# 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? | Inadequate |
| 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? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection on 12 September 2022. This was to follow up on breaches of regulations and enforcement identified at our previous inspection on 11 January 2022.

At the previous inspection in January 2022, we rated the service as inadequate overall. This was because we rated the provider as inadequate for providing safe and well-led services, requires improvement for providing effective services and good for providing caring and responsive services. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was served with a warning notice for Regulation 12, Safe Care and Treatment and a requirement notice for Regulation 17, Good governance.

At this inspection in September 2022, we found that the provider had not complied with all of the elements in the warning notice and we identified further concerns.

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 is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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 part of this inspection.

**Our key findings were:**

# Overall summary

- The service did not have adequate safety systems and processes in place to keep people safe for example safe prescribing, medicines management and infection prevention and control.
- The processes for documenting care and treatment patients received were not always completed adequately to keep patients safe.
- Staff treated patients with compassion, respect and kindness and involved them in decisions about their care.
- 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.

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:

- Continue to embed the process for verifying the age of patients.

This service was placed in special measures in January 2022. Insufficient improvements have been made such that there remains an overall rating of inadequate and for safe, effective and well-led services. Due to further serious concerns identified, we took urgent action to suspend the provider from providing regulated activities from this location for the period of one month. The service will be kept under review and if needed could be escalated to further enforcement action. Where necessary, another inspection will be conducted, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

**Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA**

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services.

## Our inspection team

Our inspection team was led by a CQC inspector**.** The team included a GP Specialist Advisor.

## 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. 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 service 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 Medical Director, one healthcare assistant, one dental nurse and one new employee who was unqualified, but who we were told would be trained to become a healthcare assistant. 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:**

At the previous inspection in January 2022, we rated the provider as Inadequate for providing safe services 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.

At this inspection, we found:

- The service was able to evidence that 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 still did not have appropriate arrangements in place for the management of infection prevention and control.
- The service was still not able to evidence that all staff immunisation checks were complete and up to date.
- There were still ineffective systems and arrangements for managing and storing medicines, including controlled drugs, refrigerated medicines and emergency medicines putting patients at risk.
- The service was still not consistently checking that patients were over the age of 18 years before offering treatment.
- The provider was able to evidence that staff had received a DBS check.
- The provider was unable to evidence that they had signed up to receive MHRA alerts and there was no policy regarding the evaluation of these alerts.
- Individual care records were still not always written and managed in a way that kept patients safe.
- The service did not have systems to keep people safe from harm, for example safe prescribing, medicines management and infection prevention and control.
- There were ineffective systems to assess, monitor and manage risks to patient safety.
- Staff did not have the information they needed to deliver safe care and treatment to patients.
- We saw no evidence that the service learned or made improvements when things went wrong.

**Safety systems and processes**

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

- The provider had not conducted safety risk assessments for example a fire risk assessment or a legionella risk assessment. The health and safety risk assessment we reviewed was incomplete and therefore we could not be assured of its effectiveness. The service had some appropriate safety policies, which were available to staff. The provider was unable to provide evidence that staff received safety information for example fire safety or health and safety from the service as part of their induction and refresher training.

Inadequate

# Are services safe?

- Whilst the service only treated adults over 18 years of age, the identification of patients was not consistently being checked to verify the age of the patient. We examined seven patient records and saw that only one patient had been asked to show proof of their date of birth. The provider told us that only new patients are being asked for age verification, not existing patients. We were told that the staff member who greeted the patient carried out this check, but the medical director did not have any oversight of this process and they did not verify that the check had been completed.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out some staff checks at the time of recruitment and on an ongoing basis where appropriate. We examined staff files for six members of staff. We found that none of them had a written job description, only two staff members had any references, and none had an interview summary documented. 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). We saw that one staff member who was responsible for disposing of used sharps instruments had not received any Hepatitis B vaccinations. No associated risk assessment had been carried out. We also saw that there was no record of any immunity to Hepatitis B for two additional staff members.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- There was not an effective system to manage infection prevention and control (IPC). An IPC audit dated 5 April 2022 contained questions which had been ticked as compliant, yet when asked about these questions, we were told that these should not have been ticked as they were not correct. For example “Is there a trained waste management officer” which was ticked as yes but the IPC lead did not know what this meant. No staff member took responsibility for having completed this audit. We were not assured that all that was reasonably practicable was being done to reduce the risk of infection at the service. We were shown an audit dated 7 February 2022 which had highlighted that a legionella risk assessment had not been carried out, and this had been marked as non-compliant. However, no action had been taken to address this. Therefore we were not assured that all that was reasonably practicable was being done to reduce the risk of infection at the service.
- A legionella risk assessment had not been undertaken and therefore we were not assured that patients or staff were being protected from contracting legionella.
- The provider ensured that equipment but not the facilities were safe and that equipment was maintained according to manufacturers’ instructions. There were systems for safely managing healthcare waste.

