J M A Healthcare Limited

Gosforth Private Clinic

Inspection report

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Date of inspection visit: 15 December 2021
Date of publication: 17/02/2022

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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

This was a short- notice announced focused, follow up inspection. This meant the provider had limited notice that we were inspecting. Following our previous inspection in September 2021, we took action to suspend the service from providing regulated activity. This inspection was undertaken to check the service had made sufficient improvements to allow the provision of regulated activities to resume.

Due to the focused nature of this inspection we did not rate the service and the ratings from our previous inspection remained unchanged.

This inspection found the provider had made sufficient improvement in quality and safety, which meant we did not take further action to extend the provider's suspension.

This was because:

- **Staff understood how to protect patients from abuse. Most staff had completed training on how to recognise and report abuse and they were clear how to apply it.**
- **The maintenance and use of facilities, equipment and premises mostly kept people safe.**
- **We found evidence of how staff identified and quickly acted upon patients at risk of deterioration.**
- **There was a new process in place to ensure records were managed and stored securely.**
- **The service had improved processes to make sure staff were competent for their roles, although further improvements were required.**

However:

- **The service did not provide mandatory training in key skills to all staff. Although there was now a system in place to make sure everyone completed it, it was not robust.**
- **The service did not always control infection risk well.**
- **There was not a robust system in place to ensure patients were supported to make informed decisions about their care and treatment.**
- **Not all leaders understood the responsibilities and obligations they had as the provider to meet the standards required by the regulations.**
- **Leaders did not always operate effective governance processes throughout the service, although there were some improved governance processes in place.**

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Inspected but not rated	Due to the focused nature of this inspection, we did not rate the service. • There was a lack of evidence that all staff had training in key skills, however, they did have an awareness of safeguarding processes to protect patients from abuse. • The service did not always control infection risk well. • There was not a robust system in place to ensure patients were supported to make informed decisions about their care and treatment. • Not all leaders understood the responsibilities and obligations they had as the provider to meet the standards required by the regulations. • Although there were some improved governance processes in place, systems were not always effective. • There was evidence staff identified and quickly acted upon patients at risk of deterioration. • There was an improved system and policy in place for staff to manage records. • The service had improved processes to make sure staff were competent for their roles, although further improvement was required.

Summary of findings

Contents

Summary of this inspection

Background to Gosforth Private Clinic

Gosforth Private Clinic Ltd is registered to provide diagnostic and screening procedures, surgical procedures, and treatment of disease, disorder, and injury. On 30 November 2021, the registered manager applied to remove surgical procedures from their registered regulated activities. This application was under review at the time of our inspection.

The registered manager had been in post since the clinic opened in 2015.

The provider's statement of purpose dated 06 December 2021, stated regulated activities to be diagnostic and screening procedures and treatment of disease, disorder and injury.

Specifically, the service provided cardiology consultations and non-invasive cardiology tests. These included echocardiography, ambulatory heart monitoring and 12-lead electrocardiography.

Patients over the age of 18, could contact the clinic directly to book an appointment or be referred by a GP or another provider.

Following our previous inspection on 14 September 2021, we suspended the provider under Section 31 of the Health and Social Care Act 2008. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so.

On 15 December 2021, we conducted a focused follow up inspection. This was to determine whether there was enough evidence that the provider had taken appropriate action, to mitigate immediate risks to patients.

How we carried out this inspection

Our inspection was a short notice announced inspection. This was to ensure the registered manager, nominated individual and appropriate staff would be present, as the service was closed.

The team that inspected the service comprised of four CQC inspectors. The inspection team was overseen by Sarah Dronsfield, Head of Hospitals Inspection.

Outstanding practice

We did not find any outstanding practice during our inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

We told the service that it must take action to bring services into line with the following legal requirements. This action related to diagnostic and screening procedures and treatment of disease, disorder, or injury:

- The service must ensure systems used to identify mandatory training and monitor staff compliance are robust. (Regulation 17(1))
- The provider must ensure all equipment is cleaned and maintained in line with manufacturer's guidance and that this is recorded appropriately. (Regulation 15(1))
- The provider must ensure there is an annual audit schedule, to assess, monitor and improve the quality and safety of the services provided. This includes but is not limited to an effective audit of service user records. (Regulation17(2a)
- The provider must ensure there is a robust system in place to ensure patients are supported to make informed decisions about their care and treatment. (Regulation 17)
- The provider must ensure the ratings poster is always prominently displayed for service users at the service. (Regulation 17)

Action the service should take to improve:

- The provider should ensure staff have access to emergency equipment which is reflective of local emergency procedures and policies.
- The provider should ensure all staff complete a lone working risk assessment in accordance with local policy.
- The provider should ensure all staff receive an appraisal of their performance whilst working in the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Diagnostic and screening services

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Diagnostic and screening services safe?

