Quality Life Centre Ltd

Quality Of Life Medical Centre

Inspection report

573 Green Lanes
London
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Date of inspection visit: 2 and 8 November 2017
Date of publication: 05/03/2018

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced comprehensive inspection of Quality of Life Medical Centre Limited over two days on 2 and 8 November 2017. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations after receiving information of concern regarding consultations undertaken at the service.

We found this service was not proving safe, effective, caring, responsive and well led services in accordance with the relevant regulation.

Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL. The provider has the right to make an appeal against this decision to the First-tier Tribunal (Health, Education and Social Care Chamber), under Section 32(1) of the Health and Social Care Act 2008, within 28 days of the date of the notice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our findings were:

Are services safe?

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

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 not providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was not 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.

Background

Summary of findings

We carried out an unannounced comprehensive inspection at Quality of Life Medical Centre under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned as a result of information we received from an external organisation, regarding concerns about consultations carried out at the service. We carried out the inspection to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Quality Life Medical Centre is a clinic providing a private doctor service, located in the Green Lanes area of the London Borough of Haringey. The service is used mostly by Turkish speakers.

The service is registered to carry out the regulated activities of diagnostic and screening procedures, family planning, surgical procedures, and treatment of disease, disorder and injury. This service is also registered to carry out the regulated activity of services in slimming clinics although at the time of this inspection, the service was not carrying out this regulated activity. At Quality of Life Medical Centre the aesthetic cosmetic treatments that are also provided are exempt from CQC regulation.

The service employs a full-time administration manager and one receptionist and a full-time 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. The Registered Manager is also trained to carry out ultrasonography and phlebotomy. (Ultrasonography is a diagnostic imaging technique based on the application of ultrasound, used to see internal body structures such as tendons, muscles, joints, blood vessels and internal organs. Phlebotomistsare people trained to draw blood from a patient). The service also employs a cardiologist, a urologist, a surgeon, a GP and a doctor referred to as an internist, all of whom work part time.

Quality of Life Medical Centre provides walk-in and same-day doctor and urgent GP appointments as well as pre-bookable appointments with a range of part-time clinicians including a cardiologist, urologist, gynaecologist and a surgeon.

The service is open between 8am to 7pm from Monday to Saturday and between 10am and 5pm on Sunday.

This inspection was an unannounced urgent inspection which meant that we did not ask for CQC comment cards to be completed by patients prior to our inspection.

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. Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL.

- The registered manager, who was not on the General Medical Council's (GMC) 'List of Registered Medical Practitioners', had examined and treated patients.
- The service offered a walk-in service, including for the treatment of children but there was no medicine available to treat meningitis or septicaemia. Meningitis and septicaemia are illnesses that can escalate in a short period of time and although these can affect anyone, young children are at the highest risk of contracting bacterial meningitis and septicaemia.
- The practice did not have effective arrangements in place to ensure all clinical staff had access to information necessary for providing safe care and treatment, for instance guidelines from NICE and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- There were out of date medicines alongside 'in date' medicines ready for use. For instance, we found adrenaline which had passed its expiry date four months previously and a topical antibiotic treatment and an anticonvulsantmedicine which were more than two months past their expiry dates.
- The service did not have effective arrangements in place to manage medicines held at the location. An unlocked cupboard in one consulting room contained 582 capsules of a medicine used to treat epilepsy and neuropathic pain, 510 tablets used to treat pain and 96 tablets normally prescribed to treat depression.
- The provider did not have a system in place for reporting and recording significant events. Neither did the practice identify significant events in order to carry out analyses or take action to improve safety at the practice.
- Only the registered manager had received training to an appropriate level in safeguarding children and adults. We were told that clinical staff undertaking part-time sessional work at the service had received training in safeguarding in their main places of employment but the service could not provide evidence of this. Non-clinical members of staff were unable to demonstrate an understanding of safeguarding or their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances.
- There were no arrangements in place to provide chaperones for patients. Staff we spoke with were unable to describe the role of a chaperone or to describe any circumstances when the attendance of a chaperone might be appropriate.
- The provider had not undertaken appropriate recruitment checks prior to employing staff including clinical and non-clinical staff. This included evidence of satisfactory conduct in previous employments in the form of references for clinicians, details of appropriate checks through the Disclosure and Barring Service (DBS) and proof of identity.
- The provider sterilised reusable minor surgery equipment on the premises but did not have a written process to ensure sterilising equipment was used safely or effectively and was unable to provide evidence of any occasion when the equipment had been serviced or calibrated.
- There was no evidence that any member of staff had received training in basic life saving skills.