**Risks to patients**

**There were ineffective systems 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 no induction system for staff.
- We saw that whilst medicines and equipment were available to deal with medical emergencies, the provider was unaware that the strength of one emergency medicine used to treat acute anaphylaxis, was incorrect. We were told by the medical director and an additional staff member that they were unaware that this was not the correct strength to use, despite their own guidelines documenting this. We also saw that one medicine was included in the emergency kit for treating a cardiac emergency which was not included on the service’s guidelines regarding how to treat a cardiac emergency. We found that one medicine used to treat hypoglycaemia was not stored in the refrigerator and the expiry date had not been shortened to ensure it remained effective and safe to use. Staff therefore did not understand their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.

Inadequate

# Are services safe?

- We found that the checklists being used to ensure medical emergency medicines were safe to use were ineffective, as not all medicines held in the emergency kit were included on this checklist. For example, the service held two different strengths of adrenaline but the checklist included only one entry for adrenaline and it was unclear which strength was actually being checked. In addition, it did not show when new medicines had been ordered. This meant that we could not be assured that all the medicines necessary to treat an emergency were safe to use, therefore placing patients at risk of serious harm.
- There were appropriate indemnity arrangements in place.

**Information to deliver safe care and treatment**

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

- Individual care records were not written or managed in a way that kept patients safe. The care records we saw did not show that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. For example, we saw that a treatment was being provided for which the Body Mass Index (BMI) should be recorded. We looked at records of a patient who received this treatment and there was no record of their BMI. This meant that the records were incomplete. In addition, we asked about post-operative care for patients and we were given the example of a patient who after a surgical procedure, had a catheter fitted and were given a ten millilitre syringe of anaesthetic solution to administer themselves at home, in one millilitre doses. There was no evidence in the patient record that any written instructions were given and patients were at risk of incorrect and potentially harmful administration of the treatment which could cause pain, discomfort and additional complications.
- We saw records of a patient who was treated for a post-operative infection, 36 days after their surgery. We saw that no microbiological advice had been obtained regarding the best, if any, antibiotics to prescribe. We were subsequently provided with details of the sensitivities.
- The patient had received multiple doses of injected antibiotics. This patient was at risk of receiving an unnecessary or ineffective treatment and also exposed the patient to potential side effects from the medicine. The medicine which was prescribed could affect the patients' kidney function and hearing, but this had not been tested either prior to or after treatment. This placed the patient at risk of damage to their hearing and kidneys.
- We also saw that the clinical records did not demonstrate safe prescribing. For example, the actual dose prescribed, and the site of administration were not always recorded.
- We saw that when an injection was administered, a photograph was taken to show the lot number and expiry date of the medicine. However, patient records we examined did not always include the photographic evidence.
- 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 some of the patient records we viewed.
- 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.**

- The systems and arrangements for managing medicines including controlled drugs, emergency medicines and equipment did not minimise risks. During the inspection, we saw that the fridge temperature was checked once a day when the provider was working. As the service was not open every day in the summer, the temperature was therefore taken sporadically. There was no documentation of refrigerator temperature ranges or a system to monitor this. We saw that there were thermometers in each clinical room to measure the room temperature (measured in degrees

centigrade) and we saw that there was room temperature guidance which stated that the room temperatures should not exceed 77 degrees fahrenheit. When asked, staff members did not know what this temperature was in degrees centigrade and therefore did not know if the measurements they were taking were in or out of range. We looked at room temperature charts and saw that temperatures regularly exceeded the recommended level in all three rooms where medicines were being stored. For example, we saw temperatures of 29.6°C (85.3°F), 27.4°C (81.3°F) and 26.3°C (79.3°F) recorded on 20, 22 and 15 July 2022 respectively. No action had been taken in response to these readings. Therefore we were not assured that medicines prescribed to patients were stored at temperatures that ensured they remained safe and effective.