Inspected but not rated

Mandatory training

The service did not provide mandatory training in key skills to all staff. Although there was now a system in place to make sure everyone completed it, it was not robust.

We reviewed the files of six staff employed at the service. Four files contained evidence of mandatory training certificates or a screen shot of modules completed in substantive NHS roles.

Staff we spoke with confirmed they accessed training via their substantive NHS employer and mandatory training certificates would be present within their personnel files to evidence training. If they were unable to present evidence of their NHS training, staff said they were required to source this from an independent provider of their choice and then present the certificates.

However, one newly appointed staff member about to commence in post, was still to provide evidence of training and one administrative staff who had commenced in October, had several training gaps. Another file contained a screenshot of NHS training, but one of the modules (information governance) had expired very recently.

We saw the provider introduced a training matrix since our last inspection, which they used to monitor training compliance. This referred to modules that consultants, nurses and administrative staff were required to complete. However, it did not list staff by name, so it was unclear which staff within the stated roles had completed training.

We also noted inconsistencies in the modules listed on the matrix, as not all modules referenced within individual policies we reviewed were included. For example, the matrix did not include Mental Capacity Act training and basic life support and did not stipulate the level of safeguarding adults and children training required.

The service did not have a mandatory training policy. This meant it was unclear how the provider maintained oversight of training within the service, ensured staff had received the appropriate levels of training and identified when this had lapsed. There was no formalised process that outlined how the provider would address non-compliance.

Safeguarding

Staff understood how to protect patients from abuse. Most staff had completed training on how to recognise and report abuse and they were clear how to apply it.

The provider now had a written safeguarding policy that all staff were aware of and could access. The policy signposted staff to local authority services and we saw a flow chart in each clinical room and waiting area, indicating safeguarding board contact telephone numbers.

The safeguarding lead had the level of training specified by intercollegiate guidance for their role as safeguarding lead.

We were confident that staff we spoke with would recognise abuse, know how to report it and who to report it to.

Staff understood their responsibilities in identifying adults and children at risk of, or suffering, significant harm and were able to articulate which other agencies they should inform to protect patients.

The service used a training matrix to monitor staff safeguarding training compliance. It indicated that five of the six staff employed at the service had completed safeguarding training. However, this document did not show the levels of adult and children's safeguarding training completed by individual staff in line with intercollegiate guidance.

One administrative staff had not completed safeguarding training and the registered manager told us they had reminded them to complete it. They reassured us it would be completed in January 2022.

Cleanliness, infection control and hygiene

The service did not always control infection risk well.

The provider introduced an infection prevention and control policy since our last inspection.

We saw a contract for domestic cleaning services which stipulated environmental areas to be cleaned and frequency. However, there were still no schedules that described how clinical equipment should be cleaned. Staff we spoke with explained it was the clinician's responsibility to clean clinical equipment after each clinic session and told us they used disinfectant wipes to clean the ultrasound transducer and electrocardiography (ECG) machine leads. We were unclear how the provider was assured equipment was cleaned in accordance with manufacturer's instructions.

We looked at the ECG and echocardiography machines, used for diagnostic tests. We saw some bottles of ultrasound gel that were stored inverted on the echocardiograph machine. These had leaked into the bottle holsters, and the nozzles were grubby. The cleaning record for this machine indicated it was last cleaned 02 December 2021 and the record did not state dates when the clinic was closed. We brought this to the attention of staff at the time and the holsters were cleaned and the gel bottles replaced. The ECG machine cleaning record was blank. The storage compartment on the ECG machine contained razors and assorted items such as pencils and ECG stickers, but we noted it also contained hair and fluff. We brought this to the attention of staff at the time and this was cleaned.

We saw other examples of cleaning logs however, one record was for Monday to Friday, another was for Monday to Saturday, there was one entry dated 01 December and the other dated 13 December and these records did not indicate dates when the service was closed.

Since our last inspection, the theatre room was decommissioned. However, we saw the air exchange unit service and repair records were completed in October 2021.

