Poland Medical LLP

Poland Medical - Coventry

Inspection report

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Overall summary

We carried out an announced inspection on 10 September 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check on concerns we had received and whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

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.

Poland Medical is registered with the Care Quality Commission (CQC) as an independent provider of medical services and treats both adults and children at the location in Coventry. Poland Medical is registered with the CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury. Services are provided primarily to Polish people who live in the United Kingdom.

Services are available to people on a pre-bookable appointment basis. The clinic employs doctors on a sessional basis most of whom are specialists providing a range of services from gynaecology to psychiatry. Medical consultations and diagnostic tests are provided by the clinic. No surgical procedures are carried out.

Summary of findings

The owner of the service is the registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

Poland Medical is open from 10am until 6.30pm on Sundays. Appointments can be arranged on other days by prior arrangement via the West London clinic. The provider is not required to offer an out of hours service or emergency care. Patients who require emergency medical assistance or out of hours services are requested to contact NHS direct or attend the local accident and emergency department.

Our key findings were:

- Patients' medical records that we viewed were handwritten, often illegible and of an inconsistent standard.
- Not all doctors had completed safeguarding training to the appropriate level.
- The system for sharing learning from significant events was not effective.
- The system for communicating and acting on patient safety alerts was not effective.
- There were very few formal meetings and no full practice meetings. This was considered by the service to be impractical, because the doctors worked on a sessional basis.
- There were no multi-disciplinary meetings.
- Staff were not supported by the provider in their clinical professional development.
- We did not see any evidence of clinical supervision.
- Doctors had completed training, but it was not always effective. For example, the doctors we spoke with were not aware of the provisions of the Mental Capacity Act (2005).
- Information about services, fees and how to complain was available.
- Not all risks to patients were assessed and monitored. For example, there were no infection control audits.
- Medicines and equipment for dealing with medical emergencies was available, but the systems for monitoring them were not always effective. For example, we found one medicine to be out of date.
- There was no system for the reconciliation of pathology results. We were told that results were sent directly to the patient from the laboratory, which meant that the clinic did not receive the results unless notified by the patient.
- There were limited formal governance arrangements.
- There was a broad range of policies and procedures, but individual documents were neither signed nor dated by the reviewer. The index was dated January 2015. We were told that policies and procedures were reviewed every three years.
- The health and safety policy, dated 2009, was overdue for review.
- The premises were visibly clean and tidy.
- A registered manager was in place, but they were not able to be on site on the day of the inspection.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure that patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

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

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

Summary of findings

- Review the emergency medicines held to ensure that they in line with the risks associated with the range of procedures carried out at the clinic.
- Review the system of managing communication with a patient's NHS doctor.

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 Enforcement section at the end of this report).

- The clinic had systems and processes to keep patients safe. However, these were not always effective. For example, not all doctors had been trained to the appropriate safeguarding level and we saw that a potential safeguarding concern had not been flagged with the appropriate authorities. There was not a meeting structure to discuss safeguarding concerns, but referral protocols were available.
- Infection control audits were not carried out.
- Prescription forms were securely stored.
- The practice had no system in place to flag up vulnerable patients or those with a learning disability if they attended the clinic.
- There was no system to ensure that patient information was recorded in patient care records in line with the 'Records Management Code of Practice for Health and Social Care 2016'. Patients' medical records were handwritten, often illegible and of a variable standard. We noted a consistent absence of recorded diagnosis or presumptive diagnosis.
- There was a system for the reporting and investigation of incidents and significant events. We did not see evidence of any significant events, so we were unable to check whether the system was effective. Doctors and staff we spoke with told us that they referred any incidents to the registered manager for action.
- The clinic had adequate arrangements in place to respond to emergencies and major incidents. However, the system for monitoring emergency medicines was not always effective. For example, we found that one medicine was out of date and there was no benzylpenicillin for injection available or water for injection to go with it.
- There was no system for the reconciliation of pathology test results.
- It was unclear how doctors communicated with other services, for example, the patients' NHS GPs. (Details of the patients' NHS GPs were not always recorded on their registration forms, because it was optional and the question about permission to share information with the NHS GP was only asked at the initial visit.)
- There were procedures for assessing, monitoring and managing risks to patient and staff safety, but they were not always effective. For example, there were no infection control audits.