- We were told that the Controlled Drugs Accountable Officer for the service was a staff member, however neither the named staff member nor the medical director knew what this role entailed.
- We saw a Controlled Drugs audit, dated 8 August 2022 which concluded that all drug entries had been correctly supported by two signatories. When we looked at the controlled drugs register, we saw multiple entries which were only supported by one signatory. We therefore found this audit to be wholly ineffective and demonstrated that the governance procedures in the service were not sufficient to provide assurance of safe handling of controlled drugs.
- The service kept prescription stationery securely.
- The service did not carry out any medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. We also saw that the antibiotics being prescribed to patients as a first-line antibiotic did not follow guidelines and we could not see that the decision was evidence-based.
- Staff prescribed, administered and supplied medicines to patients and gave advice on medicines which was not in line with legal requirements and current national guidance. We saw that where a different approach was taken from national guidance, there was not a clear rationale for this which protected patient safety.
- A process was in place for checking medicines held in the service, but this was not safe or effective and records were inaccurate. For example, we saw a checklist for tracking medicines kept in the drugs cabinet was updated weekly (last completed on 7 September 2022, three working days prior to the inspection), but we saw that the quantity of certain medicines on the checklist did not match the actual number of medicines present. We found that four tablets of 30mg codeine were marked as being present on the checklist, however these were not in the drugs cabinet and staff did not know where these were. After the inspection, we were sent a photograph of four tablets of codeine which we were told had since been found somewhere else in the service. We also found that the checklist stated that there were 274 tablets of ciprofloxacin in the drugs cabinet, but we saw that there were only 261. The provider was unaware that there were 13 tablets unaccounted for. In addition, the checklist was not checking all medicines held, for example the service held two different doses of co-codamol yet only one dose was being checked according to the checklist. Therefore there was insufficient oversight of the medicines held in the service and unauthorised removal of medicines may not be identified.
- We saw that a patient information leaflet was available for patients prescribed a certain strength of a pain medication. However, the service also prescribed a higher strength of the same medication yet there was no patient information leaflet available for this medicine. Therefore patients may not be receiving all the information needed to take their medicines safely, putting them at risk of harm.
- We saw evidence that steroids were prescribed. However, the medical director was unaware of the amount of steroids contained in the medicine prescribed. We did not have assurance that the provider was aware of what was being provided to patients which gave us concern regarding the competency of staff.
- We saw that patients who were prescribed steroids, were not assessed regarding whether they required a steroid warning card.
- Some of the medicines the service prescribes are unlicensed. 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). We did not see any evidence that patients were advised that their treatment was unlicensed and therefore they could not make an informed choice about whether or not to receive this treatment.

Inadequate

# Are services safe?

**Track record on safety and incidents**

**The service did not have a good safety record.**

- There were not comprehensive risk assessments in relation to safety issues. The service told us that they had not had a significant event or incident since 2020. However, we found various issues which constituted a significant event, for example missing tablets from their medicine's cabinet, yet this had not been identified as such by the provider.
- The service did not monitor or review activity which could have led to the service implementing safety improvements.

**Lessons learned and improvements made**

**We saw no evidence that the service learned or made improvements when things went wrong.**

- There was no system in place for recording and acting on significant events.
- We were told that there had been no significant events since 2020 and so we were unable to assess if the service learned from these events or made improvements.
- As we were told that there had been no complaints, and there were no examples provided of when things had gone wrong, we were unable to assess if the provider complied with the requirements of the Duty of Candour.
- There was no evidence that the service acted on and learned from external safety events nor from patient and medicine safety alerts. During the inspection, we were told that the service had signed up to receive MHRA alerts which were evaluated for relevance to the service by the provider. However, we were shown no confirmation of this, or any guidance regarding the criteria for evaluating if an alert was relevant to the service, and we saw evidence that previous MHRA alerts were not being followed, for example the need to provide a steroid card when prescribing high doses to steroid medication to patients.

