Origem Limited

# London Prevention Clinic

## Inspection report

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## Overall summary

We carried out an announced comprehensive inspection on 19 April 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

**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 providing caring services in accordance with the relevant regulations.

**Are services responsive?**

We found that this service was 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.

We carried out this 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 meeting the legal requirements and Regulations associated with the Health and Social Care Act 2008.

London Prevention Clinic is an independent health service based in London.

**Our key findings were:**

- Not all of the clinical staff had the required level of child safeguarding training relevant to their role.
- Some staff members, including clinicians, had not had an enhanced disclosure and barring service check.
- 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.
- There was no evidence that the service was aware of or acted upon medicines safety alerts.
- No fire drills have been carried out and there was no evidence of fire alarm tests and fire extinguisher checks.
- Prescriptions were kept securely.
- Patient records were not written and managed in a way that kept patients safe.
- The service had not completed any quality improvement activity, such as clinical audits.

# Summary of findings

- Staff had not received specific training to carry out the activities they were undertaking at the service, for example the sonographer in relation to mammograms and a doctor in relation to cervical smear tests.
- The service had appropriate and safe systems for verifying a patient's identity at the time of registration.
- The service treated patients with kindness, respect and compassion, and patient feedback was positive about the care and treatment provided.
- The service did not have a business continuity plan in place in case of an emergency.
- 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.
- Staff told us that they felt supported, were able to raise concerns, and were confident that these would be addressed.

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 systems for ensuring sharps bins are labelled.
- Review the process for obtaining patient consent.
- Consider the necessity of having a business continuity plan in place.

# 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. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- Not all of the clinical staff had the required level of child safeguarding training relevant to their role.
- Some staff members, including clinical staff, had not had an enhanced disclosure and barring service check.
- 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.
- There was no evidence that the service was aware of or acted upon medicines safety alerts.
- The fire safety processes were inadequate.
- Individual care records were not written and managed in a way that kept patients safe.
- Prescriptions were kept securely.
- 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.

**Are services effective?**

We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- There was no evidence that the service delivered care in line with current evidence based guidance.
- The service had not completed any quality improvement activity, such as clinical audits.
- 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 in relation to mammograms and one of the doctors in relation to cervical smear tests.
- The service did not routinely share information with patients' NHS General Practitioner.
- The service had appropriate and safe systems for verifying a patient's identity at the time of registration.

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations.

- The service treated patients with kindness, respect and compassion, and patient feedback was positive about the care and treatment provided.
- Staff helped patients be involved in decisions about their care.
- The service complied with the Data Protection Act 1998 and was registered with the Information Commissioner's Office.
- Disposable curtains were provided in consulting and treatment rooms for patients if needed to maintain dignity.

**Are services responsive to people's needs?**

We found that this service was providing responsive care in accordance with the relevant regulations.

- The facilities and premises were appropriate for the services delivered.
- Information leaflets in the reception area were available in English and Portuguese.
- The appointment system was easy to use and patients could choose which doctor or clinician they wanted to see.

# Summary of findings

- The service had a complaints policy in place. We saw a leaflet in reception which detailed how patients could make a complaint, as well as a feedback box labelled for 'complaints and compliments'.

**Are services well-led?**

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- The service had not established effective governance arrangements for managing risks, issues and performance.
- Many policies were not specific to the service.
- The service did not have effective processes to manage current and future performance as no quality improvement activity to monitor clinicians' performance and clinical care had been carried out.
- The service's record system was not adequate to ensure patient safety; there was no method for the service to review or audit prescribing as the prescriptions were not attached to patient records on their system.
- The service did not have a business continuity plan in place in case of an emergency.
- Staff told us that they felt supported, were able to raise concerns, and were confident that these would be addressed. We saw evidence of full staff meetings being held on a monthly basis.

# 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). Two doctors, a radiographer, a sonographer, a psychologist, a nutritionist and an administration assistant work at the service.

London Prevention Clinic registered with the CQC in June 2017 and had seen 196 patients as of the date of inspection. The service is registered with the CQC 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 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.

We carried out this inspection as a part of our comprehensive inspection programme of independent health providers.

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

The inspection was carried out on 19 April 2018. During the visit we:

- Spoke with a range of staff, including the lead doctor (and nominated individual), the other doctor (and registered manager), sonographer and administration assistant.
- Reviewed a sample of patient care and treatment records.
- Reviewed patient feedback for the service.

