Dr David O'Connell

CP Medical Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection at CP Medical Clinic on 11 December 2018 to follow up the concerns identified at our previous inspection in June 2018. You can find the reports of our previous inspections by selecting the 'all reports' link on our website.

This inspection was an announced focused inspection carried out on 4 February 2019 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulation that we identified at our previous inspection on 11 December 2018.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This report covers our findings in relation to those requirements and improvements made since our last inspection.

CP Medical Clinic provides private medical services at 61-63 Sloane Avenue in the Royal Borough of Kensington and Chelsea and treats adults and children. The provider, Dr David O'Connell is registered with CQC under the Health and Social Care Act 2008 to provide the regulated activity of Treatment of disease, disorder and injury at this location.

At this inspection we found action had been taken on most of the issues identified at the previous inspections.

Our findings were:

Are services safe?

We found that this service was providing safe 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.

Our key findings were:

- The service had succeeded in making improvements to most aspects of policy and protocol, but there were areas for improvement identified. The provider was not consistently following policies and procedures used by staff at the host clinic.
- The service had reviewed risks associated with the service's premises and ensured formal safety risk assessments were carried out at regular intervals to reduce risks to patients and staff.
- Management of fire risk kept people safe. The service had maintained a record of fire drills as outlined in the fire risk assessment.
- The provider monitored people on high-risk medicines. Records we looked at showed patients' health was monitored in relation to the use of medicines and followed up on appropriately.
- The provider had started to implement a system to ensure the safe management of prescribing of controlled drugs.

Summary of findings

- Records were not always written and managed in a way to keep people safe. Patient notes were not easily accessible in an emergency and it was not possible for the provider to share information with other services when there was an urgent need.
- CCTV cameras in the two consulting rooms had been removed. The provider did not have signs up warning people about CCTV recording in the host clinic. Staff put up signs during our inspection.
- There was no employee record for one member of staff who was employed by the provider in the carrying on of regulated activities and no record of a DBS check. During our inspection, the provider was able to obtain evidence of DBS disclosure application for the employee.
- Governance arrangements had improved to ensure effective oversight of risk. There was a controlled drugs policy in place and leaders had completed priority actions from the fire safety risk assessment.

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

- 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 ease of access to patient notes kept by the provider.
- Continue to develop quality improvement systems that monitor the positive impact on quality of care and patient outcomes.
- Review the systems for checking expiry dates on medicines stored by the provider.
- Review the process for sourcing patient feedback to improve and develop the service.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

CP Medical Clinic

Detailed findings

Background to this inspection

CP Medical Clinic is a private doctor's consultation service for adults and children in the Royal Borough of Kensington and Chelsea. Dr David O'Connell is registered as an individual provider with the Care Quality Commission to provide the regulated activity of treatment of disease, disorder or injury. Regulated activities are provided at one host clinic location, 61-63 Sloane Avenue, London SW3 3DH.

The host clinic premises are located on the ground floor and in the basement of a converted residential property. The host clinic is not registered with or regulated by CQC, though CP Medical had adopted some of its policies and processes. The premises are leased by the director of the host clinic. There is a shared entrance, three consultations rooms, a waiting area, reception and toilet facilities. The director of the host clinic runs a pharmacy on the ground floor.

General medical services provided include routine medical consultations and examinations, vaccinations and travel vaccinations and health screening. There are 20-30 consultations carried out weekly.

Medical services at the host clinic are provided by the registered provider, eleven private doctors and four specialist consultants. The work of the other doctors and consultants does not form part of this inspection. The registered provider works 16 hours a week at the service and performs approximately 12 consultations a week there, the other consultations being performed by the other doctors. Dr O'Connell's service is open between 9am – 9pm, Monday to Saturday and 4pm – 8pm on Sunday. There is a service manager who oversees all administrative and managerial duties at the host clinic. The host clinic employs a team of part time reception staff who receive Dr O'Connell's patients when they arrive for an appointment.

How we inspected the service:

Our inspection team on 4 February 2019 was led by a CQC Lead Inspector and included a GP specialist advisor and a second CQC inspector.

