Origem Limited

London Prevention Clinic

Inspection report

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Overall summary

We previously carried out an announced comprehensive inspection of London Prevention Clinic on 19 April 2018 and found that the service was not providing safe, effective or well-led care and was in breach of Regulation 12: 'Safe care and treatment' and Regulation 17: 'Good governance' of the Health and Social Care Act 2008. In line with the Care Quality Commission's (CQC) enforcement processes we issued two warning notices which required London Prevention Clinic to comply with the Regulations by 15 June 2018. The full comprehensive report of the 19 April 2018 inspection can be found by selecting the 'all reports' link for London Prevention Clinic on our website at www.cqc.org.uk.

We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was now meeting the Regulations of the Health and Social Care Act 2008.

The previous inspection on 19 April 2018 identified areas where the provider had not complied with Regulation 12: 'Safe care and treatment'. We found:

- Patient records were not written and managed in a way that kept patients safe.
- There was no evidence the service reviewed and acted upon medicines safety alerts.
- The service did not have all the required medicines or equipment to use in a medical emergency and there was no evidence that regular checks of emergency medicines were completed.
- Some staff members, including clinical staff, had not had an enhanced disclosure and barring service (DBS) check.
- There was no evidence that staff had received training to carry out the activities they were undertaking at the service, for example three members of clinical staff in relation to basic life support training, the sonographer in relation to mammograms and one of the doctors in relation to cervical smear tests.

The inspection on 19 April 2018 also identified areas where the provider had not complied with Regulation 17: 'Good governance'. We found:

- The service had not completed any quality improvement activity, such as clinical audits.
- There was no method to audit prescribing as prescriptions were not attached to patient records or retained on the computer system.
- There was no system to check that clinical staff had professional indemnity insurance and there was no evidence of professional indemnity insurance for some clinical staff.
- The fire safety processes were not effective. No fire drills had been carried out and there was no evidence of fire alarm tests and fire extinguisher checks.

Summary of findings

- Many policies were not specific to the service, as they identified individuals who did not work for the service as leads in certain areas, and outlined processes which were not actually in place for the service.

At this inspection on 19 June 2018 we found that the provider had taken some action in relation to the provision of safe, effective and well-led care, however there were still breaches of the Regulations.

Our key findings were:

- Patient records were not written and managed in a way that kept patients safe and we saw evidence of inappropriate prescribing.
- There was no system to ensure medicines or safety alerts were recorded, discussed and acted upon by staff.
- Not all clinical staff had enhanced disclosure and barring service (DBS) checks.
- The service did not consistently deliver care in line with current evidence based guidance.
- Some of the policies were not specific to the service, as they identified individuals who did not work for the service and outlined processes which were not actually in place.
- All clinicians had completed basic life support training.
- The service had appropriate arrangements for emergency medicines and equipment.
- The service had started to undertake some quality improvement activity.
- The record system had been updated so that prescriptions would be saved to patients' records.
- Mammograms were sent to a company to be reported on by consultant radiologists.
- The doctor had completed an online training course in cervical smear tests.
- Fire safety processes had improved and were effective.
- There were appropriate professional indemnity arrangements in place for clinicians.

We identified regulations that were not being met and the provider must:

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

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Review the necessity for clinicians undertaking cervical smear tests to demonstrate they are taking adequate samples.
- Review the language in which patient records are written by clinicians.

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?

In relation to the provision of safe care we found:

- All clinicians had completed basic life support training.
- The service had appropriate arrangements for emergency medicines and equipment.
- Patient records were not written and managed in a way that kept patients safe.
- We saw evidence of inappropriate prescribing.
- There was no system to ensure medicines or safety alerts were recorded, discussed and acted upon by staff.
- Not all clinical staff had enhanced DBS checks.

Are services effective?

In relation to the provision of effective care we found:

- The service had started to complete some quality improvement activity, such as an ultrasound referral audit.
- The record system had been updated so that prescriptions would be saved to patients' records.
- Mammograms were sent to a company to be reported on by consultant radiologists.
- The doctor had completed an online training course in cervical smear tests.
- The service did not consistently deliver care in line with current evidence based guidance.

Are services well-led?

In relation to the provision of well-led care we found:

- Fire safety processes had improved and were effective.
- There were appropriate professional indemnity arrangements in place for clinicians.
- Some of the policies were not specific to the service.

London Prevention Clinic

Detailed findings

Background to this inspection

London Prevention Clinic is an independent health service based in Canary Wharf, London. The service offers blood tests, ECGs, physical examinations, health screenings and check-ups for adults over the age of 18, who primarily come from Brazil. The service also provides mammography and ultrasound (abdominal, breasts, pelvic).

The service registered with the CQC in June 2017 to provide the following regulated activities: diagnostic and screening procedures; and treatment of disease, disorder and injury.

