David Dighton

Loughton Private Medical Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection at Loughton Private Medical Clinic on 30 October 2018. At that inspection, we found that the service was not carrying out safe, effective or well-led care. Breaches of regulation were identified.

We served warning notices in respect of the governance and safety at the practice. This was because medicines were not being stored or managed in accordance with legislation and guidance, patients accessing the slimming clinic were not being appropriately monitored and there was poor clinical record keeping. Further risks were identified which included a lack of effective systems to ensure patients were protected from the risk of abuse and poor infection control. Patients' identification was not being checked.

We carried out an announced focused inspection at Loughton Private Medical Clinic on 11 March 2019. We found that necessary improvements had been made and the provider had met the requirements of the warning notices.

Our findings were:

Are services safe?

Necessary improvements had been made. The provider had met the requirements of the warning notice.

Are services effective?

Necessary improvements had been made. The provider had met the requirements of the warning notice.

Are services well-led?

Necessary improvements had been made. The provider had met the requirements of the warning notice.

The provider should:

- Finalise the safeguarding vulnerable adults' policy.
- Continue to improve and embed systems to check patients' identification and record consent to share information with their GP.
- Continue to improve systems to share information with the patient's GP.
- Evidence adherence to current regulated activities in clinical notes.

Loughton Private Medical Clinic

Detailed findings

Background to this inspection

Loughton Private Medical Clinic is an independent consulting doctors service.

The registered provider of all regulated activities at this location is Dr David Dighton, who is a doctor (in this report referred to as 'the provider'). At our previous inspection, the provider delivered a private general medical consultation service, a slimming clinic and a cardiac diagnostic centre. At that time, he was regulated to provide diagnostic and screening procedures, treatment of disease, disorder or injury and services in slimming clinics.

Since our previous inspection the provider has deregistered for treatment of disease, disorder or injury and services in slimming clinics and therefore, no longer holds a slimming clinic or a private general medical consultation service. Loughton Private Medical Clinic now functions as a cardiac diagnostics centre only.

The provider is supported by a clinical physiologist. The doctor who was previously employed to deliver the slimming clinic no longer works at the service.

The service is open from 9.30am until 5pm on a Monday, Tuesday Thursday and Friday. It is open until lunchtime on a Wednesday.

We previously carried out an announced comprehensive inspection at Loughton Private Medical Clinic on 30th October 2018. At that inspection, we found that the service was not carrying out safe, effective or well-led care and breaches of regulation were identified. Warning notices were served in respect of the safety and governance.

At this inspection, we found that necessary improvements had been made and the provider had met the requirements of the warning notice.

Are services safe?

Our findings

What we found at our inspection of 30th October 2018

At our previous inspection, we identified risks in relation to safeguarding children and vulnerable adults. As the practice did not routinely check patients' identification, they could not be assured that patients accessing the slimming clinic were aged over 18. There was no policy to safeguard vulnerable adults from abuse.

Also at that inspection, risks were identified in respect of infection control, storage and management of medicines including controlled drugs, recruitment checks and indemnities of clinical staff, lack of detail in patient records, information sharing with the patient's usual GP, significant events and patient safety alerts.

What we found at our inspection of 11th March 2019

Safety systems and processes

Since our previous inspection, the provider has deregistered for two regulated activities, treatment of disease, disorder or injury and slimming clinics. They no longer prescribe or hold medicines. They do not see children under the age of 18 and there are no longer any other doctors working at the service.

Due to the cessation of these regulated activities, significant risks that we had identified in our inspection of October 2018 have been mitigated or removed. These included child safeguarding procedures, checks of clinical staff and safe storage of medicines, including controlled drugs.

In relation to other risks previously identified, there was now an infection control policy in place and an infection control audit had been completed. Where actions were required, these had been identified and completed as necessary.

Systems to manage and respond to adult safeguarding concerns had improved. Staff had received training for safeguarding vulnerable adults and a policy was being updated and implemented.

Information to deliver safe care and treatment

Continued action was required in respect of checking the identity of patients accessing the service, as although we saw that forms had been updated with a view to ensuring identification was being seen, these were not being consistently completed to evidence that required action had been taken. Further, whilst steps had been taken to improve systems to share information with the patient's GP, continued action was needed to embed this into routine clinical practice.

We identified instances where clinical advice had been given to patients which may not be consistent with the current regulated activity. The provider informed us that this was due to unexpected presentation of symptoms outside of their usual clinical remit and assured us that they would implement systems to mitigate the chance of this situation arising in the future.

Lessons learned and improvements made

At our most recent inspection we found that there was now a policy to record, manage and learn from significant events and we saw that these were being recorded and discussed. The provider had systems to receive patient and medicines safety alerts and an indemnity was in place which sought to provide cover for the areas of clinical practise provided.

Safe and appropriate use of medicines

At our previous inspection, we identified risks in relation to the storage and destruction of controlled drugs. At our most recent inspection, we found that controlled drugs were no longer stored. Records confirmed that controlled drugs that had been stored had been destroyed safely.

The practice had considered most if the medicines that were required in the emergency, but they still did not hold a diuretic in the event of left ventricular failure.

Are services effective?

(for example, treatment is effective)

Our findings

What we found at our inspection of 30th October 2018

We found that that patients accessing the slimming clinic were not having their needs effectively assessed as the patient's blood pressure and BMI were not being recorded. Patients were not given appropriate advice about withdrawing medicines.

What we found at our inspection of 11th March 2019

Effective needs assessment, care and treatment

As the provider had deregistered to provide a slimming clinic, necessary action had been taken to remove these risks to patients. Patients who had previously accessed the slimming clinic had been advised of other slimming clinics that they could access.

Are services well-led?

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

Our findings

What we found at our inspection of 30th October 2018

There were not effective governance arrangements and significant risks were identified. The provider did not maintain appropriate and accurate information. Systems to share information with the patients' GP were not effective.

What we found at our inspection of 11th March 2019

Governance arrangements

The provider had taken necessary action to mitigate risks: the service was now registered to provide diagnostic and screening procedures only and so had removed general medicine as well as slimming clinics from the services it provided. Medicines were no longer prescribed or stored at the location and children under the age of 18 did not access services.

Policies and procedures had been updated, including those which related to infection control and significant events. The safeguarding vulnerable adults' policy was in the process of being updated.

Appropriate and Accurate information

The provider had attended a course with a view to improve their clinical note taking and we found the detail in patient records had improved. Steps had been taken to review and implement systems to record patients' consent and share information with their GP as appropriate.