Summary of findings

- A cupboard in a consulting room used for minor surgical procedures contained urinary catheters, which showed expiration dates of 2008.
- The provider did not have a cleaning schedule for the cleaning of medical equipment, including an ultrasound scanner and ophthalmoscope and were unable to provide records showing when any medical equipment had been last cleaned.
- The service offered phlebotomy services but did not have a written policy for the management of pathology samples or a system to receive and act on the results of pathology tests in liaison with the patients NHS providers.
- There was no evidence that the provider shared relevant information with other services, for instance, by providing a patient's NHS GP with details of conditions, prescriptions or other treatments.
- The registered manager administered treatments to patients who had sourced their own medicines privately from other countries, for instance, injections for pain management. However, patient records did not include details to show what the treatment was for, and there was no indication that details of such treatment had been passed to the patient's own GP.
- Information provided about the clinicians included details which were inaccurate or misleading. The service's website had a section titled 'Meet the Doctors' and this included a photograph of the registered manager in which they were referred to as a 'Doctor', however, it was not made clear that the registered manager was not included on the GMC List of Medical Practitioners and was not qualified to practice medicine in the United Kingdom.
- The registered manager's business card referred to them as 'Doctor' and included the words 'Medical Director' in their job title and showed the letters MD after their name. This meant that there was a risk that patients who had appointments with the registered manager would incorrectly believe they had received care and treatment from an appropriately qualified person.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL.

- The service could not demonstrate that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards. For instance, there was no evidence the provider had access to guidelines issued by the national institute of health and care excellence (NICE) guidelines and they had not assured themselves that clinicians working at the service had access to this information, although a copy of the British National Formulary (BNF) was available. The British National Formulary is a reference book that contains information on prescribing and pharmacology.
- There was no evidence that the provider had recorded details of patient's past medical history, symptoms and any medicines they were currently taking. The medical record template used by the provider did not facilitate the recording of a systematic medical history, details of clinical examination and diagnosis. In addition the record was not linked to other providers involved with the management of the individual concerned.
- Patient records showed that the date of birth for patients frequently included the default value of 1 January 1970. This meant there was a risk that clinicians would provide care and treatment based on incorrect information and patients were at risk of receiving treatment or advice which would not be appropriate.
- The service did not have a quality improvement programme and did not participate in local audits, national benchmarking, accreditation, peer review or research.

Summary of findings

- The service did not monitor consultations, or carry out prescribing audits to improve patient outcomes.
- The provider did not keep records demonstrating clinical staff had the skills, knowledge and experience to effectively carry out their role.
- There was no evidence that non clinical staff had received any training since being employed at the service, including training in safeguarding, fire safety awareness, basic life support or information governance.

Are services caring?

We found that this service was not providing caring services in accordance with the relevant regulations. Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL.

- The service had not taken sufficient actions to maintain patients' privacy and dignity during examinations, investigations or treatments. For instance, privacy curtains were not provided in four of the five consulting rooms at the location, although a movable privacy screen was available in one consulting room used for ultrasound and gynaecology consultations.
- Patient information was not managed in a way that kept this information confidential. Patient records and consultation notes were kept in unlocked cupboards in two consulting rooms and a computer terminal used by the receptionist did not require a password and was left switched on at all times, including when the desk was left unattended and when the service was closed.
- Security arrangements at the service were not effective. For instance, we saw people who were not members of staff had unaccompanied access to areas where confidential patient information was available, including clinical rooms and administration offices.

Are services responsive to people's needs?

We found that this service was not providing responsive care in accordance with the relevant regulations. Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL.

- The provider's website explained that it was the service's aim to provide 'a wide range of services including walk-in and same-day doctor and urgent GP appointments'. However, the practice rota showed that a qualified GP was only available on two days each week.
- Staff told us that patients who wished to use the walk-in service would frequently be given an appointment with the registered manager. We were told that these appointments were used to assess the patient's needs and help

the patient to decide which clinician was best suited to meet those needs. Evidence we saw showed the registered manager was examining and treating patients during these appointments. The registered manager was not licenced to practice medicine in the United Kingdom. We looked at 30 separate notes of consultations and found that the registered manager had carried out nine of these examinations.

- The service had been established to provide the local Turkish speaking community with easy access to Turkish speaking medical specialists. However, some of the doctors employed at the location were not Turkish speakers and there were no arrangements in place to provide an interpreter during appointments.
- The provider did not provide information about how to access emergency medical care when the service was closed.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. On the day of inspection the registered manager of the service could not demonstrate that they had the experience, capacity or capability to run the service safely or ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, we found that they lacked the knowledge to manage significant aspects of the safety and quality of the services provided and did not have an adequate insight into the challenges faced by the service.

Following this inspection because of serious concerns we applied for and were granted an urgent, order under Section 30 of the Health and Social Care Act 2008 at Highbury Corner Magistrates Court. This had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre, a second location registered to the provider. The provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL.