The service is open from Monday to Friday from 9am to 6pm and Saturday from 9am to 1pm.

The lead doctor at the service is the nominated individual. A nominated individual is a person who is registered with the CQC to supervise the management of the regulated activities and for ensuring the quality of the services provided.

The other doctor at the service is the registered manager. A registered manager is a person who is registered with 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.

We carried out this inspection to review in detail the actions taken by the provider in relation to the warning notices issued by the CQC following the previous inspection on 19 April 2018 and to check whether the provider was now compliant with the Regulations.

Our inspection team was led by a CQC lead inspector, who was supported by a GP specialist advisor.

During this inspection on 19 June 2018 we:

- Spoke with the two doctors at the service (who were also the nominated individual and registered manager) and the administration assistant.
- Reviewed a sample of patient care and treatment records.

Are services safe?

Our findings

At our previous inspection on 19 April 2018 we identified that the arrangements for providing safe care did not comply with Regulations. We found:

- Three members of staff (one administrative, two clinical) only had basic disclosure checks, rather than an enhanced check, and for two members of clinical staff there was no evidence of any disclosure and barring service checks (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).
- There was no medical oxygen cylinder or medicine to treat anaphylaxis and no assessment of whether or not these were necessary. The pads and battery were not attached to the defibrillator and clinical staff told us they did not know or were not confident in how to use it. We saw that there were no syringes, needles or water located with the emergency medicines for administration. There was no evidence that the service carried out regular checks of the emergency medicines.
- There was no evidence in staff files that three members of clinical staff had completed basic life support training.
- The service was not signed up to receive any medicines safety alerts and there was no evidence that the service was aware of or acted upon safety alerts.
- Individual care records were not written and managed in a way that kept patients safe. We reviewed 17 patient records on the computer system. In 15 of these records we found inadequate record keeping, including: records of mammograms being completed with no associated clinical consultation notes with a doctor on the system; no evidence of clinical justification for patients having mammograms; no record of when the patient last had a mammogram; records of examinations had limited detail or were blank; no evidence of any safety-netting; no evidence of any follow-up with the patient; and no evidence that the patient was informed of test results or electrocardiogram outcomes following their appointment.
- Incoming patient referral letters were not scanned onto the system or retained by the service. Staff told us they would check the referral letter when the patient attended for their appointment, but would then hand back the letter to the patient. We reviewed patient records for appointments which the doctors told us had been incoming referrals from other services or clinicians, and we found no evidence that documented the patient had been referred and no evidence of any communication with the referring clinician.

At this inspection on 19 June 2018 we reviewed the requirements contained in the warning notices issued to the provider, and found the service had made some improvements to the provision of safe care. Specifically:

- All clinicians had completed basic life support training in April and May 2018.
- The service had appropriate medicines and equipment to use in a medical emergency and we saw evidence that regular checks of emergency medicines were completed, however there was no evidence of checks of the emergency equipment. During the inspection, the service printed off a log to complete for emergency equipment checks.

However, there were still areas where the service was not providing safe care in accordance with the Regulations:

- The service had requested new disclosure and barring service (DBS) checks for all clinicians following the previous inspection, however they had completed basic checks rather than enhanced checks; we found only one of the doctors had an enhanced DBS check. The doctors told us they had asked the individual staff members to send off for their own DBS checks and they had not checked the certificates when staff handed them in. During the inspection, the service provided evidence that they had registered with a company for enhanced DBS checks of all clinicians to be completed.
- The two doctors had registered to receive safety alerts from The Medicines and Healthcare Products Regulatory Agency (MHRA) by email, however there was no system to record or log alerts to ensure they were discussed or actioned appropriately. There was no evidence that the two doctors had discussed any recently received alerts.

Are services safe?

- Patient records, written in Portuguese, were not written and managed in a way that kept patients safe. We reviewed the records of all 17 patients that had been seen between 1 June 2018 and the date of inspection and found issues in relation to 12 of the records:

  - In eight records there was no examination recorded or very little information documented;

  - In two records the prescriptions could not be found on the record system;

  - In one record the incoming referral letter from a consultant psychiatrist was not on the record system (although the doctor had summarised the letter in the notes);

  - In two records we saw evidence of inappropriate prescribing. We saw the doctor had prescribed Isotretinoin (a medicine used in the treatment of acne); MHRA guidance states Isotretinoin should be prescribed only in a consultant-led team. We also saw the doctor had prescribed Co-Trimoxazole (an antibiotic) to treat a urinary tract infection; this is not first line treatment for these infections and National Institute for Health and Care Excellence guidance states it should only be considered for use in infections of the urinary tract when there is bacteriological evidence of sensitivity to Co-Trimoxazole and good reason to prefer this combination to a single antibacterial.