Are services effective?

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

- There was limited evidence that staff were aware of current evidence based guidance.
- All personnel files were kept at the West London location, so we were unable to check training details or recruitment processes. However, we were told by the CQC inspector who led the West London inspection that staff had received training appropriate to their roles and that there were formal processes to ensure that all members of staff received an appraisal. Two doctors we spoke with on the day of the inspection could not provide evidence of personal development.
- We did not see any evidence of a quality improvement programme or any audits at Coventry. According to the minutes of a clinical governance meeting (July 2017) that we saw, a quality improvement manager had just been appointed to introduce comprehensive auditing tools.
- There was no evidence of formal clinical supervision, mentorship or support.

Summary of findings

- We did not see evidence that the provider supported doctors in their continuing professional development.

Are services caring?

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

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

Are services responsive to people's needs?

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

- Information about the services and how to complain was available. We saw that complaints were dealt with in a timely way.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Access to the premises was not suitable for patients with disabilities.
- Appointments were available one day a week. Appointments were available on other days by prior arrangement via the West London clinic.
- Information was available in both Polish and English which was appropriate for the people using the service.
- The schedule of fees was displayed on the website and in the reception area.

Are services well-led?

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

- Governance arrangements were in place, but there was no evidence of a programme of continuous clinical and internal audit. Clinical governance meetings were held, but there was limited attendance and no system for ensuring that learning outcomes from complaints and significant events were shared across the team.
- There were no multi-disciplinary meetings.
- There was no clinical leadership in place to drive quality improvement. According to the minutes of a clinical governance meeting that we saw, a quality improvement manager had just been appointed, but the appointment was too recent to have had any effect. It was not clear whether this manager had any clinical training.
- There was a lack of day to day management supervision on site. The registered manager was based at the West London location. Staff we spoke with said that it was easy to contact the registered manager by email or by telephone.
- The handwritten patient medical records were of an inconsistent standard and frequently illegible to the translators who accompanied the inspection team.
- There was a broad range of policies and procedures, but individual documents were neither signed nor dated by the reviewer. The index was dated January 2015. We were told that policies and procedures were reviewed every three years and that staff signed a separate sheet, which was kept at the West London location, to confirm that they had read the documents. The health and safety policy, dated 2009, was overdue for review.

Summary of findings

- There were arrangements for identifying, recording and managing the majority of risks, issues and implementing mitigating actions. For example, a health and safety risk assessment had been completed, but an infection control audit had not been carried out.

Poland Medical - Coventry

Detailed findings

Background to this inspection

We carried out an announced inspection on 10 September 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check on concerns that we had received and whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor and a member of the CQC medicines team. The team was also supported by two Polish translators.

During our inspection we spoke with the reception staff and two specialist doctors. The registered manager was unable to attend the inspection. We were unable to view personnel records or training records because they were kept at the West London location. We reviewed treatment records of 21 patients.

The inspection was announced at short notice, so the service was not provided with CQC comment cards prior to our inspection. We spoke with three patients on the day of the inspection two of whom had not attended the clinic before.

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

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

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

Are services safe?

Our findings

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

Reporting, learning and improvement from incidents

- There was an incident reporting policy and there were procedures for reporting incidents. Staff we spoke with told us that they would refer any incidents to the registered manager for action. We did not see any evidence that a significant event had been reported, so we were unable to check the effectiveness of the system, including whether there was a system for sharing learning outcomes across the practice team.

Reliable safety systems and processes (including safeguarding)

