Are services effective?

Staff worked together, but did not work with other organisations to deliver effective care and treatment.

- We examined some patient clinical records (covered under the regulated activities) and saw that before providing treatment, clinicians at the service had not ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Patients were not asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. The GP letter was given to the patient to give to their GP and needed more detail to ensure safe transfer of care between providers and prescribing.

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.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- The management team told us that they understood the requirements of legislation and guidance when considering consent and decision making. They were following current legislation and guidance in verifying the age of patients prior to treatment to ensure informed consent.
- The practice had a consent policy in place but it did not make any references to the Gillick Competencies. (Gillick competency is often used to assess whether a child is mature enough to consent to treatment).
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Staff treated patients with kindness, respect and compassion.

Patients were involved in decisions about care and treatment.

The service respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- For reasons of safety and infection prevention and control related to the COVID-19 pandemic, we did not commission patient feedback with CQC comments cards. We did not speak to any patients during this inspection.
- The service told us that patients had sufficient time during their consultations to make an informed decision about the choice of treatment available to them. These would be treatments carried under the regulated activities of diagnostic and screening procedures, family planning and treatment of disease, disorder and injury.
- The service sought feedback on the quality of clinical care patients received. Feedback from patients was available on the website and on google reviews which was positive about the way staff treated people.
- The service had a score of 4.9 out of five from 236 reviews. Over 98.7% had scored Excellent or Very Good. Only three had given a score three or below.
- Staff understood patients' personal, cultural, social and religious needs.
- The service 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.

- Interpretation services were not readily available for patients who did not have English as a first language. We were told that it was very rare to have a patient who could not speak good English.
- Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service responded to and met people's needs.

Patients had timely access to the service.

The service took complaints and concerns seriously.

Responding to and meeting people's needs

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

- We were told and we saw that patients' individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and where possible, continuity of care, for example, late evening appointments for working age people.
- The provider offered services to adults and children over 13 years of age.
- The service offered consultations to anyone who requested it and paid the appropriate fee and did not discriminate against anyone.
- The service website was well designed and clear and simple to read. However, the provider did tell us that there were services, such as family planning and menopause not being delivered at present but they were not able to remove this from the website due to access rights.
- We were told that they provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients.
- The facilities and premises were appropriate for the services delivered but did not have disabled access.

Timely access to the service

Patients were able to access care and treatment from the service 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 could access the service in a timely way by making their appointment over the telephone or in person. The clinic was open Mon 9:00am to 4:00pm, Tues 10:00am to 8:00pm, Wed 10:00am to 6:30pm,Thurs 10:00am to 8:00pm, Fri 9:00am to 6:30pm and Sat 9:00am to 3:00pm.
- The service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or contact their own GP or NHS111.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available on the service website. A complaints notice was situated at the reception desk with a QR code that patients could scan to read the complaints policy.

Good

Are services responsive to people's needs?

Information was not available to inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint. We saw two complaints (relating to non-regulated activities as we were told there had not been any complaints relating to regulated activities provided). We saw limited evidence that these had been discussed and learning shared in minutes of meetings we reviewed.

- Staff treated patients who made complaints compassionately.
- The service had complaint policy and procedures in place with timescales for responding to the complaint.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

There was a lack of good governance in some areas.

There were some issues identified around the processes for managing risk.

The service did not always have appropriate and accurate information.

There was limited evidence of learning, continuous improvement and innovation.

Leadership capacity and capability.

Leaders did not effectively demonstrate how they used their capacity and skills to deliver high-quality, sustainable care.

- Leaders at the service were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. However, oversight of some governance arrangements was not always effective and the provider could not demonstrate how full oversight was being monitored.
- Staff we spoke with told us that leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

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

Culture

The service did not always have a culture of high-quality sustainable care.

- The service focussed on the needs of the patients. However, they did not always have safe systems and processes in place.
- The provider was aware of the duty of candour but only had some systems in place to ensure compliance with the CQC requirements.
- Staff felt respected, supported and valued.
- The service focused on the needs of patients.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Governance arrangements

Requires Improvement

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management but these need to be strengthened further.