- The registered manager told us they knew the computer passwords for some of the qualified clinicians who worked at the service, including the GP, and they would log on to the computer system using those passwords when they wanted to review a patient record. This meant we could not be assured around the confidentiality arrangements for patient notes recorded on the clinical system.
- The provider described a vision to provide a wide range of services including walk-in and same-day doctor, urgent GP appointments, a sexual health clinic, medical testing and vaccinations but did not have a robust or realistic strategy for achieving this vision.
- The service had a limited number of policies in place but these were not location specific and had not been made available to staff. For instance, there was no recruitment policy, the infection prevention and control policy referred to a dental location and the safeguarding policy did not include details of local safeguarding contacts. Staff we spoke with us they had not seen the safeguarding policy and were not aware of how they could access this document.
- Arrangements for identifying, recording and managing risks were not effective. For example, although the service had undertaken a fire risk assessment, this had been carried out internally by the registered manager without professional advice, also the risk of legionella had not been assessed.
- There was no clinical leadership at the service which meant there was no oversight of clinical processes, prescribing, patient records or consultation notes.

Summary of findings

- The service did not have systems and processes in place to enable them to accurately assess their performance. We reviewed 30 patient records and found the computer system's default date of birth had not been changed for four of these patients.
- The service did not hold staff meetings for clinical or non-clinical staff.
- The provider could not demonstrate an awareness of the requirements of the duty of candour and did not have systems in place to ensure, compliance with the duty.

Quality Of Life Medical Centre

Detailed findings

Background to this inspection

We inspected Quality of Life Medical Centre over two days, 2 November 2017 and 8 November 2017. Our inspection team was led by a CQC Lead Inspector accompanied by a GP Specialist Advisor and a member of the CQC medicines team. The inspection visit on 2 November was undertaken by a CQC inspector and a CQC Pharmacist Specialist supported by a CQC appointed Interpreter. The inspection visit on 8 November was led by two CQC inspectors and included a GP specialist adviser and the team was supported by a CQC appointed Interpreter.

During our visit we:

- Spoke with a range of staff (registered manager, two non-clinical members of staff and one doctor).
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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.

Patients were at serious risk of harm because the registered manager, who was not on the GMC List of Medical Practitioners, was undertaking patient consultations and providing care and treatment to patients.The service did not have policies and procedures in place to identify, report, investigate or learn from accidents, incidents and significant events. There were limited processes in place to manage infection prevention and control at the service and those processes that were in place were either not being followed or were ineffective. The practice did not have systems in place to ensure that children and vulnerable adults were kept safe from harm and abuse. The service had not made arrangements to provide a chaperone service and could not demonstrate an understanding of why this service might be required. The service had not undertaken appropriate recruitment checks for clinical and non-clinical staff, prior to employment. There were limited procedures in place for assessing, monitoring and managing risks to patient and staff safety. The arrangements for managing medicines, including emergency medicines and vaccines, were ineffective and a substantial risk of causing harm to patients. Staff employed at the service had not received annual basic life support training and although the service had a defibrillator available, there was no evidence that any staff had been trained how to operate this. The service had not made arrangements to ensure clinical staff had access to national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

Safe track record and learning

The provider did not have a system in place for reporting and recording significant events. The practice did not identify significant events to carry out analyses or take action to improve safety in the practice.

- Staff told us they would inform the registered manager of any incidents but there was no system in place to ensure that this happened. Staff we spoke with were unable to demonstrate an understanding of what could constitute a significant event or a serious incident.
- The provider did not have any records of incident reports, patient safety alerts or minutes of meetings where significant events had been discussed although we were aware of recent incidents which could have been considered to be significant events. For instance, when we visited the location on 2 November 2017, we told the provider we had concerns around the management of medicines at the location, as we had found significant quantities of medicines only available by prescription and out of date emergency medicine in an unlocked cupboard in a consulting room. However, this had not been recorded as a significant event and there was no evidence to demonstrate that this had been discussed by staff or that any learning points had been identified.
- Staff we spoke with, including the registered manager were unable to describe a process to support the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Safety systems and processes

- We found evidence which showed that the registered manager, who was not on the GMC List of Registered Medical Practitioners, had undertaken consultations with patients. This evidence showed that they had also carried out examinations of patients, including children and had undertaken ultrasonography procedures for pregnant women. For instance, we reviewed details of appointments recorded in the provider's patient record system and saw that appointments were regularly made to see the registered manager. We also saw consultation notes for appointments which had been completed in the name of the registered manager and these included details of diagnoses and referrals to secondary care providers.
- The registered manager had received training in safeguarding and they had been trained to child safeguarding level three, however there was no evidence that other members of staff had received any training in safeguarding. We were told that sessional clinical staff had undertaken safeguarding training in their main employments, but the provider did not have evidence to demonstrate this. The provider had a safeguarding policy but we were told that this had not been shared with staff and we noted that the policy did not include details of local safeguarding contacts. Staff we spoke with told us they did not know if there was a safeguarding policy in place and were unable to

demonstrate an understanding of safeguarding or their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. For instance, when we asked one member of staff what they understood safeguarding to mean, they told us where to find the fire exit. Another member of staff told us they would look on the internet for advice but were not able to assure us that they had sufficient knowledge of safeguarding terminology to undertake effective research.