We asked for CQC comment cards to be completed by patients prior to the inspection. However, no comment cards had been completed. We reviewed nine General Medical Council (GMC) patient questionnaires which were all positive about the service and care received.

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.

**Safety systems and processes**

- Electrical equipment was maintained according to manufacturers' instructions and the service had contracts in place for the checking of clinical machines. There were systems for safely managing healthcare waste, and we saw cleaning schedules for the premises and equipment.
- There was an effective system to manage infection prevention and control, although we saw that the sharps bin was not dated.
- A legionella risk assessment had been carried out by an external company in May 2017 which did not identify any hazards.
- Not all of the clinical staff had the required level of child safeguarding training, as set out in The Intercollegiate Guideline "Safeguarding Children and Young People: roles and competences for health care staff" (2014). We asked to see certificates for child safeguarding training and found in staff files that the two doctors had only completed training to level 1.
- Following the inspection, the service sent us certificates demonstrating that one of the doctors had completed level 3 child safeguarding training on 24 October 2016, and the other doctor on 23 April 2018.
- There was a safeguarding flowchart in all consultation rooms, which clearly set out the process for reporting a safeguarding concern and listed contact details for the Local Authority's Emergency Duty Team.
- We looked at seven staff files to review the service's recruitment checks. We found that 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 a leaflet in the reception area that advised patients they could request a chaperone. Although clinical staff had not received specific training to be a chaperone, one staff member we spoke to about chaperoning had a good understanding of what was required and their responsibilities as a chaperone. Following the inspection, we were provided evidence that one of the non-clinical staff members had completed chaperone training on 21 May 2018.

**Risks to patients**

There were ineffective systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed depending on how busy the service was.
- We looked at the service's arrangements for medical emergencies on the day of inspection and found there was no medical oxygen cylinder or medicine to treat anaphylaxis and no assessment of whether or not these were required. 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.
- Following the inspection, the service sent us evidence that a medical oxygen cylinder had been ordered and medicine to treat anaphylaxis had been purchased. The service also sent a photograph of a poster placed on the wall next to the defibrillator with instructions for use, and an email advising that the medicines would be checked on a weekly basis and the defibrillator on a daily basis.
- We looked at seven staff files and found that there was no evidence that three members of clinical staff had completed basic life support training. Following the inspection, the service sent us certificates demonstrating that all clinicians completed the training in April and May 2018.
- The registered manager told us that 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. Following the inspection, the

service sent us an email stating that all clinicians have signed up for email safety alerts from the Medicines and Healthcare Products Regulatory Agency and that these will be discussed in clinicians' meetings.

- We looked at seven staff files during the inspection and found that there was no evidence that two clinical members of staff had professional indemnity insurance. Following the inspection, we received evidence that one of these clinicians had insurance in place.
- We saw a fire risk assessment dated May 2017 which identified the necessity for fire drills and checks to be carried out. The doctors told us that no fire drills have been carried out. We asked for evidence of fire alarm tests and fire extinguisher checks and the service was unable to provide this. Following the inspection, the service told us that fire drills would be completed every six months and they held a meeting with the landlord of the premises who agreed that weekly fire alarm tests and monthly extinguisher checks would be completed. We also received evidence that staff had completed fire safety training.

**Information to deliver safe care and treatment**

- 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.
- The service told us that they had not yet made any outgoing patient referrals to other organisations or agencies, so we were unable to assess whether referral letters contained all of the necessary information.
- Following the inspection, the service sent us evidence that they had requested changes to the record system, including mandatory fields to be completed for consultation notes and incoming referral information, consultation templates, and alerts to notify clinicians if a patient had not returned to a follow up or if an image or test results had not been attached to the record.

**Safe and appropriate use of medicines**

- The service did not have effective systems for managing emergency medicines and equipment in order to minimise risks to patients.
- Prescriptions were kept securely, as prescriptions were printed directly from the secure computer system and the service did not hold any blank prescriptions.
- The service was not monitoring whether clinicians prescribed, administered or supplied medicines in line with legal requirements and current national guidance. The doctors told us the service had not audited prescribing. When we reviewed the computer system, we found that there was no method for the service to review or audit prescribing as the prescriptions were not attached to patient records on the system.
- Following the inspection, the service sent us evidence that they had requested changes to the record system, including a search function to list all prescriptions.
- We reviewed 17 patient records on the computer system and found there was no evidence that patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.