The service had systems, processes and practices in place to minimise risks to patient safety, but they were not always fully implemented to ensure patient safety was maintained.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The registered manager was the lead member of staff for safeguarding. Safeguarding referral protocols were displayed in the consulting rooms and in the reception office.
- Staff we spoke with demonstrated that they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults. All non-clinical staff and most of the doctors were trained to child protection or child safeguarding level two. However, it is a requirement set out in the Intercollegiate Guidelines (ICG) for all clinical staff working with children to be trained to child protection level three.
- We noted a potential safeguarding concern in a patient's medical record which had not been flagged to the appropriate authorities.
- There was no process in place to alert clinical staff of any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability. There was no register of vulnerable adults and children.
- The service had a chaperone policy. A notice was displayed in the reception area to advise patients that chaperones were available if required. We saw records of patients being offered a chaperone during consultations including intimate examinations. Reception staff who acted as chaperones had received chaperone training, understood the role, and they had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was no system of reconciliation for pathology results. Blood and urine samples were sent to an external laboratory for analysis. Interpretation of test results was an additional service and patients could choose whether to have their results interpreted by the clinic or elsewhere. We were told that results were sent directly to the patient. There was no procedure to check whether the results had been received or by whom or whether any follow up treatment was required.
- We viewed the blood borne viruses policy and staff confirmed that they had regular blood tests. We were told that all immunisation records were kept at the West London location, so we were unable to check them.

Medical emergencies

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

- The clinic had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- All staff received annual basic life support training.
- Emergency medicines were easily available to staff in a secure area of the practice and all staff knew of their location. All the medicines were stored securely, but one medicine was out of date.There was no benzylpenicillin for injection available or water for injection to go with it. We were subsequently informed that the out of date medicine had been replaced and that benzylpenicillin for injection and water for injection were now included in the range of emergency medicines.
- The clinic had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. Contact details for key members of staff were included.

Are services safe?

Staffing

We were unable to check whether the registration details of the doctors had been verified before employment, because the records were kept at the West London location. However, we were told by the CQC inspector who led the West London inspection that:

- All the doctors working at the West London location were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a licence to practice.
- All doctors were appropriately registered with the GMC.
- All the doctors had professional indemnity insurance that covered the scope of their practice.
- All the doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). All the doctors were following the required appraisal and revalidation processes.
- The personnel files of all the clinical and non-clinical staff had been reviewed and that most appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, qualifications and appropriate checks through the Disclosure and Barring Service. Written references from previous employments were not available. The manager told us these were usually taken verbally, however in future they would ensure written references were obtained.

Monitoring health & safety and responding to risks

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

- We viewed the health and safety policy. It was dated 2009, so it was overdue for review. We viewed the health and safety inspection report, which had been carried out in September 2017.
- A fire drill had been carried out in April 2017 and there was a fire risk assessment, dated March 2009. There was no evidence provided that this had been reviewed.
- The clinic had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Infection control

- We observed the premises to be visibly clean and tidy and we saw that cleaning records were maintained.
- There were infection control policies in place and records confirmed that staff had received up to date training. A professional company was contracted to remove clinical waste, which was stored securely in locked bins.
- We did not see an infection control audit to monitor infection control risks. We were subsequently informed by the West London inspector that the registered manager confirmed that infection control audits had not been carried out.
- There was a spillage kit in the reception office to deal with the spillage of bodily fluids such as urine, blood and vomit. The policy was viewed.
- There was a sharps injury policy. Sharps bins were provided in all the consulting rooms, but the bin in one room was neither dated nor secured.
- All instruments used for treatment were single use.

Premises and equipment

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

Safe and effective use of medicines

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

- We viewed the medicines management policy. It stated that emergency medicines were to be checked every week, but they were actually checked on a monthly basis. The system was not effective, because we found that one emergency medicine had expired in April 2017. We were subsequently informed that this medicine was replaced.
- Patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA) were received by the registered manager and we saw a file of alerts. It was unclear how the alerts were communicated to staff or acted on. The doctors we spoke with could not recall any recent alerts and the policy stated that viewing of alerts was optional. We

Are services safe?

were subsequently told that the registered manager had issued a memo directing clinical staff to familiarise themselves with patient safety alerts, but that the policy had not been updated to reflect this change.

- Prescriptions were issued on a private basis. Prescription forms were stored securely.
- We did not see any audits of medicines to monitor the quality of the prescribing.
- We observed that prescribing was not in line with GMC guidelines for prescribing medicines and medical devices 2013.
- We noted a lack of sharing of information with the patients' GPs.
- There was a lack of detail with regard to the prescribing of an antibiotic to which a patient was allergic.
- We saw frequent prescribing of antibiotics without any evidence to support active antimicrobial stewardship, as evidenced by policy or audit.
- We noted consistent absence of recorded diagnosis or presumptive diagnosis in the patient records we viewed.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

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

Staff training and experience

We were unable to check staff training records or personnel records, because they were all kept at the West London location. However, we were told by the CQC inspector who led the West London inspection that:

- The clinic had an induction programme for newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals. All staff had received an appraisal in the last 12 months.
- Staff received training that included: safeguarding, basic life support, fire safety awareness, chaperoning, consent, confidentiality and equality and diversity.
- The clinic could demonstrate role-specific training and updating for relevant staff.

