# Dr Berni

## Inspection report

40-42
Kingsway, Waterloo
Liverpool
L22 4RQ
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Date of inspection visit: 20, 22 and 26 June 2023
Date of publication: 11/09/2023

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? | Requires Improvement |

# Overall summary

We carried out an announced comprehensive inspection at Dr Berni on 20, 22 and 26 June 2023.

Overall, the practice is rated as inadequate.

Safe - Inadequate

Effective - Inadequate

Caring - Good

Responsive - Good

Well-led – Requires improvement

This was the first comprehensive inspection of the practice since it was registered under a new legal entity.

The full reports for previous inspections can be found by selecting the 'all reports' link for Dr Berni on our website at www.cqc.org.uk

**Why we carried out this inspection**

We carried out this inspection in line with our inspection priorities for inspecting newly registered services.

**How we carried out the inspection**

This inspection was carried out in a way that enabled us to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice's patient records system (this was with consent from the provider and in line with all data protection and information governance requirements).
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit.

**Our findings**

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

**We found that:**

# Overall summary

- The arrangements for managing medicines did not always keep patients safe.
- Systems for managing historical safety alerts were not always effective.
- Care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways. Patients with long-term conditions were not always receiving appropriate monitoring and reviews. Patient consultation records were not always sufficiently detailed to demonstrate the actions taken and the rationale for care and treatment decisions.
- The delivery of high quality care is not assured by the governance arrangements.
- Arrangements for identifying, recording and managing risks were not fully effective.

- Staff dealt with patients with kindness and respect.
- Patient feedback about their involvement in decisions about their care and being treated with care and concern was positive.
- Patients were able to make appointments in a way that met their needs.
- Feedback from patients was being used to drive improvement.

We found breaches of regulations. The provider **must:**

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good clinical governance in accordance with the fundamental standards of care.

Whilst not a breach of regulations the provider **should:**

- Take action to ensure patient records and registers are accurate in relation to all patients for whom there is a safeguarding concern.
- Take action to review the learning needs of members of the staff team and ensure training is planned to meet any identified needs.
- Implement a programme of effective clinical audit aimed at assessing and improving patient care and treatment.
- Ensure immunisation status checks have been obtained for all staff.
- Take action to increase the number of patients undergoing cancer screening.
- Introduce patient surveys and encourage patients to join a Patient Participation Group (PPG) to consult with patients and obtain their views and use this to drive improvement.

We wrote to the provider in June 2023 within a Section 31 letter, seeking evidence to assure us that immediate action was being taken to address the main issues that were identified by the inspection.

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

**Details of our findings and the evidence supporting our ratings are set out in the evidence tables.**

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

Chief Inspector of Health Care

## Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities. A second CQC inspector carried out a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

## Background to Dr Berni

Dr Berni is located in Waterloo, Liverpool, Merseyside at:

40-42 Kingsway

Waterloo

Liverpool

Merseyside

L22 4RQ

The provider is registered with CQC to provide the following regulated activities:

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

The registered provider for the service is Dr Gustavo Adolfo Berni.

The practice staff team includes 7 GPs, one of whom is the lead GP (provider); 4 salaried and 3 locum GPs (5 whole time equivalent GPs): 3 practice nurses (1.8 whole time equivalent): a practice manager and a team of administrative/ reception staff.

The practice provides GP services to approximately 9,200 patients living in the Waterloo and Crosby area of Liverpool.

The practice is open Monday to Friday 8am to 6.30pm. Patients can book appointments in person, via the telephone or online.

Outside of practice opening hours patients can access the out of hours GP by calling the NHS 111 service. Out of hours services are provided by Primary Care 24 (Merseyside) Limited. Extended access is provided locally by another service provider, where late evening and weekend appointments are available.

The practice treats patients of all ages and provides a range of primary medical services.

The practice is situated within the Cheshire and Merseyside Integrated Care System (ICS) and delivers services as part of a General Medical Services contract with NHS England.

The practice is part of a wider network of GP practices.

Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the sixth decile (6 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 97.3% White, 1.1% Mixed, 1.1% Asian and 0.3% Black.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way to people who used the service. In particular:<br><br>• Care and treatment was not always being delivered in line with best practice guidance.<br>• There was a lack of monitoring of patients in terms of the medicines they were prescribed. Medication reviews were not always effective in ensuring appropriate and safe care and treatment.<br>• Patients with long term conditions were overdue monitoring checks.<br><br>• Actions were not always taken to ensure that patients with a potential missed diagnosis were identified, followed up or monitored appropriately.<br>• Consultation notes did not always demonstrate that an appropriate examination had been carried out and did not always include the rational for care and treatment decisions.<br><br>Breach of Regulation 12 (1)(2)(a)(b)(c)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider was not able to demonstrate that systems and processes were in place to effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. In particular: |

This section is primarily information for the provider

# Enforcement actions

- Clinical governance systems and processes for assessing, monitoring and improving the clinical care and treatment provided to patients were not clearly set out.
- Clinical governance systems failed to identify and mitigate risks to the health, safety and welfare of patients.
- The arrangements for clinical governance failed to ensure that relevant national clinical guidance was being followed in the provision of care and treatment.
- There was ineffective governance linked to the prescribing of medicines.
- Patient safety alerts were not always acted upon and there was ineffective governance of the system in place for responding to these.
- There was limited clinical audit activity and no planned programme of clinical audit to asses and improve care and treatment.
- The system for recognising, investigating and acting upon significant events was not effective.

Breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.