**Lessons learned and improvements made**

- The service had a policy for recording and acting on significant events and incidents. However, this was not specific to the service and described a process which

the registered manager told us was not actually in place (the policy referred to forms being completed and placed in a file in the Practice Manager's room, which was not the service's own process).

- Staff understood their duty to raise concerns and report incidents and near misses, and explained that the two doctors at the service were responsible for reviewing any incidents. Staff told us that they were confident that the doctors would support and listen to them if they did report anything.
- There was a system in place for recording significant events and complaints. We saw policies which demonstrated that, where patients had been impacted, they would receive an explanation of the service's investigation, a fair outcome, and an apology if appropriate. We were told that there had not been any significant events or complaints since the service opened, but that these would be discussed in staff meetings if they occurred.
- The service's policies demonstrated an awareness of the Duty of Candour requirements; they outlined that patients would be given a full explanation of the service's investigation and an apology if appropriate.

# 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.

**Effective assessment, care and treatment**

- There was no evidence that 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.
- The doctors told us that they read journals to stay up to date with current best practice, but were not able to give any examples of recent learning when asked.
- When we reviewed patient records, we found there was no evidence 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.
- Following the inspection, the service sent us an email advising that audits are planned for June 2018 and changes were to be made to the record system to enable this.

**Effective staffing**

- The service had an induction programme for staff, which covered topics such as using the computer system, the service dress code, and confidentiality. However, the induction checklist we saw did not detail what specific training staff had to complete, and the service did not retain completed induction checklists in staff members' files.
- 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.
- Following the inspection, the service sent us an email stating that they have currently ceased carrying out mammograms and the nominated individual was exploring whether a clinic overseas could complete the mammogram reporting.
- Staff told us that they were encouraged and given opportunities to develop, for example the administration assistant said the doctors had suggested they complete a phlebotomy training course.
- The service had a capability procedure in place for managing staff when their performance was poor or variable.

**Coordinating patient care and information sharing**

- The doctors told that us the service would make referrals to other health services if required. However, the service had not made any referrals since it opened in June 2017 and therefore we were unable to assess whether relevant information was shared by the service. The patient records we reviewed did not contain all necessary information such as the details of the consultation, examination, and any test outcomes which could then be passed on to another health service or clinician.
- The service did not routinely share information with patients' NHS General Practitioner. One of the doctors said that, if a patient asked them for information to be communicated to their NHS GP, they would put something in writing and hand it to the patient to pass on to their GP.

**Consent to care and treatment**

- When patients arrived for their appointments they were given a consent form to sign before they saw the clinician. When we asked one of the doctors about this form, they acknowledged that consent cannot be obtained before an examination or procedure has been fully explained to the patient and that this form was not evidence of valid informed consent.
- The service had appropriate and safe systems for verifying a patient's identity at the time of registration.

# Are services caring?

## Our findings

We found that this service was providing caring services in accordance with the relevant regulations.

**Kindness, respect and compassion**

- The service treated patients with kindness, respect and compassion. Staff told us that they respected patients' personal and social needs.
- We asked for CQC comment cards to be completed by patients prior to the inspection. However, no comment cards had been completed. Instead, we reviewed nine General Medical Council (GMC) patient questionnaires which the service had made available for patients to complete, which were dated from September 2017 to April 2018. All the questionnaires were positive about the care received, and one described the doctors as being very kind.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care.

- The service did not offer interpretation services, but staff told us that they spoke other languages, including Portuguese and Spanish, which they could use when communicating with patients. Leaflets in the reception area were available in English and Portuguese.
- Information leaflets were available in reception which detailed the various services offered and explained what having a mammogram or ultrasound entailed.
- In the completed GMC patient questionnaires, 100% of nine respondents stated that the doctors were very good at explaining their condition and treatment, and were very good at involving them in decisions about their treatment.

**Privacy and Dignity**

Staff recognised the importance of patients' privacy and dignity.

- The service complied with the Data Protection Act 1998 and was registered with the Information Commissioner's Office (ICO).
- The administration assistant told us that the service did not use any paper records and that all information was stored on the secure computer system.
- Staff told us that doors were closed during consultations and that sensitive patient information was not discussed in public areas.
- We saw that disposable curtains were provided in consulting and treatment rooms for patients if needed to maintain dignity.
- In the completed GMC patient questionnaires, 100% of nine respondents stated that they strongly agreed with the statement that the doctors would keep their information confidential.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

We found that this service was providing responsive care in accordance with the relevant regulations.

**Responding to and meeting people's needs**

The service organised and delivered services to meet patients' needs.