- There were no arrangements in place to provide chaperones for patients. Staff we spoke with were unable to describe the role of a chaperone or to describe any circumstances when the attendance of a chaperone might be appropriate. For instance, when we asked one member of staff whether chaperones were available, they told us they could arrange an interpreter. When we described the role of the chaperone in more detail, the same person told us they had been asked to carry out the role on a small number of occasions and would do so if they weren't busy with other duties. However, they had not received training to carry out this role and had not 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.
- The practice had limited processes in place to maintain appropriate standards of cleanliness and hygiene but these were not effective. The registered manager was the infection prevention and control (IPC) lead but there was no evidence that they had received any training to carry out this role and no evidence that any other staff had received training in this area. The provider had not undertaken an IPC audit, there were no cleaning schedules in place and no evidence that cleaning was monitored. Although there was an IPC protocol in place, this was not practice specific and referred to a different location registered to the same provider, but this was a dental location.
- We reviewed cleaning arrangements at the location and found that there was only a single mop available for cleaning clinical and non-clinical areas of the premises. We also found that the single cleaning bucket available contained dirty water which meant there was a significant risk of cross infection. It is recommended to use different cleaning equipment to prevent cross contamination between clinical and non-clinical areas. There were no Control of Substances Hazardous to Health (COSHH) safety data sheets for the cleaning products used.
- There were no arrangements in place to ensure that spillages of bodily fluids, including blood and vomit, could be safely cleaned. There were no biohazard spillage kits available for staff to use. When we asked how the provider would clean such spills, they showed us a large container of oil and told us they would use this with some tissue or cloth although they were unable to explain how this would keep patients and staff safe from the risk of infection.
- The practice had not undertaken an assessment of the risk associated with legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The provider sterilised reusable minor surgery equipment on the premises but did not have a written process to ensure sterilising equipment was used safely or effectively and was unable to provide evidence of any occasion when the equipment had been serviced or calibrated. The provider did not maintain records showing when the equipment had been used or which equipment had been sterilised.
- Arrangements to mitigate against risks of inadequate hand hygiene and processes in place to prevent poor hand hygiene were inadequate. For instance, there was no hot water available for hand washing in the room used for minor surgical procedures. In addition, the sink provided in this room had hand operated taps which meant there was a risk of cross contamination. The sink was of a type that had an overflow hole and a stopper which meant there was a risk that bacteria could grow in these areas. We asked the provider why there was no hot water in this room and he told us that the water heater in this room was in need of repair.
- None of the sharps boxes were labelled with the start date of use and two sharps boxes were found to contain sharps. It is recommended that sharps boxes are disposed of within three months of use or earlier if the sharps box is two thirds full.
- We looked in a cupboard in the room used for minor surgery and found a large quantity of urinary catheters, some of which showed expiration dates of 2008 and some which had an expiration date of 2012. The expiration date on these items refers to the date at which the equipment can longer be considered to be

sterile. This meant there was a risk that patients would be placed at serious risk of infection if these items had been used to treat people. When we pointed these items out to the registered manager, they told us these were due to be disposed of and asked inspectors not to record these items as evidence. We were later told that the catheters had been brought to the location by a patient of the service who was unsure how to dispose of them.

- The provider did not have a cleaning schedule for the cleaning of medical equipment, including an ultrasound scanner and ophthalmoscope and were unable to provide records showing when any medical equipment had been cleaned.
- The provider told us they offered phlebotomy services but did not have a written policy for the management of pathology samples. For instance, there was no guidance around documenting requested tests in the patient record system and no system in place to track and reconcile tests requested against results received.

Staffing

- We reviewed personnel files of the five clinicians and found that these did not include records to show that appropriate recruitment checks had been undertaken prior to employment. For example, there was no evidence of satisfactory conduct in previous employments in the form of references for any clinician whilst only two included details of appropriate checks through the DBS and one did not include any proof of identity.
- There were no personnel files available for non-clinical staff employed at the service which meant we were unable to see proof of identification, evidence of satisfactory conduct in previous employments in the form of references and the appropriate checks through the DBS.

