The Monteiro Clinic Limited

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Inspection report

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Overall summary

This service is not rated in this inspection. (There were two previous inspections. The first on 4 September 2018,when the service was found not to be providing safe, effective or well led care. The second inspection on 9 May 2019 rated the practice as inadequate. It was rated as inadequate for providing safe, effective and well led care, and good for caring and responsive care.)

We carried out this announced focussed inspection at The Monteiro Clinic on 10 July 2019 to check if the practice had demonstrated improvement in areas detailed as needing improvement in warning notices issued following the inspection on 9 May 2019. The inspection focussed solely on the areas detailed in the warning notices.

The warning notices detailed the following areas:

- Patients who were attending for medicals (such as those requiring clearance to drive heavy goods vehicles) were not having identity checks recorded, as such the service could not guarantee the identity of the patient.
- In three of the 11 records that we reviewed, there was no record on the database that blood and other test results had been checked by a doctor.
- The service did not have a failsafe system to follow up referrals made requiring a two-week appointment.
- Nurses were not trained to undertake long term conditions monitoring that they were required to do as part of their role.
- The service did not have safeguarding registers in place. the lead GP who was the safeguarding lead said that they had not made any safeguarding referrals, but a referral was made for a patient who had been the victim of domestic violence in the period leading to the inspection.
- The service was clean and the cleaner signed when they attended, but there was no cleaning schedule detailing exactly what should be cleaned and when.
- The service did not have adequate prescription security measures in place.
- The service did not record where chaperones had been offered or when they had been in the consultation even where intimate examinations and procedures were required.
- The service did not adequately record consent. Forms for consent to the fitting of implants were not sufficiently detailed.
- There were insufficient governance issues in place to review and manage the issues identified in this inspection that required improvement.
- One of the doctors at the practice had a basic Disclosure and Barring Service check only. An enhanced check is required for clinical staff.
- The database at the practice could not be audited, and doctors at the practice seemed unaware where on the patient record to include information.

Summary of findings

At this inspection we found that the practice had addressed some of the issues from the warning notices. However, we noted that there were areas that had not been addressed, and a clinical records review showed clinical care which was inadequate.

We found that:

- The service did not provide care in a way that kept patients safe and protected them from avoidable harm.
- Patients did not receive effective care from clinicians at the practice, and there were inadequate systems to ensure staff were fit for the role they were undertaking and the management of consent.
- The way the practice was led and managed did not promote the delivery of high-quality, person-centre care. There was a lack of governance systems, protocols and systems to provide safe and effective care.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance.

(Please see the specific details on action required at the end of this report).

This service was placed in special measures and had warning notices placed against it at the last inspection. Insufficient improvements have been made to ensure that patients are receiving safe, effective and well led care. We have also found significant concerns about the care being provided to patients through clinical record review. Therefore, we are taking action in line with our enforcement procedures. A condition has been put in place to remove The Monteiro Clinic Limited, 2 Clapham Park Road, London, SW9 0JG from the provider's registration. Regulated activities may no longer be carried out at this location.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

The Monteiro Clinic Limited

Detailed findings

Background to this inspection

The Monteiro Clinic Limited is an independent provider of medical services. The service provides a full range of General Practice services. The service is provided primarily for patients for whom Spanish or Portuguese are their first language who make up 70% of the services list. Services are provided at 2 Clapham Road, Oval, London, SW9 0JG in the London borough of Lambeth. All patients attending the service referred themselves for treatment; none are referred from NHS services. The patients seen at the service attend sometimes just for one appointment, while many patients attend for follow up of long term conditions. The majority of patients who use the service are adults, but some children are also seen. The provider also provides services at three other sites providing dental care and beauty and skin care services.

The service is open Monday to Friday from 8:30am to 7pm and Saturday 8:30am to 4pm. The service does not offer elective care outside of these hours.

The premise is located on two floors. The property is leased by the provider and the premises consist of a patient reception area, five consulting rooms and a dispensary.

The service is operated by a general practitioner who works at the service. The service also employs three nurses, a service manager and four receptionists. There are six other GPs who work at the service, they are not employed by the service, working on a contract basis. The nursing service had been suspended at a provider level prior to this inspection, meaning the nurses were not providing clinical care at the time of this inspection.

The lead clinician is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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 service is registered with the CQC to provide treatment of disease, disorder or injury and diagnostic and screening procedures.

During the inspection we used a number of methods to support our judgement of the services provided. For example, we interviewed staff, and reviewed documents relating to the service.

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

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

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

Our inspection team was led by a CQC lead inspector. The team included a member of the CQC medicines team and a General Practitioner specialist advisor.

Are services safe?