  - In one record the patient had a blood test but there was no evidence on the record system or otherwise that the patient was informed of the results.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 19 April 2018 we identified that the arrangements for providing effective care did not comply with Regulations. We found:

- There was no evidence the service delivered care in line with current evidence based guidance. The patient records we reviewed contained limited detail and there was an absence of examination findings, test results and follow-ups with patients. There was no evidence in patient records that the doctors advised patients what to do if their condition got worse and where to seek further help and support.
- The service had not reviewed the effectiveness and appropriateness of the care provided through quality improvement activity since it opened in June 2017.
- There was no method for the service to review or audit prescribing as the prescriptions were not attached to patient records on the system.
- There was no evidence that staff had received specific training to carry out the activities they were undertaking at the service. For example, the sonographer was interpreting and reporting on mammograms and there was no evidence that they were qualified or competent to do so, and one of the clinicians was undertaking cervical smear tests and there was no evidence of specific training to perform this role or evidence of them maintaining their competency in this area.

At this inspection on 19 June 2018 we reviewed the requirements contained in the warning notices issued to the provider, and found the service had made some improvements to the provision of effective care. Specifically:

- The service had started to undertake some quality improvement activity. We saw that an audit was in progress which assessed whether the service was compliant with ultrasound referral guidance. At the time of the inspection, the service had reviewed 19 ultrasound referrals between 31 January 2018 and 2 June 2018 and found that 73.6% of patients were referred for appropriate investigation. The service had made suggested changes to improve this figure, including training for clinicians, discussion of any cases which might require a referral, and easy access to the guidance.
- The service had updated their record system in June 2018; prescriptions were issued from within the patient record and a copy of the prescription would automatically save to that patient's record.
- The sonographer was no longer interpreting and reporting on mammograms. Mammograms were now sent to a diagnostics company using UK-based consultant radiologists for reporting.
- The doctor who was undertaking cervical smear tests had completed an online training course in cervical smears in May 2018, although there was no evidence of audits or monitoring to check that the doctor was competent in taking adequate samples.

However, there was still an area where the service was not providing effective care in accordance with the Regulations:

- Patient records contained limited detail and we saw examples in records where the service was not delivering care and treatment in line with current evidence based guidance.

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 19 April 2018 we identified that the arrangements for providing well-led care did not comply with Regulations. We found:

- Many of the policies in place were not specific to the service, as they identified individuals who did not work for the service as leads in certain areas, and outlined processes that the registered manager told us were not actually in place for the service.
- The service did not have adequate fire safety processes in place. No fire drills had been carried out and there was no evidence of fire alarm tests and fire extinguisher checks.
- There was no system to check that clinical staff had current professional indemnity insurance; there was no evidence that two clinical members of staff had professional indemnity insurance.

At this inspection on 19 June 2018 we reviewed the requirements contained in the warning notices issued to the provider, and found the service had made some improvements to the provision of well-led care. Specifically:

- Fire safety processes had improved since the last inspection. We saw all staff had completed fire safety training and a fire risk assessment had been completed for the service. We were told that fire drills and fire alarm tests within the service had been completed and we received evidence following the inspection that these were being documented. We did not see evidence of fire drills, fire alarm tests and fire extinguisher checks for the whole building; this was the landlord's responsibility and we saw evidence that the service had repeatedly contacted the landlord to ask for evidence of checks.
- All clinicians had appropriate professional indemnity arrangements in place and evidence of this was kept within staff files.

However, there was still an area where the service was not providing well-led care in accordance with the Regulations:

- Some of the policies were not specific to the service, as they identified individuals who did not work for the service and outlined processes which were not actually in place. For example:

  - The significant event policy identified the 'Practice Manager' as the lead for significant events, when one of the doctors was the lead, and the policy also referred to reporting incidents to the 'Practice Manager's personal assistant' or the 'lead GP partner' who do not work at the service. The policy also stated that learning from events would be shared in 'Nurse team meetings' when these meetings do not take place as no nurses work for the service.

  - The health and safety policy referred to the 'PN/HCA' and 'GP' as being trained first aiders, when there were no practice nurses, healthcare assistants or GPs working at the service.

  - The emergency drugs policy identified the 'Practice Manager' as the deputy lead, when one of the doctors acted as the deputy lead.

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 How the regulation was not being met: The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Inadequate record keeping and inappropriate prescribing. • No system to ensure medicines or safety alerts were recorded, discussed and acted upon. • Not all clinical staff had enhanced DBS checks. **These matters are 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 How the regulation was not being met: The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

This section is primarily information for the provider

Enforcement actions

- Some policies were not specific to the service, as they identified individuals who did not work for the service and outlined processes which were not actually in place.

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