Risks to patients

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

- The location had an up to date fire risk assessment but this had been undertaken by the registered manager and had not been reviewed by a professional adviser. There was no evidence that the provider had carried out a fire drill since the premises had been commissioned in February 2017. Fire marshals had not been designated, staff were unable to identify an assembly point and there was no fire evacuation plan in place to ensure that staff could support patients with mobility problems to vacate the premises. We saw evidence that the fire detection system had been inspected in 2016.
- Clinical equipment had not been calibrated to ensure it was in good working order. The registered manager told us that the location had been in operation for less than a year which meant that clinical equipment in use was not yet due for an annual calibration visit. However, we did not see evidence to confirm that the equipment was new when it was brought into use at the location which meant there was a risk that it had not been calibrated in line with best practice. Electrical equipment was checked to ensure it was safe to use
- The provider had a defibrillator available on the premises but with the exception of an electrical safety test which had been carried out in January 2017, we could not see any records to show that this was checked regularly to ensure that it was in working order when it was needed. There was oxygen and masks available on the premises but there was no process in place to check these regularly to ensure they would be available in an emergency.
- There was no evidence that any member of staff had received training in basic life saving skills. One member of staff we spoke with told us they had received life saving skills training in a previous employment but was unable to provide any evidence showing when this had been received or what the training had included.
- The service was promoted as providing a walk-in service which meant that there was a possibility that patients with acute medical conditions would visit the location. However, when we reviewed emergency medicines available at the location, we found that there were no medicines available to treat meningitis or septicaemia. Meningitis and septicaemia are illnesses that can escalate very quickly and although these can affect anyone, young children are at the highest risk of contracting bacterial meningitis and septicaemia.
- The provider was unable to demonstrate that all clinicians working at the service had suitable professional indemnity arrangements in place. We reviewed the HR records of five clinicians who undertook consultations at the location and found that only two of these included details of valid professional indemnity arrangements. The registered manager showed us a document which they told us was a

malpractice insurance policy providing cover for up to five doctors providing clinical services, however, the policy document we saw did not include a schedule of insured persons or any reference to the number of persons who were covered by the policy.

Information to deliver safe care and treatment

- The practice did not have effective arrangements in place to ensure all clinical staff had access to information necessary for providing safe care and treatment, for instance guidelines from NICE and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). We were told that all clinicians working at the service had concurrent employments in NHS providers and had access to guidelines at those employments, however, the provider could not provide any evidence to confirm this and had not undertaken any assessment to be assured that clinicians reviewed or acted on updated information. We noted that the defibrillator provided at the service was a model for which an urgent safety alert had been issued by the MHRA within the previous six months, however, as the provider had not made arrangements to receive alerts, they were unaware that there was a serious risk that the defibrillator would not function properly when it was needed.
- The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system. For instance, we reviewed 30 patient records and found that these did not contain sufficient information to enable another clinician to take over care or to support a diagnosis and action plan.
- The service offered ultrasound examinations for pregnant women and these were carried out by the registered manager. However although they had received training in ultrasonography, we were unable to see evidence that results from ultrasound examinations were routinely forwarded to specialists for review. The provider had not made arrangements to provide a chaperone service for patients having ultrasound examinations.

Patients had access to information about the clinicians available but some of the information shown was inaccurate or misleading.

- The service's website had a section titled 'Meet the Doctors' and this included a photograph of the registered manager in which they were referred to as a 'Doctor', however, it was not made clear that the registered manager was not included on the GMC List of Medical Practitioners and was not qualified to practice medicine in the United Kingdom.
- In the waiting area there was a noticeboard which displayed numerous Turkish language newspaper articles, which featured the registered manager. A number of these articles referred to the registered manager as a 'clinical doctor' and 'specialist in paediatrics.
- We also noted that the registered manager's business card which was available at reception, referred to them as 'Doctor', included the words 'Medical Director' in their job title and showed the letters MD after their name. This meant that there was a risk that patients who had appointments with the registered manager would incorrectly believe they had received care and treatment from an appropriately qualified person.

Safe and appropriate use of medicines

During our inspection we looked at the systems in place for managing medicines and found they were inadequate.

- The service did not have effective arrangements in place to manage medicines held at the location. The registered manager was unable to tell us what medicines were held or provide any clinical assessment indicating how the service had decided which medicines to stock. During our visit on 2 November 2017, we looked in an unlocked cupboard in one consulting room and found 582 capsules of a medicine used to treat epilepsy and neuropathic pain, 510 tablets used to treat pain and 96 tablets normally prescribed to treat depression. The boxes containing the antiepileptic medicine displayed traces of a pharmacy label but this had been substantially removed and it was not possible to read the name of the pharmacy or the name of the person or organisation to whom the tablets had been dispensed. When we asked the registered manager why these tablets were there, we were initially told that these belonged to a clinician. Shortly afterwards, the registered manager told us that these had been prescribed to a member of staff who had brought them to the premises in order to get advice about how to use these medicines. As we were leaving the premises a short while later, the member of staff told us the medicines were theirs and that they had brought their

entire supply to the surgery as they felt they spent most of their time at work rather than at home. When we visited on 8 November 2017, we noted that all of this medicine had been removed.