Before visiting, we reviewed a range of information we hold about the service.

As part of the inspection we:

- Spoke with clinical and non-clinical staff including the registered provider, service director and administrative staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed service policies, procedures and other relevant documentation.
- Looked at the systems in place for the running of the service.

On this focussed inspection we asked the following question about the service:

- Is it Safe?
- Is it Well-led?

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

Are services safe?

Our findings

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse. At our inspection in December 2018, the provider had not managed the systems to keep people safe and safeguarded from abuse effectively. At this inspection, we found arrangements had improved, for example, there was evidence of practical steps taken to address high priority actions identified from fire risk assessments. We found that this provider was providing a safe service in accordance with the relevant regulations.

- Policy and procedure had been tightened. The provider, Dr O'Connell, had adopted the host clinic's updated suite of policies and procedures. These health and safety policies and procedures followed guidance from a quality compliance company.
- The provider had reviewed risks associated with the service's fire safety protocol.
- At our previous inspection in December 2018, there was limited evidence of what precautions and practical steps the provider had taken to remove or minimise risks in relation to legionella. For example, the host clinic confirmed that legionella assessments were undertaken by the premise's management service; however, there was no record of regular audit arrangements to control the risk of legionella bacteria. At this inspection, we found there was a legionella risk assessment process in place but staff told us the premises management service had not responded to an email request from the hosting clinic to share records of assessment for legionella. The service director told us he had booked an external company to carry out a legionella assessment on 15 March 2019. We saw legionella testing had been carried out 15 June 2018 and no bacteria was present. The host clinic manager and director had completed online Legionella Awareness training on 31 January and 1 February 2019.
- There were no clear arrangements to carry out staff checks at the time of recruitment and on an ongoing basis where appropriate. The provider, Dr O'Connell had not followed the host clinic's policy to request a Disclosure and Barring Services (DBS) check for all staff working at the service. At our inspection in December 2018, there was no employee record for one member of staff who was employed by the provider in the carrying on of regulated activities and no record of a DBS check. The provider had not carried out a risk assessment or provided a clear rationale for the decision not to carry out a DBS check on the member of staff. At this inspection, we spoke to the provider about the arrangements regarding his employment of a personal assistant (PA) off site at another location. The provider told us that the PA was employed by an agency. The provider did not have a DBS check in place for his PA and there was no record of a risk assessment. We were invited to meet the personal assistant. We asked to see evidence of a DBS check and the PA contacted the agency immediately and sent evidence of an invoice for a DBS disclosure application.
- There were no clear arrangements in place to receive and comply with patient safety alerts, for example, those issued through the Medicines and Healthcare Products Regulatory Authority (MHRA). The provider, Dr O'Connell had not adopted the host clinic's medicines and safety alert protocols. There was no system in place to enable sharing of evidence-based guidance with medical staff who worked at the service. The provider had not followed the host clinic's policy to keep a record of safety alerts received with a record of action required. We were invited to inspect the paper-based patient records which the provider stored off site at another address from CP Medical Clinic. There was still an inability to search patient records and share information with other services in a timely way. We asked the provider to tell us how he was informed of alerts. We saw evidence of email alerts received by the provider from the Independent Doctors Federation (IDF) and the Department of Health but there was no system to show these had been read and acted on.

Risks to patients

The host clinic had systems to assess, monitor and manage risks to patient safety, although these were not consistently followed by the provider. At our December 2018 inspection we found some risks to patient safety were not managed well. At this inspection we found arrangements had improved, for example, the service had assessed fire safety risks and had systems in place to manage legionella risks.

- At our previous inspection we identified risks relating to insufficient management of fire risk. At this inspection we found fire safety arrangements kept patients safe. At

our inspection in December 2018, one of the high priority fire safety actions identified in the fire risk assessment performed on 20 May 2018, had not been completed. The provider had failed to install a manual call point within the basement. There was no reasonable method of raising the alarm in the basement. At this inspection, we saw a manual call point had been installed in the basement and saw it had been tested.