Inadequate

# Are services effective?

**We rated effective as Inadequate because:**

At our previous inspection in January 2022, the provider was rated as requires improvement for providing effective services 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.

At this inspection, we found that:

- The provider still did not have up to date records for the induction of staff or an induction policy.
- Patients' notes were still not always recorded in a timely manner.
- The provider still did not always document in the patients' record the medicines which had been prescribed and administered.
- The provider had still not completed a prescribing audit.
- The provider did not have systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians did not fully assess needs and they did not always deliver care and treatment in line with current legislation, standards and guidance.
- The service was involved in some quality improvement activity, but these were ineffective.
- The service sometimes worked well with other organisations

**Effective needs assessment, care and treatment**

**The provider did not have systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians did not fully assess needs and they did not always deliver care and treatment in line with current legislation, standards and guidance (relevant to their service)**

- Patients' immediate and ongoing needs were not always fully assessed. For example, we saw that an asthmatic patient had received treatment with a steroid injection for allergy symptoms, yet there was no evidence that their medical history had been considered or taken into account. There was also no evidence that the patient had been examined or the diagnosis confirmed, and there was no evidence that risks of the medication had been explained to the patient or shared with the patient's GP.
- Clinical records were not always contemporaneous. For example we saw that one entry in a patient record was completed two days after the date of treatment.
- Clinicians did not always have enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.

**Monitoring care and treatment**

**The service was involved in some quality improvement activity, but these were ineffective**.

- The provider told us that audits such as an antibiotic audit, a prescribing audit, or a post-operative infection audit were not carried out. The service was therefore not using audits to make improvements. In addition, we saw

completed audits which were ineffective, for example a clinical records audit, dated 12 March 2022 where the clinical records of the service were compared to advised guidelines. The result was 100% compliant, after answering 190 questions. However, we saw that there were multiple omissions and errors within the service's clinical records and therefore we found this audit to be wholly ineffective. We saw a Controlled Drugs audit, dated 8 August 2022 which concluded that all drug entries had been correctly supported by two signatories. When we looked at the controlled drugs register, we saw multiple entries which were only supported by one signatory. Again, we therefore found this audit to be wholly ineffective.

**Effective staffing**

**Staff had the skills, knowledge and experience to carry out their roles but there was no induction for new staff members.**

- All staff were appropriately qualified. However, there was no induction programme for newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) 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.

**Coordinating patient care and information sharing**

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

- Staff referred to, and communicated effectively with, other services when appropriate. We saw some communications between the service and the patients' GP. However, we found that following treatment with some medicines, there had been no communication with the patients' GP. This resulted in the GP not being aware of the treatment received in this clinic which could potentially compromise the patients' care.
- We did not see that before providing treatment, the provider always had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was sometimes shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

**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.
- We could not be assured that risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

**Consent to care and treatment**

Inadequate

# Are services effective?

**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 but did not always give patients all the information required to make an informed choice.

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.

**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 treated people.
- We were not assured that patients were given all the information necessary to make an informed decision.

**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.

**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 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.
- We saw that referrals and transfers to other services were undertaken in a timely way.

**Listening and learning from concerns and complaints**

**We were unable to assess if the service took complaints and concerns seriously as we were told there had not been any complaints.**

- Information about how to make a complaint or raise concerns was available on the service's website and also displayed in the waiting room.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaints policy and procedure in place.

Inadequate

# Are services well-led?

We rated well-led as Inadequate because:

At the previous inspection in January 2022, the provider was rated as inadequate for providing well-led services 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.
- 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.

