# Dr Glancey Clinics

## Inspection report

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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 | Inadequate |
| Are services safe? | Inadequate |
| Are services effective? | Requires Improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Inadequate |

# Overall summary

**This service is rated as Inadequate overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Dr. Glancey Clinics on 11 January 2022. Dr. Glancey Clinics is registered under the Health and Social Care Act 2008 to provide the following regulated activities:

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

This service provides independent surgical and non-surgical aesthetic services, offering a mix of regulated treatments as well as other non-regulated aesthetic treatments. 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 Medical Director was in the process of applying to be 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.

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 service website and on Google, that patients were consistently positive about the service, describing staff as professional, helpful and caring. We did not speak with patients as the service did not have patients booked to be seen on the day of the inspection.

**Our key findings were:**

- The service did not have adequate safety systems and processes in place, or oversight of these, to keep people safe.
- The processes for documenting care and treatment patients received were not always completed. Not all staff had completed training relevant to their role.
- Staff treated patients with compassion, respect and kindness and involved them in decisions about their care.
- The service encouraged and valued feedback from patients. Feedback was positive about the service.
- The leadership and governance arrangements at the service were not effective. There was little understanding of the management of risks, a lack of assurance and failures in the systems and processes to ensure safe, effective and well led services.

# Overall summary

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Care and treatment must be provided in a safe way for service users.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report).

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

- Improve the arrangements in place for the follow up of histology results and referral requests made to GPs, for referral on when a skin cancer diagnosis had been made.
- Improve the system for the review of policies and procedures so it is clear which versions are current.
- Improve the arrangements for the documentation of completed appraisals.
- Implement a process to verify the age of patients.
- Implement a process so that medicines prescribed for a named patient should only be used for that patient.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP Specialist Advisor and two CQC Inspectors, one of whom supported the inspection remotely. A member of the CQC medicines team was involved in an advisory role.

## Background to Dr Glancey Clinics

- The name of the provider is Dr. Glancey Clinics Limited. The registered address of the provider is 3-7 Dickens House, Guithavon Street, Witham, CM8 1BJ.
- The provider has one registered location, based in Essex at The Constable Country Medical Centre, Heath Road, East Bergholt, Essex, CO7 6RT. We visited this location as part of our inspection. The provider first registered with the CQC in 2019 and is registered to provide services to adults aged 18 years and over.
- Services offered include those that fall under registration, such as hair transplants, liposuction, labiaplasty, surgical face and neck lifts, thread lift, hay fever injections (Kenalog), skinny jab and joint injections. The provider also offered Accutane however, the provider had not yet prescribed this to any patients. Other procedures that do not fall under the scope of registration include for example, Botox injections, warts and other skin lesions.
- The clinic is located at The Constable County Medical Centre, a purpose-built GP practice on the outskirts of East Bergholt.
- The provider's website is https://www.drglancey-clinics.com
- The practice is open on Mondays, Tuesdays, Wednesdays and Fridays from 9am until 5pm.

**How we inspected this service**

Before the inspection, we asked the provider to send us some information, which was reviewed prior to the inspection day. We also reviewed information held by CQC on our internal systems.

During the inspection we spoke with the only staff member present which was the Medical Director. We made observations of the facilities and service provision and reviewed documents, records and information held by the service.

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.

Inadequate

# Are services safe?

**We rated safe as Inadequate because:**

- The service was not able to evidence that all staff received up-to-date training appropriate to their role. This included safeguarding children and safeguarding adults, infection prevention and control and fire safety training.
- The service did not have appropriate arrangements in place for the management of infection prevention and control.
- The service was not able to evidence staff immunisation checks were complete and up to date.
- There were ineffective systems and arrangements for managing and storing medicines. including controlled drugs, refrigerated medicines, emergency medicines and medical equipment.
- The service did not have a system to check that patients were over the age of 18 years (where necessary) before offering treatment.
- The provider was unable to evidence that staff who acted as chaperones were trained for the role and had received a DBS check.
- The provider was not signed up to receive MHRA alerts and therefore had no process to review and act on relevant alerts and to share them with staff.
- Individual care records were not always written and managed in a way that kept patients safe.