- We found out of date medicines alongside in date medicines ready for use. For instance, during our visit to the location on 2 November 2017, we found adrenaline which had passed its expiry date four months previously. When we visited on 8 November 2017, we found a topical antibiotic treatment and an anticonvulsant medicine which were more than two months past their expiry dates. Expired items were isolated during the inspection and the registered manager told us they would arrange for destruction of the medicines, however we were not provided with evidence that this had happened.
- We did not see evidence of a medicines management policy or procedure. The provider had not carried out a risk assessment to identify which medicines would only be prescribed if a patient were to consent to the sharing of information with their own GP. We reviewed 30 patient records and found that none of these contained patient GP contact details.
- There was no evidence that the service received, acted on or shared learning from healthcare or medicines alerts.

Lessons learned and improvements made

There was no evidence that provider was aware of or complied with the requirements of the Duty of Candour. There were no systems in place to support the identification, reporting or investigation of notifiable safety incidents. When we asked the registered manager about this, we were told that there had been no safety incidents since the service had opened in February 2017.

Are services effective?

(for example, treatment is effective)

Our findings

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

There was no evidence that the provider had systems in place to ensure patient's needs were assessed effectively or that care was delivered in line with current guidelines. There was no effective system in place to share information with other service's including patient's GPs and limited evidence that staff sought patients' consent to care and treatment in line with legislation and guidance.

Effective needs assessment, care and treatment

- The service could not demonstrate that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards. For instance, there was no evidence the provider had access to guidelines issued by the National Institute of Health and Care Excellence (NICE) guidelines and they had not assured themselves that clinicians working at the service had access to this information, although a copy of the British National Formulary (BNF) was available. (The British National Formulary is a reference book that contains information on prescribing and pharmacology).
- There was no evidence that guidelines were discussed with doctors in clinical meetings.
- We reviewed 30 medical records and found that there was no evidence that the provider had recorded details of patient's past medical history, symptoms or any medicines they were currently taking. The medical record template used by the provider did not facilitate the recording of a systematic medical history, details of clinical examination and diagnosis. In addition the record was not linked to other providers involved with the management of the individual concerned.
- We noted that four patient records we looked at showed that the date of birth for the patient had not been changed from the default value of 1 January 1970. This meant there was a risk that clinicians would provide care and treatment based on incorrect information and patients were at risk of receiving treatment or advice which would not be appropriate.

Monitoring care and treatment

- The service did not have a quality improvement programme and did not participate in local audits, national benchmarking, accreditation, peer review or research. Information about patients' outcomes was not available, collected, monitored or used to make improvements. We were told that plans were in place to undertake clinical audits in the future but there was no evidence to demonstrate this.
- The service did not monitor consultations, or carry out prescribing audits to improve patient outcomes.

Effective staffing

The provider did not keep records demonstrating clinical staff had the skills, knowledge or experience to effectively carry out their role. We were told that all clinicians undertaking consultations at the service also worked for NHS employers and that records of on-going training were maintained by these employers. However, the provider had not asked for copies of any documents to ensure that training was up to date or relevant to the services offered by the provider.

- Clinicians working in the service did not have direct clinical supervision, monitoring, support, appraisals or training needs analysis and there was no evidence that clinical meetings were held at the service.
- The service did not have an induction programme for newly appointed staff, including clinical and non-clinical staff.
- The service had been open for less than one year which meant that annual appraisals were not yet due. However, we were unable to see any processes in place to ensure that staff had the skills needed to cover the scope of their work. There was no evidence of any ongoing support, for instance coaching or mentoring and although we were told that staff had had one to one meetings, there were no records to demonstrate this.
- There was no evidence that non clinical staff had received any training since being employed at the service, including training around safeguarding, fire safety awareness, basic life support or information governance. The registered manager told us that staff had received informal briefings around safeguarding but was unable to provide any evidence of the areas covered or materials used to support this training.

Coordinating patient care and information sharing

- We were unable to see evidence that the provider shared relevant information with other services in line with GMC guidance, for instance, by providing a patient's

Are services effective?

(for example, treatment is effective)

NHS GP with details of conditions, prescriptions or other treatments. When we asked about this, we were told that patients were offered the option of sharing information with their GP and if they requested this, they were given the information in an envelope and asked to deliver this to the GP in person. We saw details of an occasion when a child had been prescribed with an antibiotic but had returned to the service with a parent a week later to report an allergic reaction to the medicine prescribed. There was no evidence that this information had been shared with the patient's own GP which meant there was a risk the patient could be prescribed the same medicine again.