- The facilities and premises were appropriate for the services delivered.
- The service did not have disabled access due to the constraints of the building, but the registered manager told us that patients with disabilities who could not access the service would be referred on to another hospital in London.
- The service did not discriminate against any nationality, but the majority of patients who accessed the service were originally from Brazil.
- The service had leaflets available in the reception area which explained procedures such as a mammogram and ultrasound, which were available in English and Portuguese.

**Timely access to the service**

Patients were able to access care and treatment from the service within an acceptable timescale for their needs.

- The service is open from Monday to Friday 9am to 6pm and Saturday 9am to 1pm.
- The appointment system was easy to use and patients could book appointments using a landline number, mobile telephone number, through WhatsApp (an encrypted messenger application for smartphones) or through the service's website.
- Staff said that patients could choose which doctor or clinician they wanted to see.
- Staff told us that they would book patients in for any required follow-up consultation immediately, to avoid any delays.

**Listening and learning from concerns and complaints**

The service had a complaints policy in place.

- We saw a leaflet in reception which detailed how patients could make a complaint, as well as a feedback box labelled for 'complaints and compliments'.
- We reviewed the complaints policy which referenced that patients would receive an apology if appropriate.
- Staff told us that any complaints would be reviewed and dealt with by one of the doctors.
- The service had not received any complaints since it opened in June 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 care in accordance with the relevant regulations.

**Governance arrangements**

The service had not established effective governance arrangements for managing risks, issues and performance.

- The service had policies which were accessible to staff on the computer system. However, 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 that the registered manager told us were not actually in place for the service. These policies included: 'Emergency Drugs'; 'Incident Management Procedure'; 'Health and Safety'; and 'Infection Control'. Following the inspection, the service sent us confirmation the doctors would be reviewing all policies.
- The service did not have effective processes to manage current and future performance as no quality improvement activity to monitor clinicians' performance and treatment had been carried out. The service's record system was not adequate to ensure patient safety, as there was no method for the service to review or audit prescribing as the prescriptions were not attached to patient records on their system. Following the inspection, we received evidence that the service had changed its record system.
- The registered manager told us that they had oversight of serious incidents and complaints, although none had been received since the service opened.
- No staff member was responsible for assessing and acting upon medicines safety alerts.
- The service did not have a business continuity plan in place. The registered manager told that, in the event of an emergency such as a power cut, the service would close and patient appointments would be cancelled. Following the inspection, the service forwarded us an email from their accountant and management consultant confirming that a business continuity plan was being drafted.
- The service did not have adequate fire safety processes in place.
- There was no system to check that clinical staff had current professional indemnity insurance.

**Leadership capacity and service culture**

- There was a clear staffing structure in place. Staff understood their roles and responsibilities, including in respect of infection control.
- The two doctors were responsible for the organisational direction and development of the service and the day to day running of it.
- Staff told us that they felt supported, were able to raise concerns, and were confident that these would be addressed.
- We saw evidence of full staff meetings being held on a monthly basis. These meetings discussed management of the service, training, staffing and any other issues that arose.
- The doctors told us that staff had not had an appraisal by the service, as they had not yet been working for a full year.
- There was no evidence of formal clinical supervision or peer review for the clinicians working at the service.

**Appropriate and accurate information**

- There was no evidence that the service acted on appropriate and accurate information, in that quality and performance information was not used to monitor and ensure effective care and treatment.

**Continuous improvement and innovation**

- The service had not completed any quality improvement activity to drive improvement or innovation.
- The service had a feedback box in the reception area for complaints and compliments from patients.
- Staff explained that, as no complaints had been received and no significant events had occurred since the service opened, they had not made any responsive changes to the service.

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<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met:<br>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:<br>• Inadequate record keeping.<br>• No evidence the service reviewed and acted on medicines safety alerts.<br>• Emergency medicines and equipment missing and no evidence of regular checks.<br>• Not all staff had enhanced DBS checks.<br>• No evidence of specific staff training and competencies in relation to: basic life support; interpretation and reporting on mammograms; and completing cervical smear tests.<br>**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<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>How the regulation was not being met:<br>There were inadequate systems and processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided: |

This section is primarily information for the provider

# Enforcement actions

- No quality improvement activity, such as clinical audits, carried out by the service. No method to audit prescribing as prescriptions not attached to patient records or retained on the computer system.
- No evidence of professional indemnity insurance for some staff.
- Inadequate fire safety processes.
- Policies were not specific to the service.

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