**Safety systems and processes**

**The service did not have all the systems necessary to keep people safe and safeguarded from abuse.**

- The provider conducted safety risk assessments. It had some appropriate safety policies, which were regularly reviewed and available for staff. However, the safeguarding adult policy did not contain any local safeguarding information. The provider was unable to provide evidence that staff received safety information for example fire safety, health and safety from the service as part of their induction and refresher training.
- Whilst the service only treated adults over 18 years of age, the identification of patients was not being checked to verify the age of the patient. Following the inspection, the provider advised they would add wording to their initial enquiry or confirmation of appointment emails stating that ID would be requested to confirm the patients' age. This system needed to be embedded.
- The provider had obtained Disclosure and Barring Service (DBS) checks for four staff members. However, two of these were from a previous employer, one was requested from a different organisation and one did not detail this information. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The provider was unable to evidence that staff who acted as chaperones were trained for the role and had received a DBS check.
- The provider was unable to evidence that all staff had received up-to-date safeguarding and safety training appropriate to their role. Whilst the Medical Director had completed adult safeguarding training to the appropriate level, this had not been completed by other staff. There was no evidence that any staff had completed child safeguarding training.
- The provider was not able to evidence staff immunisation checks were complete and up to date for all staff. This was available for one member of staff. A risk assessment for their roles had not been undertaken.
- The arrangements to manage infection prevention and control was not effective. There was no infection prevention and control audit. We were told that a new member of staff who was due to start in January 2022 would be the infection control lead and would undertake this audit. There was no evidence that staff had completed any infection prevention and control training.
- Whilst we saw evidence of a completed deep cleaning form to confirm cleaning had occurred, there was no documentation regarding what this entailed. We were advised that the landlord had stopped cleaning the provider's area of the building from November 2021. We were told that the cleaning schedules needed to be agreed and implemented.

Inadequate

# Are services safe?

- We were told the landlord was responsible for assessing the risk of Legionella and the provider did not have assurance this had been completed. Following the inspection, the provider was not able to submit a Legionella risk assessment and although monthly water temperature checks were undertaken, there was no evidence these were being carried out in the provider's area of the building.
- There were systems for safely managing healthcare waste.
- The provider ensured that some facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.
- 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 to assess, monitor and manage risks to patient safety.**

- There were arrangements for planning and monitoring the number and mix of staff needed.
- The induction system for staff was ineffective as the provider was unable to provide evidence of completed inductions for all staff.
- The provider told us that all staff had recently completed Basic Life Support training. However, the certificates had not yet been received.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements 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 were not always written and managed in a way that kept patients safe. The care records we examined showed that prescriptions were not consistently recorded in the patient records. This information is needed to deliver safe care and treatment and was therefore unavailable to relevant staff in an accessible way. Following the inspection, the provider confirmed they will save a copy of each prescription sent to the patient.
- The service did have systems in place for sharing information with staff and other agencies, for example the patients GP, to enable them to deliver safe care and treatment. However, we were unable to see evidence of this in patient records as patients had declined consent for the provider to share information with their GP. The provider assured us that information would be shared with the patients GP if it was absolutely necessary, although they had not needed to share information with a patients GP as yet.
- 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.**

- On the day of inspection there were no medical emergency drugs on site apart from one bottle of hydrocortisone. The provider told us these medicines had been removed as they were out of date and a new order had been placed, however, the provider was unable to provide evidence of this on the day of inspection. Following our inspection, we were sent evidence which showed that emergency medicines had been ordered after our visit. However, these did not include all the medications recommended by the provider's trainer for Basic Life Support and no defibrillator pads were ordered.