Our findings

At our previous inspection on 9 May 2019, we found the following areas of concerns in relation to the provision of safe services that contributed to our decision to issue a warning notice:

- Patients who were attending for medicals (such as those requiring clearance to drive heavy goods vehicles) were not having identity checks recorded, as such the service could not guarantee the identity of the patient.
- In three of the 11 records that we reviewed, there was no record on the database that pathology results had been checked by a doctor.
- The service did not have a failsafe system to follow up referrals made requiring a two week appointment.
- The service did not have safeguarding registers in place. the lead GP said that they had not made any safeguarding referrals, however, records seen indicated a referral was made for a patient who had been the victim of domestic violence in the period leading to the inspection.
- The service was clean and the cleaner signed when they attended, but there was no cleaning schedule detailing what should be cleaned and when.
- The service did not have adequate prescription security measures in place.
- One of the doctors at the practice had a basic Disclosure and Barring Service check only. An enhanced check is required.

At our inspection on 10 July we found the following:

- The service had implemented a policy to ensure that all those attending for medicals relating to employment were subject to identity checks. We noted from the 24 records that we reviewed that clinicians were not routinely recording where identification checks had been requested.
- We reviewed 24 records as part of the inspection. Pathology results were being reviewed in the majority of records that we reviewed, however in five of the records we reviewed, we noted that blood tests that ought to be required had not been requested by the doctor prior to dispensing further medicine. For example, three patients taking ACE inhibitors to control hypertension had either never had kidney function tests or had not had these tests in at least three years. Impairment of kidney function is a recognised side effect of taking ACE inhibitors, and kidney function tests should be requested annually.
- The service had implemented a system to follow up all referrals. However, the system did not differentiate between urgent and non-urgent referrals. The system involved two text reminders to the patient. This was not a failsafe system.
- The practice did not have formalised safeguarding registers in place at the time of this follow up inspection. We could see that a database search had been set up to search for safeguarding issues, but it did not locate one record where a safeguarding referral had been made.
- The practice was clean, and the practice had implemented a checklist system for the cleaner to use. We could see that this was being used by the cleaners.
- The practice had ensured that all prescription stationary was securely stored, with usage of prescriptions monitored.
- The practice had ensured that all doctors at the practice had undertaken an advanced Disclosure and Barring Service check.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 9 May 2019, we found the following areas of concerns in relation to the provision of safe services that contributed to our decision to issue a warning notice:

- Nurses were not trained to undertake long term conditions monitoring that they were required to do as part of their role.
- The service did not record where chaperones had been offered or when they had been in the consultation even where intimate examinations and procedures were required.
- The service did not adequately record consent. Forms for consent to the fitting of implants were not sufficiently detailed.
- The database at the practice could not be audited, and doctors at the practice seemed unaware where on the patient record to include information.

At our inspection on 10 July we found the following:

- The practice had implemented some training for nursing staff, but it was insufficient to remove the condition which had suspended the nursing service at a provider level. We found evidence that practice nurses had potentially been undertaking nursing duties during the period that the service had been suspended, and had been documenting consultations that GPs had undertaken.
- As part of a clinical record review, we looked at 24 records. There was no record in those records of chaperones being offered or being present, or of where consent had been recorded.
- The database at the practice had previously been difficult to audit and as a consequence clinical records could not easily be reviewed. Since the last comprehensive inspection, the practice had incorporated a number of searches. These searches were limited to eight clinical conditions. We reviewed 24 clinical records. Of these records, 15 showed patient care that was not in line with best practice guidelines. These are detailed as follows:
- A patient was prescribed methotrexate by a doctor on 29 April 2019. Methotrexate is prescribed for a variety of conditions including rheumatoid arthritis. There is a requirement for patients to have full blood count, renal function and liver function tests repeated every 1 – 2 weeks until therapy is stabilised, thereafter every 2 – 3 months, in order to monitor for potentially fatal side effects. The patient did not have a blood test until 10 July 2019.
- A patient attended The Monteiro Clinic on 15 March 2019 and 20 May 2019 and was prescribed quetiapine for depression. There was no assessment of the patient in the clinical notes to indicate whether the doctor had assured themselves the prescription was appropriate. There was no record of advice given to the patient about possible side effects. The patient was coded as having depression, not major depression. Quetiapine is normally a last choice treatment option due to the potential side effects. Therefore the decision to prescribe this medicine exposed this patient to unnecessary risk of harm. There was no record as to why another first choice option had not been considered.
- A patient attended The Monteiro Clinic on 15 March 2019 and 15 April 2019 and was prescribed quetiapine for stress and anxiety. The record of the consultation did not detail why this was prescribed as opposed to a first line choice treatment. Quetiapine is not a licensed medicine for the treatment of stress and anxiety.
- A patient attended The Monteiro Clinic on 10 May 2019 and 4 June 2019 and was prescribed quetiapine for stress and anxiety. The notes do not detail why this was prescribed. Quetiapine is not a licensed medicine for the treatment of stress and anxiety. There are other treatments available that are licensed for treating stress and anxiety that do not have the same severe side effects. Not trying those medicines first exposes patients to the risk of harm as a result of those side effects.
- A patient attended on 7 March 2019 and was prescribed quetiapine for depression. There was no assessment of the patient in the clinical notes to indicate whether or not the doctor had assured themselves that the prescription was appropriate. There was no record as to why another first choice option had not been considered.
- We reviewed the clinical records of two patients who had been prescribed a course of six diclofenac injections for inflammatory pain. Naproxen is the usual first choice treatment for inflammatory pain. There was no record on the patient's notes as to why diclofenac injection was used for these conditions.