The two doctors we spoke with at Coventry could not provide details of continuing professional development on the day of the inspection.

Working with other services

- The registration form gave patients the choice of whether they would like copies of notes concerning their consultation and treatment forwarding to their NHS doctor.
- We were told that patient information was only shared on request. Letters for the patient's NHS GP were given to the patient. We did not see a policy which provided guidance on information sharing.
- The doctors told us that they referred patients to a range of specialists in primary and secondary care if they needed treatment that the practice did not provide.

Consent to care and treatment

- The clinic had a consent policy in place and the doctors had received training on consent. There was no evidence of identity checks for parental responsibility and no consistent recording of who attended with a child (there were signatures on relevant forms, but there was no indication of the signatory's relationship with the child).
- One doctor we spoke with showed a lack of understanding of the requirement to assess children and young people using Gillick competence and Fraser guidelines when providing care and treatment. (Gillick competence is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate specifically to contraception and sexual health advice and treatment.) The consent for children policy did not include any reference to Fraser guidelines, although it had a description of Gillick competence.
- Neither doctor we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. We were subsequently told by the West London inspector that all the doctors had received MCA training. The consent policy did not contain any reference to the MCA.
- We were told that any treatment including fees was explained to the patient prior to the procedure and that people then made informed decisions about their care.
- The schedule of fees was displayed on the service website and in the reception area.
- We did not see any evidence of a quality improvement programme or any audits at Coventry. According to the minutes of a clinical governance meeting (July 2017) that we saw, a quality improvement manager had just been appointed to introduce comprehensive auditing tools.
- There was no evidence of formal clinical supervision, mentorship or support.
- We did not see evidence that the provider supported doctors in their continuing professional development.

Are services caring?

Our findings

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

Respect, dignity, compassion & empathy

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

Involvement in decisions about care and treatment

- The service gave patients clear information to help them make informed choices including information on the website. The information included details of the specialist doctors, the scope of services offered and the schedule of fees.
- Patients we spoke with told us that the doctors were very professional and helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

- Access to the clinic was not suitable for people with disabilities because there was a step leading up to the main entrance and there was no disabled toilet. We were told that patients with access problems were advised to contact the clinic in advance, so that they could be referred to alternative local NHS or private clinics if suitable access could not be provided. This was also stated on the clinic's website.
- Baby changing facilities were available and there were play tables for children in the reception area.
- A hearing loop was provided for patients who were hard of hearing.
- Staff told us that all patients attending the clinic were either Polish or English speaking. Translation services were not necessary, because staff spoke both Polish and English.
- There was a clinic leaflet which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also services available.
- Information was also available on the website in both Polish and English.
- All patients attending the clinic referred themselves for treatment; none were referred from NHS services. The doctors told us that they referred patients to NHS services when appropriate.

Tackling inequity and promoting equality

- The clinic offered appointments primarily to Polish patients who lived in the area (and had viable finance available) and did not discriminate against any nationality.
- The clinic's website was available in both Polish and English languages.

Access to the service

- The service was open on Sundays from 10am until 6.30pm, which was convenient for patients who could not attend during weekdays. Appointments were available on other days by prior arrangement via the West London surgery. Appointments were available on a pre-bookable basis. Patients could access the service by making an appointment either in person or over the telephone. Urgent appointments were not provided.

Concerns & complaints

There was a system for handling complaints and concerns.

- The complaints policy and procedures were clear and detailed with adequate response times.
- The registered manager was the designated responsible person who handled all complaints in the service. We were told that the complaints log was held at the West London location.
- A complaints leaflet was available to help patients understand the complaints system. Information about how to complain was available on the website.
- We saw that two complaints had been discussed at a clinical governance meeting in July 2017 and appropriately actioned. One complaint concerned a patient who had attended the clinic for an appointment which had been cancelled by the doctor. Reception staff had tried to contact the patient, but did not have the current telephone number. The patient was offered a free consultation and reception staff were reminded to double check patients' contact details.