Inadequate

# Are services safe?

- At the inspection, we saw two checklists named, 'Expiry of Medicine Check' and 'Resus Trolley Check'. However, there was no guidance detailing what checks should be undertaken in order for these to be completed.
- On the day of inspection, we checked the expiry dates of a sample of the medicines and medical equipment stocked at the location. We found some medical equipment had expired. For example, swabs expired in November 2006, and IV catheters which expired in July 2017 and July 2021. We found two sets of defibrillator pads which had both expired in January 2021. This had not been identified during the monitoring checks completed Monday, Tuesday, Wednesday, and Friday from November 2021 up to 8 December 2021 and then the week of 4 to 10 January 2022. Following the inspection, the provider sent evidence of items which they planned to discard.
- Following the inspection, the provider sent guidance for the use of Automated External Defibrillators which had multiple references to dental staff. This guidance had not been adapted to the service.
- We saw evidence that medicines that required refrigeration were stored in the premises' refrigerator. We were told that the fridge temperature was being documented at different times, two to three times a week. However, there was no documentation of refrigerator temperature ranges or a system to monitor this. During the site visit we noted the temperatures ranged from 1.90C to 6.40C within a 15-minute timespan, this is out of the recommended temperature ranges. There was not a policy for the monitoring of refrigerator temperatures and actions to take if the temperatures went out of the recommended temperature range.
- Room temperature checks were not recorded to ensure non-refrigerated medicines were stored within the recommended temperature ranges.
- The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Where there was a different approach taken from national guidance there was not a clear rationale for this that protected patient safety.
- Some of the medicines this service prescribes are unlicensed for example Bioidentical Hormone Replacement Therapy. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are not recommended by the National Institute for Health and Care Excellence (NICE) or the British Menopause Society. NICE Guidance states that clinicians must explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown.

**Track record on safety and incidents**

**The service had a good safety record.**

- There were risk assessments in relation to safety issues.
- The service monitored and reviewed activity in relation to safety incidents which helped it to understand risks and led to safety improvements.

**Lessons learned and improvements made**

**Generally, the service learned and made improvements when things went wrong.**

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, after a medical emergency, additional checks were implemented to ensure the safety of patients.

Inadequate

# Are services safe?

- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- There was no evidence that the service acted on and learned from external safety events nor from patient and medicine safety alerts.
- On the day of the inspection, we were told that two doses of a steroid medication had been administered to some patients. In May 2021 there was a Medicines and Healthcare products Regulatory Agency (MHRA) alert for this medicine, of which the provider was unaware.
- The provider was not signed up to receive MHRA alerts and therefore had no process to review and act on relevant alerts and to share them with staff. Following our inspection, we saw evidence that the provider had registered to receive MHRA safety alerts.

Requires Improvement

# Are services effective?

**We rated effective as Requires improvement because:**

- The provider did not have up to date records for the induction and the completion of training.
- Patients' notes were not always recorded in a timely manner and notes from consultations were not always documented if they were not appropriate for recording in patient letters.
- Medicines prescribed and administered to patients were not always documented in the patients' record.
- The provider had not completed a prescribing audit.
- The process for following up on patient samples which had been sent for histology was not clear.

**Effective needs assessment, care and treatment**

**The provider had some systems to keep clinicians up to date with current evidence-based practice. We saw some evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).**

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- During our review of patient records, we found that although detailed patient letters were written following a consultation, no consultation notes were recorded. We found one patient had been administered medicine which had not been documented in their patient record. In relation to another patient, we were told a surgical procedure had been undertaken which included administration of local anaesthetic and placement of sutures on 10 January 2022 which had not yet been recorded in the patients' notes. For a third patient, we were told a lipoma removal had been undertaken with no preoperative consultation documented. The provider acknowledged where improvements were needed.
- The care records we examined showed that prescriptions were not consistently recorded in the patient records.
- We were told about safeguarding concerns the provider had about an adult patient. However, the provider could not evidence this had been recorded in the patients' record nor whether the wider impact of these safeguarding concerns on children within the family had been considered.