- The registered manager told us they sometimes administered treatments to patients who had sourced their own medicines privately from other countries, for instance, injections for pain management. Although we saw records indicating when these medicines had been administered and the dose involved, there were no details to show what the treatment was for, and no indication that information to demonstrate whether details of any such treatment had been passed to the patient's own GP. This meant there was a risk that GPs who would not have a full understanding of a patient's full medical history could subsequently prescribe inappropriate treatment.

Supporting patients to live healthier lives

There was no evidence that the service identified patients who may be in need of extra support and signposted those to relevant services.

Consent to care and treatment

There was no evidence that staff sought patients' consent to care and treatment in line with legislation and guidance.

- The registered manager told us that staff had not received training around the consent and decision-making requirements of legislation and guidance, for instance, the Mental Capacity Act 2005.
- There was no evidence to demonstrate that staff routinely carried out assessments of capacity to consent in line with relevant guidance when providing care and treatment for children and young people.
- The registered manager showed us a copy of a consent form which we were told was given to patient's undergoing treatments at the service. However, we did not see any completed versions of this form and there were no processes in place to monitor that patients were asked to complete these forms.

Are services caring?

Our findings

We found that this service was not providing services in a way which was caring.

Kindness, respect and compassion

- The service had not taken sufficient actions to maintain patients' privacy and dignity during examinations, investigations and treatments. For instance, privacy curtains were not provided in four of the five consulting rooms, although a movable privacy screen was available in one consulting room used for ultrasound and gynaecology consultations.
- During our inspection, we noted that a person who was not a member of staff was sitting in the administration office where patient information was stored. We observed that information about patient appointments was visible on a screen in this office and this was not protected at times when the visitor was left alone in the area. On the day of the inspection, we were told this person was paying a social visit to the location. On the day of the inspection, we also observed a different person who was not a member of staff, enter an unoccupied consultation room without challenge and remain there for up to fifteen minutes. When we inspected this room a short while later, we found patient consultation notes in an unlocked cupboard and supplies of an injectable product used in medical aesthetic procedures on an open shelf. This room also contained clinical equipment, including an ultrasound scanner. We asked the registered manager who this person was and were told they were a patient who was due to have an ultrasound appointment. Following the inspection, we were told that the person who had been in the administration office was a graphic designer who was providing contractor services around designing advertisement leaflets and that the second visitor was a personal friend of the registered manager who was paying a social visit and who had waited in a kitchen area.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Involvement in decisions about care and treatment

The provider's website contained information about the services available, although this did not include pricing information. Information about pricing was available at the service location.

Privacy and Dignity

The provider had not taken steps to ensure that confidential information about patients was managed in a way which protected patient's privacy and dignity. We found patient records in unlocked cupboards in two consulting rooms. These records included patient's name and addresses, details of consultations and treatments given. We observed consultation rooms were left open and were not locked when not in use. We also found that the computer used by the receptionist was not protected by a password and was not closed down properly when the premises was closed. Although this computer did not have access to medical records, it had access to appointment information which included the patient's name and home address.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- The provider's website explained that it was the service's aim to provide 'a wide range of services including walk-in and same-day doctor and urgent GP appointments'. However, we were given a copy of the clinic rota and this showed that a qualified GP was only available on two days each week. This meant that there was a risk that patients who visited the location expecting to see a GP on the other five days each week would not be able to do so and treatment could be significantly delayed.
- We were told that patients who wished to use the walk-in service would normally be given an appointment with the registered manager, who was not licenced to practice medicine in the United Kingdom. The registered manager told us these were not consultations but were appointments to discuss the patient's condition or needs, with a view to identifying which clinician would best suit the patient's needs. We were told that the patient would then be advised to make an appointment with that clinician on a day when the clinician was available. The registered manager told us that they did not prescribe medicine during these appointments, but would sometimes recommend treatments which were available without a prescription. On the day of the inspection, we saw notes which demonstrated that patients had been examined and provided with care and treatment during these appointments. We also saw copies of letters, referring patients to secondary care and these had been signed by the registered manager.
- The registered manager told us the service had been established to provide the local Turkish speaking community with easy access to Turkish speaking medical specialists, including a gynaecologist, cardiologist, urologist and surgeon. However, we found that the gynaecologist employed by the service did not speak Turkish and there were no arrangements in place to provide interpreter services during these appointments.
- Although the location had been established primarily to provide medical services to the Turkish speaking community, people who spoke other languages could also make appointments but there were no arrangements in place to provide interpreter services to these patients, although we were told that family members would sometimes translate for patients. However, this was not in line with best practice.
- The provider did not provide information about how to access emergency medical care when the service was closed.
- There were accessible facilities, but the location did not have a hearing loop in place.
- The service was open between 8am and 7pm Monday to Saturday and between 10am and 5pm on Sunday.
- Two of the consulting rooms were located on the first floor and were not accessible to some patients. Arrangements were in place to accommodate these patients on the ground floor.