- We saw that structures, processes and systems to support good governance and management were in place but they needed to be further embedded to be effective. This included the system for the management of medicines, management of fire safety and legionella, and monitoring of the cold chain.
- Leaders had established most policies, procedures and activities to ensure safety but they were not assuring themselves that they were working as intended. For example, safe prescribing of medicines, monitoring risk, such as fire and legionella and monitoring of the cold chain. Some of the policies we reviewed did not contain current and up to date information, for example, Gillick competencies, female genital mutilation, or full practice fire safety procedures.
- Staff appeared clear on their roles and accountabilities.
- Staff meetings took place on a regular basis but the meeting minutes did not demonstrate that quality and safety were discussed. During the inspection the management team told us that going forward they would have a set agenda which would contain items such as patient safety alerts, incidents, complaints, infection control, and training.

Managing risks, issues and performance

There were processes for managing risks, issues and performance but these needed strengthening further.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas such as management of medicines and medical records required improvement.
- There were two staff members at the service who carried out the regulated activities and there was no quality monitoring undertaken due to a low number of patients receiving care and treatment.
- Leaders had oversight of incidents and complaints but the system for safety alerts needed further work.
- The service was not able to demonstrate that clinical audit had had a positive impact on quality of care and outcomes for patients. However, the service sought feedback on the quality of clinical care patients received. Feedback from patients was available on the website and on google reviews which was positive about the way staff treated people
- The provider had a formal documented business continuity plan in place

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- The service had some quality and operation information which was used to ensure and improve performance. Performance information was combined with the views of the patients. This was mainly in relation to the caring and responsiveness of the service. However, they did not always have the appropriate information available to monitor the safety of the service.
- Care and treatment records were kept securely but contained limited information. For example, some records lacked past medical history, current medications and name of GP practice. Since the inspection, the service told us that they have reviewed and updated the forms to include this information.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients and the public to support high-quality sustainable services.

- The service encouraged feedback from patients to shape their services.

Requires Improvement

Are services well-led?

- Patients were encouraged to leave reviews on the service's website.
- The service had initiated an online networking tool to communicate quickly with staff members. This networking platform was used to share information, staffing matters and monitor the resources.

Continuous improvement and innovation

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

- There was focus on continuous learning but the service were not able to demonstrate improvements in the quality of care. First cycle audits had been carried but were not detailed enough to demonstration continuous improvement.
- The service made use of internal and external reviews of incidents and complaints but we did not see much evidence that learning was shared and used to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance How the regulation was not being met: The registered person did not have effective governance, assurance and auditing processes 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. Regulation 17 HSCA (RA) Regulations 2014 Good Governance How the regulation was not being met: The registered person did not have effective governance, assurance and auditing processes 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. • There was a lack of good governance in some areas. In particular: • Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner. For example, some clinical records lacked medical histories and current medications. • The service did not have reliable systems for appropriate and safe handling of medicines. • Prescribing was not audited or reviewed to identify areas for quality improvement. • The provider was not completing any clinical audits and therefore there was no scope to ensure care was being provided in line with standards and to make any relevant improvements. • The system in place for patient safety alerts was not effective.

This section is primarily information for the provider

Requirement notices

There was additional evidence of poor governance in particular:-

The provider did not do all that was reasonably practicable to ensure oversight of legal frameworks that allows some registered health professionals to administer specified medicines were signed.

- Management of risk and its associated actions were not fully completed and documented.
- Staff immunisation records were not fully completed for those who carried out regulated activities.
- References were not requested when carrying out recruitment processes.
- Management of the cold chain did not have full oversight to ensure that any issues with the refrigerator were actioned in a timely manner.
- Some policies were not detailed to ensure they contained all the relevant information to provide guidance to staff. For example, pathology results, fire safety, sharps, COSHH, Safeguarding adults, incident and significant events, complaints.
- Meeting minutes did not contain detailed information on discussion, learning and actions. For example, incidents, complaints, patient safety alerts.

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