**Monitoring care and treatment**

**The service was involved in some quality improvement activity**.

- The provider submitted two non clinical audits. We reviewed a documentation audit which had been completed in December 2021 which reviewed 25 patient records. The provider scored 97%. The methodology of the audit was unclear. The audit identified two patients for whom the consent form was not signed, 13 patients for whom the COVID-19 form had not been completed and two patients for whom the date of birth was not recorded.
- The provider had not completed a prescribing audit or any audits to demonstrate clinical effectiveness or adherence to good clinical practice.

**Effective staffing**

**Staff did not all have 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. However, the provider was unable to provide evidence of a completed induction programme for four of their staff members.
- Medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.

Requires Improvement

# Are services effective?

- The provider was aware of the learning needs of staff and had a "Mandatory Training Record". However, the provider was unable to provide evidence of up to date records of training which included fire safety, infection prevention and control and child safeguarding. Whilst the Medical Director had completed adult safeguarding training to the appropriate level, this had not been completed by other staff. Following the inspection, the provider advised that all staff would complete training deemed mandatory.

**Coordinating patient care and information sharing**

**Staff worked together, and worked with other organisations, to deliver effective care and treatment.**

- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP.
- Patients received coordinated and person-centred care. Patient information was shared appropriately, and staff referred to other services for example histology. However, we were unable to see evidence of effective working with other agencies as patients had declined consent for the provider to share information with other agencies.
- The process for following up on patient samples which had been sent for histology were not clear.
- We saw evidence that the service monitored the process for seeking consent appropriately.

**Supporting patients to live healthier lives**

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

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified and highlighted to patients.

**Consent to care and treatment**

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

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

Good

# Are services caring?

**We rated caring as Good because:**

Staff treated patients with kindness and compassion and involved them in decisions about their care. Staff protected patients' privacy and dignity.

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- 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 available for patients who did not have English as a first language, however we were told that these had never been needed.

**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 organised and delivered services to meet patients' needs. There were short waiting times for appointments and patients were advised of treatment prices in advance.

**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.**

- The provider understood the needs of their patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, the clinic was based on the first floor and a lift was available for patients to use. Adjustable couches were available in the theatre, recovery and consultation rooms.

**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 reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

**Listening and learning from concerns and complaints**

**The service had a documented process to receive and respond to complaints to improve the quality of care.**

- The service had complaint policy and procedures in place. The service had not received any complaints in relation to regulated activity, so we were not able to review how they had learned lessons from individual concerns, complaints and from analysis of trends.
- Information about how to make a complaint or raise concerns was not available on the website. The complaints policy was available in the waiting room at the clinic. However, this was not the most recent version of the complaints policy, which included information about the independent sector complaints adjudication service. Following the inspection, the provider sent evidence that they had added complaints information to their website and displayed their current complaints policy in the waiting room.

Inadequate

# Are services well-led?

**We rated well-led as Inadequate because:**

- The structures, processes, and systems to support good governance and management were not clearly set out or understood by all members of staff. For example, infection control, medicine checks and safeguarding.
- The service could not evidence they had systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk. This included for example, infection prevention and control and the safe and effective management of medicines.
- The provider did not have oversight of the completion of training deemed mandatory by the provider, and staff had not completed all training relevant to their role.
- The staff were not always clear on their roles and accountabilities.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider did not have oversight of safety alerts and was not signed up to receive safety alerts.
- The provider did not have robust systems in place to ensure regular audits were carried out.

**Leadership capacity and capability**

**Leaders had the capacity and skills to deliver high-quality, sustainable care.**

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

**Vision and strategy**

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

- We saw evidence of a vision and set of values.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

**Culture**

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients. However, they did not always have safe systems and process in place.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- We saw no evidence of a process for ensuring all staff received the development they required. We were informed that appraisals were conducted but saw no documentation to support this.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. We saw no evidence that staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

Inadequate

# Are services well-led?

**There was a lack of clear responsibilities, roles and systems of accountability to support good governance and management.**