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.

Governance arrangements

There was a governance framework which supported the delivery of good care, but there were shortfalls.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The manager and the doctors had lead roles in key areas. For example, the registered manager was the safeguarding lead and one of the specialist doctors was the lead for appraisals.
- Practice specific policies were implemented and were available to all staff. However, individual policies were neither dated nor signed. The index of policies showed that they were last reviewed in January 2015. We were told that it was customary to review the documents every three years and that staff were required to sign a separate sheet, which was kept at the West London location, to confirm that they had read the documents. The health and safety policy was last reviewed in 2009.
- We viewed the minutes of one clinical governance meeting which was held in July 2017. We were told that these meetings were held quarterly. The meetings were attended by the board members. The board consisted of the registered manager, the medical advisor and a doctor who was an appraiser. Formal practice meetings, which would have provided the opportunity for lessons to be learned and shared across the team following significant events and complaints, did not take place. We were told that it was impractical to hold full team meetings, because doctors worked on a sessional basis. It was not clear how staff who could not attend these meetings were informed of discussions or decisions.
- There was no evidence of a quality improvement programme or continuous clinical and internal audit in place to monitor quality and to drive improvements. Clinical audit was limited and infection control audits were not carried out. We did not see any clinical audits to monitor the quality of prescribing. According to the minutes of a clinical governance meeting that we saw, a quality improvement manager had just been appointed to introduce comprehensive auditing tools. It was not clear whether this manager had any clinical training.
- There were appropriate arrangements for identifying, recording and managing the majority of risks, issues and implementing mitigating actions. For example, a health and safety risk assessment had been completed in April 2017.
- Patients' medical records were handwritten in Polish, often illegible (translators could not decipher them) and of a variable standard. We reviewed 21 patients' medical records. We noted a consistent absence of recorded diagnosis or presumptive diagnosis. We saw that referral letters were written in English.

Leadership, openness and transparency

- There was no formal clinical leadership and oversight. The registered manager of the clinic had a non-clinical background. One of the specialist doctors was the medical advisor who advised the clinic on medical matters, but we saw no evidence that clinical leadership was provided to drive quality improvement. The doctors provided a wide variety of specialist services on a sessional basis, which made it difficult for them to work as a team.
- Staff told us that there was an open culture within the practice and that they felt that they could raise any issues with the registered manager.
- The registered manager was based at the West London location, but staff said that the manager could easily be contacted for advice and support.

Learning and improvement

- There was no evidence of support for continuing professional development or systems for communicating learning outcomes from incidents or complaints.
- There was no evidence of formal clinical supervision, mentorship or support.

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

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met:** The registered person had systems and processes that were operating ineffectively in that they failed to ensure all staff received safeguarding training at a suitable level for their role. This is in breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met:** • The registered person had systems and processes that were operating ineffectively in that they failed to enable the registered person to maintain accurate, complete, contemporaneous and legible records of service users in respect of care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. • Where responsibility for the care and treatment of service users was shared with, or transferred to other persons, the registered person had not ensured that information was shared or transferred to ensure that timely care planning took place to ensure the health, safety and welfare of the service users. • The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The system for monitoring emergency medicines was not always effective and doctors did not have a clear understanding of the principles of Fraser guidelines or Gillick competency. These matters are in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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

How the regulation was not being met:

- The registered person had systems and processes that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. There was no programme of quality improvement monitoring including continuous clinical and internal audit in place to monitor quality and to make improvements. Clinical audit was limited and infection control audits were not in place. There were no medicine audits to monitor the quality of prescribing. There was no effective system for the reconciliation of pathology test results. There was no effective system for communicating or sharing learning from patient safety alerts, significant events, or complaints. Individual policies were not dated or signed. The health and safety policy 2009 was overdue for a review.
- The registered person had not ensured that systems were in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The registered person had not ensured that management and clinical oversight arrangements were in place on a daily basis.
- There was no formal meeting structure in place for multi-disciplinary or full practice meetings.

These matters are in breach of regulation 17(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.