Inspected but not rated

Diagnostic and screening services

Staff we spoke with explained the service now only used two clinical rooms and did not provide any surgical regulated activities. We saw both clinical rooms were free of clutter, examination couches were clean and had disposable paper rolls, there were disposable privacy curtains that were dated, and most items were stored appropriately. The exception was a first aid box stored on the floor. We brought this to the attention of staff at the time and it was moved.

Waiting areas were clean and had suitable furnishings which were clean and well-maintained.

Environment and equipment

The maintenance and use of facilities, equipment and premises mostly kept people safe.

The provider had completed environmental risk assessments for both clinical rooms used to deliver patient care and decluttered clinical areas. Staff we spoke with explained there was now a dedicated storage room for consumables.

In addition, we saw environmental risk assessments for fire safety and water legionella testing.

Clinical weigh scales were calibrated. Clinicians that used diagnostic equipment, explained the machines conducted a self-calibration test when switched on. However, the machines had not been used since our last inspection, and we did not see evidence of start-up self-calibration records.

We saw emergency resuscitation equipment was stored in a clinical room, in a tagged trolley and was easy for staff to access in the event of an emergency. However, the trolley contained additional emergency advanced clinical algorithms which described administration of intravenous medications. It contained medical gases (cylinder oxygen) and additional equipment such as suction machine, cannulas, syringes and consumable items. The need for this equipment was not risk assessed or aligned to the new medical emergency / resuscitation policy. This meant there was a risk that staff may use equipment and medical gases they were not trained to use, in the event of an emergency. We brought this to the attention of staff at the time.

We saw the provider had introduced a new medical device management policy. Staff we spoke with told us all clinical equipment was serviced annually and we saw evidence of service records for the ECG, echocardiography machine, blood pressure monitor and defibrillator, on file.

We saw a lone working policy which stated all staff working alone should have a lone working risk assessment. However, none of the staff files we reviewed contained one.

Although the service was closed, and there was a sign on the front door, on two separate occasions during our inspection, members of the public accessed the building and were looking for staff. There was no obvious means for them to alert staff when reception was unmanned.

This meant we had concerns that potential risks to staff working alone and security of clinical areas were not sufficiently mitigated.

Assessing and responding to patient risk

We found evidence of how staff identified and quickly acted upon patients at risk of deterioration.

We saw a new serious conditions policy that directed staff to refer patients to NHS if any serious conditions were identified.

Inspected but not rated

Diagnostic and screening services

In addition, we saw a new statement of purpose, which described specific, non-invasive diagnostic procedures undertaken and it stated clearly, the service no longer provided surgical procedures.

The statement of purpose indicated they provided services for patients aged 18 and above. It did not state any exclusions. However, the registered manager explained each patient was assessed individually for suitability to attend the clinic. If for example, they had a complex medical history, they would be redirected to the NHS, as stated in the serious conditions policy.

We saw the provider had introduced a template questionnaire, to be completed with patients at consultation, prior to receiving diagnostic tests. This required patients to disclose previous cardiology history and if they had experienced chest pain. Staff we spoke with explained that individual clinicians would also review referral documentation in advance of consultation, which contained more detail about patient's health history.

The provider had introduced a policy for identification and management of a deteriorating patient. This described early signs of deterioration, escalation and a flow chart for staff to follow. There was detailed information on what to do in clinical scenarios that could happen in the clinic and how to respond. Staff we spoke with were familiar with the processes described in the policy.

Records

There was a new process in place to ensure records were managed and stored securely.

The provider had introduced an information governance and record keeping policy. This stated the retention periods for all types of records, information sharing protocols and stipulated that information governance training was mandatory for all staff.

In addition, the provider reviewed their system to manage patient records and implemented an electronic platform to enable paper records that were stored off site to be scanned and uploaded. This meant they would be accessible to staff in an emergency.

There was now a procedure in place that described the process for informing GP's of consultation and treatment. The policy stated that patients had the right to decline this but were required to sign a declaration confirming their choice.

The registered manager explained they were working towards holding electronic records only, from January 2022. In the interim, there was a lockable filing cabinet available to hold any paper records on site, however, we were told there were currently no records on site, because the service was suspended and they did not plan to consult with patients until January 2022. We saw a new information security policy, which stated the computerised records system was password protected.

We were unable to check whether paper records were comprehensive or met record keeping standards and the records audit alluded to in the provider's action plan had still not been completed. The registered manager told us this would be completed within the next two months.

We saw evidence the provider was registered with the Information Commissioner's Office.