- We saw evidence that structures, processes and systems to support good governance and management were not clearly set out or understood by all members of staff. This included the arrangement of management of medicine and infection prevention and control.
- Staff were not always clear on their roles and accountabilities.
- Leaders had established some policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, some of the policies and procedures we reviewed were not specific to the service and did not contain sufficient guidance for staff to undertake their roles. We also noted it was not clear which were the latest versions of policies available to staff. Following the inspection, the provider showed evidence of a new process where dividers had been used to segregate these policies.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Managing risks, issues and performance**

**There were not clear and effective processes for managing risks, although there were some processes for managing issues and performance.**

- There were some processes to identify, understand, monitor and address current and future risks. However, the service could not evidence they had effective processes to assess and monitor risks around infection control and the safe management of medicines.
- The service had processes to manage current and future performance.
- We saw limited evidence that the performance of clinical staff could be demonstrated through audits. There was no clear evidence that changes had been implemented to improve quality as a result of these audits.
- The provider did not have oversight of safety alerts.
- The provider had oversight of incidents and complaints.
- The provider had plans in place for some major incidents.

**Appropriate and accurate information**

**The service did not always have appropriate and accurate information to monitor performance and deliver high quality care.**

- The provider had some quality and operational information to ensure and improve performance. Performance information was combined with the views of patients. This was mainly in relation to the caring and responsiveness of the service. However, they did not always have appropriate information available to monitor the safety of the service provided.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

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

**The service involved patients, the public, staff and external partners to support high-quality sustainable services.**

Inadequate

# Are services well-led?

- The service encouraged and heard views and concerns from the public, patients and staff and acted on them to shape services and culture.
- We saw some evidence of systems to support improvement and innovation work.
- Staff could describe to us the systems in place for patients to give feedback. For example, using an online system and questionnaires in the waiting room. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings. For example, one staff member suggested more comfortable seating the in the waiting room which was actioned.

**Continuous improvement and innovation**

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

- We saw some evidence of a focus on continuous learning and improvement.
- The service made use of reviews of incidents and complaints. 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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>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.<br><br>How the regulation was not being met:<br><br>• The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.<br>• Disclosing and Barring Service (DBS) checks for four staff members. However, two of these were from a previous employer, one was requested from a different organisation and one did not detail this information. However, there was no risk assessment in place to identify and mitigate any associated risks.<br>• The provider did not have guidance in place for what actions staff needed to undertake for checks they completed. This included cleaning, checks of medicines and medical equipment. Some of the policies and guidance we reviewed did not contain clear information which related to the service. For example, in relation to guidance for the use of Automated External Defibrillators and safeguarding adults.<br>• The service did not have a system to check the identity of patients before offering treatment.<br>• The provider was not signed up to receive MHRA alerts and therefore had no process to review and act on relevant alerts and to share them with staff.<br>• There was not an effective system for the oversight of completion of training.<br>• Some of the policies and procedures we reviewed were not specific to the service and did not contain sufficient guidance for staff to undertake their roles. |

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.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury<br>Surgical procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>We served a Section 29 Warning Notice to the provider for Regulation 12, Safe Care and Treatment on 26 January 2022. The provider was given 5 weeks to comply with the Warning Notice.<br><br>• The registered person did not have arrangements in place to take appropriate action for all medical emergencies that could occur, and had not assessed the associated risks.<br>• There were no effective arrangements in place to safely manage medicines.<br>• We found evidence that not all medicines were administered and prescribed safely.<br>• Infection prevention and control risks were not fully assessed. This included the completion of infection prevention and control audits, and guidance for what cleaning needs to be undertaken as part of the cleaning checks.<br>• The risk of and prevent the spread of infections including those that are health care acquired had not been undertaken.<br>• The system and process in place did not ensure all staff members had appropriate training to ensure the safety of patients.<br>• We found not all individual care records were written and managed in a way that kept patients safe.<br>• The system and process in place failed to evidence that the service acted on and learned from external safety events as well as patient and medicine safety alerts.<br>• The service was registered to provide treatment to adults over 18 years of age. There was no system in place to verify the age of patients to ensure patients under the age of 18 were not treated. |