Listening and learning from concerns and complaints

The practice did not have an effective system for handling complaints and concerns. Although there was a 'comments and complaints' form available, there was no complaints policy or procedure in place and there was no information available to help patients understand the complaints system.

The provider told us they had not received any complaints since they had been registered in February 2017.

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 services in accordance with the relevant regulations.

Leadership capacity and capability;

On the day of inspection the registered manager of the service could not demonstrate that they had the experience, capacity or capability to run the service safely or ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, we found that they lacked the knowledge to manage significant aspects of the safety and quality of the services provided and did not have an adequate insight into the challenges faced by the service.

The provider could not demonstrate an awareness of the requirements of the duty of candour and did not have systems in place to ensure compliance with the duty. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There were no processes in place to identify, record or investigate significant events, for instance when things went wrong with care and treatment.

Whilst practice staff told us that they felt supported, it was unclear how staff, some of whom were new to working in the field of healthcare, were supported in their role due to the absence of any scheduled training, review, appraisal, support or allocated time for development. There was an absolute lack of systems to support and promote learning, openness and transparency.

Vision and strategy

The provider described a vision to provide a wide range of services including walk-in and same-day doctor, urgent GP appointments, a sexual health clinic, medical testing and vaccinations but did not have a robust, realistic strategy for achieving this vision. For instance, although the service advertised walk-in appointments, for the majority of time that the service was open, there were no qualified clinicians on the premises.

Governance arrangements

The provider's governance framework to support the delivery of safe, good quality care was inadequate. This meant that we were not assured services provided were safe or effective.

- The provider allowed a person who was not on the GMC List of Registered Medical Practitioners to examine and treat patients.
- The registered manager told us they knew the computer passwords for some of the qualified clinicians who worked at the service, including the GP, and they would log on to the computer system using those passwords when they wanted to review a patient record. This meant we could not be assured around the confidentiality arrangements for patient notes recorded on the clinical system.
- Security arrangements at the service were not effective. For instance, we noted that people who were not members of staff were able to access clinical rooms and administration offices unaccompanied and without being challenged by managers or staff.
- Patient information was not managed in a way that kept this information confidential. We found patient records and consultation notes in unlocked cupboards in two consulting rooms and were told that the computer terminal used by the receptionist did not require a password and was left switched on at all times, including when the desk was left unattended and when the service was closed.
- Risks within the practice were not effectively managed and risk assessments were either unavailable or insufficient. For instance, the fire risk assessment had been undertaken by the registered manager without expert advice and there was no assessment of the risks associated with legionella.
- The service had a limited number of policies in place but these were not location specific and had not been made available to staff. For instance, there was no recruitment policy, the infection prevention and control policy referred to a dental location and the safeguarding policy did not include details of local safeguarding contacts. Staff we spoke with told us they had not seen the safeguarding policy and were not aware of how they could access this document.
- There no arrangements in place to provide a chaperone service. One non-clinical member of staff told us they would undertake the role if asked and if they weren't busy with other duties but they had not received suitable training and had not received a Disclosure and Barring Service check.
- The provider had not carried out appropriate recruitment checks on staff before employing them.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- There was no clinical leadership at the service which meant there was no oversight of patient records or consultation notes. We reviewed 30 medical records and found that there was no evidence that the provider had recorded details of the patient's past medical history, symptoms or any medicines they were currently taking.
- The service did not have systems and processes in place to enable them to accurately assess their performance. We reviewed 30 patient records and found the computer system's default date of birth had not been changed for four of these patients.
- There was no clinical leadership or oversight of patient safety alerts, serious incidents, NICE guidelines or patient complaints. We noted that the defibrillator provided at the service was a model for which an urgent safety alert had been issued by the MHRA within the previous six months, however, as the provider had not made arrangements to receive alerts, they were unaware that there was a serious risk that the defibrillator would not function properly when it might be required in an emergency.
- The provider did not have a quality improvement programme such as clinical audit in place to improve patient outcomes.
- The service told us they did not hold staff meetings for clinical or non-clinical staff.

Engagement with patients, the public, staff and external partners

The provider could not demonstrate that it encouraged or valued feedback from patients or staff. We found a supply of satisfaction questionnaires on a desk in the reception area but the provider could not tell us if they had ever received any completed forms. There was no evidence that the service had any processes in place to help staff give feedback. Staff told us they had not had any staff meetings or one to one meetings and were unaware if there was an appraisal process in place.

There was no complaints policy in place and although the provider's website included a contact email address and telephone number, it was not clear whether this could be used to make a complaint. We were told that the service had not received any complaint since it had opened.

Continuous improvement and innovation

The provider worked largely in isolation and did not engage with other providers of primary or secondary care or stakeholders in the local health economy. The provider did not have systems in place to identify opportunities for learning or improvement.