Are Diagnostic and screening services effective?

Inspected but not rated

Diagnostic and screening services

Inspected but not rated

Competent staff

The service had improved processes to make sure staff were competent for their roles, although further improvement was required.

We reviewed six staff files. Five of six files contained a job description and all files of clinical staff contained evidence of professional qualifications and professional registration and revalidation.

The provider did not carry out appraisals of staff and relied on the appraisal carried out by the person's main employer to keep themselves informed. This meant there was still no system in place to appraise staff performance whilst employed at Gosforth Park Clinic Limited. The registered manager told us it was their responsibility to ensure appraisals were added to the staff record held at Gosforth Private Clinic and they used the training matrix to record this.

Of the six files we inspected, one contained an appraisal dated November 2012 and one did not contain an appraisal because the employee had just been appointed. The training matrix indicated three appraisals were scheduled and we found one appraisal in a file that was in date, but not captured on the training matrix.

We noted that all employees had a contract of employment on file. Clinicians had practising privileges agreements on file, however, one of these was not signed and dated by the clinician as accepted.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was not a robust system in place to ensure patients were supported to make informed decisions about their care and treatment.

We saw a new Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards policy which outlined how staff should assess capacity, but it was not linked to the consent policy.

The policy stipulated all staff must have MCA training to make decisions but, this was not shown on the mandatory training matrix we viewed and not all staff had evidence of this in their training records. The policy did not indicate who the lead was or who staff should seek advice from if they were unsure.

We saw a newly introduced consent policy. This contained screening questionnaires for the non-invasive diagnostic procedures provided by the service and associated template consent form, to be completed by the patient and clinician prior to the test.

However, the policy contained confusing information. For example, it applied to 'all patients over the age of 16', but the service only saw patients aged 18 and above. It stated written consent was required for the most invasive procedures and consent could be captured via body language, such as presenting an arm for injection. However, the service did not provide invasive procedures or injections. It stated patients should also sign their care plan to demonstrate they had given consent, but patients did not have documented care plans. We saw consent forms focused on invasive and surgical procedures, which the service did not provide. The consent policy also outlined that the staff should compete a best interest decision form. This conflicted with the assertion that patients who lacked capacity to make their own decisions were not seen at this service.

Inspected but not rated

Diagnostic and screening services

Are Diagnostic and screening services well-led?

Inspected but not rated

Leadership

Not all leaders understood their responsibilities and obligations they had as the provider to meet the standards required by the regulations.

The service was led by the registered manager. They were responsible for the governance of the service and were supported by the nominated individual.

We observed the registration certificate for the service was displayed in reception. However, the most recent ratings poster was not displayed. We brought this to the attention of the registered manager at the time and they ensured it was displayed by the end of our inspection.

Governance

Leaders did not always operate effective governance processes throughout the service, although there were some improved governance processes in place.

Although we saw improvements, there was still not a robust system in place for identifying required training and identifying gaps. The provider did not have a policy defining mandatory training requirements. It was unclear how the provider maintained oversight of training, ensured staff had received the appropriate levels of training and identified when this had lapsed. There was no formalised process that outlined how the provider would address non-compliance with training.

We saw the service now had new policies in place and associated sign- sheet system, for staff to indicate they had read and understood policies.

The registered manager explained they planned to hold monthly governance meetings. They clarified the agenda would include topics such as training compliance, safeguarding issues, any complaints, audit results, cleaning compliance and any operational issues associated with running the clinic.

However, there was still no formal schedule of audits and the retrospective clinical records audit alluded to in the provider's most recent action plan was still not completed.

Managers we spoke with told us they had implemented a new risk register, held on the computer. We did not see a copy of the risk register, however, the registered manager clarified the only risks on it were financial risks and risk associated with regulatory non-compliance.

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider did not ensure all equipment was cleaned and maintained in line with manufacturer's guidance and did not keep appropriate cleaning records. (Regulation 15(1))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not ensure systems used to identify mandatory training and monitor staff compliance were robust. (Regulation 17(1)) • The provider did not ensure there was an annual audit schedule, to assess, monitor and improve the quality and safety of the services provided. This includes but is not limited to an effective audit of service user records. (Regulation17(2a) • The provider did not ensure there was a robust system in place to ensure patients were supported to make informed decisions about their care and treatment. (Regulation 17) • The provider did not ensure the ratings poster was always prominently displayed for service users at the service. (Regulation 17)