Are services effective?

(for example, treatment is effective)

- A patient attended on 2 July 2019 for a urinary tract infection and was prescribed ciprofloxacin. There was no record as to why a broad spectrum antibiotic had been prescribed instead of a basic first choice antibiotic.
- A patient attended for a diabetes follow up on 4 May 2019. The clinical record showed that the patient was prescribed co-amoxiclav (used to treat infections) but it was unclear why this had been prescribed. The clinical record showed at the diabetic review that the patient had not had physical diabetes checks (eyesight, foot pulses and foot sensitivity) undertaken for more than a year. These checks are vital to prevent serious complications of diabetes such as sight loss and foot infections. Not doing them exposes patients to the risk of harm.
- A patient attended for a diabetes follow up on 8 April 2019. The patient's clinical record did not show that the patient had ever been referred for eyesight or foot pulse tests.
- A patient attended for a diabetes follow up on 13 May 2019. Although this was for a diabetic check there was no record of a recent HbA1C blood test on file. This test determines whether or not the diabetes is well controlled and whether or not it is being controlled by medication. The last test for this was on 30 June 2017. During this period the practice was still dispensing metformin without knowing if it was having the required effect on the patient.
- A patient with diabetes with cracking of skin on the forehead attended the clinic on 19 March 2019 and 18 June 2019 and was prescribed ciprofloxacin on both occasions. No swab tests were undertaken on either occasion to indicate that ciprofloxin should be prescribed, and it is unclear why it was prescribed a second time having not worked when first prescribed. A swab test would identify the most effective treatment options.
- A patient with high blood pressure was being treated with losartan. It is a recognized side effect of this medicine that it can impact on kidney function. The patient attended on 6 June 2019 and a repeat prescription was issued. The last time the patient's kidney function had been tested was on 1 June 2016. Regular monitoring is recommended for patients prescribed medicines of this type, with more frequent monitoring for patients with reduced renal function.
- A patient with hypertension was seen on 30 May 2019 for a follow up and was being prescribed ramipril and atenolol (both used to treat hypertension). The patient had three blood pressure readings taken that day at 192/116, 186/98 and 176/111. These are all very high readings and at the very least should have warranted urgent follow up in 2 weeks, but this was not seen to have been done. The patient attended to pick up repeat prescriptions on 30 June 2019 and 5 July 2019 and no blood pressure check was undertaken on either occasion. There were no records of blood tests for kidney function, cholesterol or blood sugar on the clinical record, all of which should have been required for the management of the condition and to monitor any potentially adverse effects of the medicine. Not doing these tests has exposed this patient to the risk of harm.
- A patient with hypertension attended for a check-up and to collect a repeat prescription on 1 June 2019. The patient was being prescribed three different ACE inhibitors, all of which require the patient having regular blood tests before commencing the medicines and shortly after taking them after which regular monitoring is recommended. There was no record on the patient record of kidney function tests. Not carrying out these checks has exposed this patient to the risk of harm.

Are services well-led?

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

Our findings

At our previous inspection on 9 May 2019, we found the following areas of concerns in relation to the provision of safe services that contributed to our decision to issue a warning notice:

- There were insufficient governance issues in place to review and manage the issues identified in this inspection that required improvement.
- The database at the practice could not be audited, and doctors at the practice seemed unaware where on the patient record to include information.

At our inspection on 10 July we found the following:

- We have found evidence that GPs did not work in accordance with national guidance and guidelines, for example, treatment of patients with hypertension and diabetes. It was not evident what guidelines they were following, if not recognised national guidance, as there were no in-house policies or procedures for clinical staff to follow.
- The practice did not have systems in place where it could assure itself that clinicians were prescribing in line with best practice as they did not audit their work. The clinical records we reviewed detailed care that was not in line with best practice guidance, showed that follow ups and tests were not being carried out and that patients with potentially serious issues were not being managed. As a result, the practice was unaware of the risks of harm to patients and had not taken any action to improve the level of care and treatment provided to patients.
- The practice manager stated that he was updating the clinical database to include best practice prompts for clinicians at the practice. It was not clear what clinical oversight there was to these changes being made.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1) The service was not assessing, treating and monitoring the care of patients in line with standards defined by national quality requirements and other local and national guidelines. 2) The service did not have a failsafe system for ensuring that urgent referrals were actioned. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1) The service had been allowing nurses to work at a time when a CQC imposed condition was in place which did not allow them to do so. 2) The database at the practice did not have functions which allowed clinical records to be easily reviewed. 3) GPs did not work in accordance with national guidance and guidelines, for example, treatment of patients with hypertension and diabetes. It was not evident what guidelines they were following, if not recognised national guidance, as there were no in-house policies or procedures for clinical staff to follow. 4) The practice did not have systems in place where it could assure itself that clinicians were prescribing in line with best practice as they did not audit their work.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.