At this inspection, we found:

- The structures, processes and systems to support good governance and management were still not clearly set out or understood by all members of staff. For example infection control and medicine checks.
- The service were still unable to evidence that 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 service did have oversight of the completion of training for staff members.
- Staff were still not always clear on their roles and accountabilities.
- Although the service told us they had signed up to receive safety alerts, we did not see evidence of this and we also saw no evidence of these alerts being integrated into patient care.
- The service did not promote a culture of high-quality sustainable care.
- The provider still did not have systems in place to ensure regular audits were carried out, were effective or led to improvements to patient care.
- Ineffective leadership and a lack of oversight and insight meant that some issues from the previous inspection had not been addressed and additionally, we found further serious concerns.

**Leadership capacity and capability;**

**Leaders did not have the capacity and skills to deliver high-quality, sustainable care.**

- Leaders were not knowledgeable about issues and priorities relating to the quality of services.
- Leaders had not addressed multiple issues highlighted in the previous inspection and included in the warning notice issued subsequently.
- 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 but had failed to deliver high quality care.**

- There was a clear vision and set of values.

Inadequate

# Are services well-led?

- 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 or processes in place.
- 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 staff with the development they need. This included appraisals for some staff members. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development.
- We found that one staff member who was involved in patient care and routinely disposed of dirty sharps instruments had not had the relevant immunisations. Therefore, there was not a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

**Although there were responsibilities, roles and systems of accountability they did not support good governance and management and were not understood or effective.**

- We saw evidence that structures, processes and systems to support good governance and management were set out, but not understood or effective. This included the management of medicines and IPC. For example, we saw an annual audit schedule in which there were multiple errors, leading to confusion regarding when these should be carried out. We saw that when audits were carried out, they were not effective. In addition, we saw that checklists for medicines such as emergency drugs were also not effective. We saw that when an issue was highlighted from the IPC audit, no action was taken to mitigate this risk.
- Staff were not 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, no fire, legionella or a full health and safety risk assessments had been carried out.

**Managing risks, issues and performance**

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

- There were some processes to identify, understand, monitor and address current and future risks. However, we were not assured that the service had an effective process to assess and monitor risks around some processes, in particular infection control and the safe management of medicines.

Inadequate

# Are services well-led?

- We saw no evidence that the performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. We saw that whilst some audits had not been completed for example prescribing or post-operative infections, the audits which had been completed had not been correctly carried out and were proven to be completely ineffective. Therefore it was clear that clinical audit did not have a positive impact on quality of care and outcomes for patients.
- Leaders had oversight of safety alerts although it was unclear how the relevance of an alert was evaluated. We also saw that some relevant safety alerts had not been actioned.
- As we were told that no incidents had taken place, we did not have assurance that the leader had oversight of these.
- We were told that the service did not have a business continuity plan.

**Appropriate and accurate information**

**The service did not always have appropriate and accurate information.**

- The provider had some quality and operational information to ensure and improve performance. Performance information was combined with the views of patients. 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.

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

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place for patients to give feedback.

**Continuous improvement and innovation**

**There was evidence of systems and processes for learning.**

- We saw evidence that staff members had completed a range of training modules, although for one staff member, multiple modules (17) had been completed on the same day.

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 |
|---|---|
| Treatment of disease, disorder or injury<br>Surgical procedures<br>Diagnostic and screening procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 (Safe Care and Treatment) and 17 (Good governance) HSCA (RA) Regulations 2014**<br>**Following the inspection, an urgent Notice of Decision to suspend the provider's registration was issued under Section 31 of the Health and Social Care Act.**<br>• The registered person did not have knowledge or arrangements in place to take appropriate action for all medical emergencies that could occur and had not assessed the associated risks.<br>• There were not effective systems to manage infection prevention and control (IPC). Infection prevention and control risks were not fully assessed and audits were ineffective.<br>• There were no effective arrangements in place to safely manage medicines.<br>• Medicines were not administered or prescribed safely.<br>• The risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities had not been assessed.<br>• 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 an ineffective system in place to verify the age of patients to ensure patients under the age of 18 were not treated.<br>• The provider did not evidence that the premises were safe and appropriate for patients and staff.<br>• The provider did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. |

This section is primarily information for the provider

# Enforcement actions

- Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.