- A fire safety risk assessment had been carried out in May 2018 and reviewed in July 2018. There were documented checks of the fire alarm tests. Staff at the host clinic told us these were completed by the building management company who carried out fire drills. We saw a weekly fire alarm test log dated 10 December 2018. We saw a copy of the last fire evacuation log dated 18 November 2018. There was a visible fire procedure in the areas of the premises used by patients. Fire extinguishers were checked annually.

Information to deliver safe care and treatment

Arrangements for recording and managing information were in place although improvements were required.

- Individual care records were not always managed in a way that kept patients safe. At this inspection, we found the provider did not use the service's electronic record system to record consultation notes and only kept hand written patient records. The provider was not able to share patient information with other staff and other agencies in an effective and timely way. The provider showed us a folder of his handwritten consultation notes of patients seen at the service. The provider told us these examples had been scanned on to the service's electronic patient record system.. We looked at 44 records. The provider's hand-written patient notes we saw, were of an acceptable standard and conformed to GMC guidelines.
- The provider, Dr O'Connell had adopted the host clinic's system to retain medical records in line with the Department of Health and Social Care (DHSC) guidance.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

At our previous inspection, the provider did not have a clear system to ensure oversight of safe prescribing. Staff had not always prescribed, administered or supplied medicines to patients and given advice on medicines in line with legal requirements and current national guidance. For example, there was no monitoring system in place for people on high risk medicines. At this inspection, we found arrangements had improved slightly. The provider had adopted most of the host clinic's medicines management protocols.

- At our inspection in December 2018, we found risks relating to arrangements for the safe management and administration of medicines. There was no suitable service protocol available for staff which reflected national guidance on prescribing high risk medicines. At this inspection, we found the service had taken steps to improve their prescribing protocol. However, the medicines policy had still not been updated to include high risk medicines prescribing. Staff showed us a print out of suggestions for drug monitoring adults in primary care, but the provider did not have a high-risk medicines policy in place. Staff told us the policy would be produced following the clinical governance meeting on 10 February 2019.
- Staff showed us a new policy for prescribing of controlled drugs which reflected national guidance on the management of prescription stationery for controlled drugs (CDs) prescribed by the provider.
- At our inspection in December 2018, the provider did not have a protocol to ensure the safe management of prescribing of controlled drugs. Prescription stationery for controlled drugs were stored off site at a different location to CP Medical Clinic and we found blank CD prescriptions stored in an unlocked drawer. At this inspection, the provider invited us to their office off site. The provider described to us how access to controlled medicines is controlled. We saw pink controlled drugs prescription pads were locked securely in a drawer with access restricted to authorised staff. The provider told us no patients are seen in the premises.
- At our previous inspection, the provider had no system of controlling and recording controlled drug prescription form movement, including recording serial numbers. There was no way of knowing if any CD prescriptions went missing. At this inspection, we saw

this concern had been addressed. The provider had implemented a system to monitor controlled drug prescriptions. We saw a record of the serial numbers of controlled drugs prescription forms.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. From records we reviewed at this inspection we found the provider was not consistent in following national guidance on antibiotic prescribing. For example, we looked at records of 21 patients who had been prescribed antibiotics. The GP SpA reviewed notes of five patients prescribed antibiotics. There was evidence of appropriate prescribing for one patient in the notes we reviewed. We spoke to the provider about his antibiotic choices as we found he was prescribing alternatives to first line antibiotics. The provider told us he does not see uncomplicated cases and therefore used broad spectrum antibiotics. We saw evidence of prescribing of ciprofloxacin but no stool sample was taken before prescribing the patient the medicine. This was not in line with national guidance. This concern was previously identified at our inspection in December 2018.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Records we reviewed showed that patients on high risk medicines were involved in regular reviews of their medicines. For example, we saw one example of a patient on hydroxychloroquine for rheumatoid arthritis. We saw the provider had taken baseline blood tests and saw a letter advising the patient to have repeat blood tests done before the next prescription was due. We asked the provider about the patient on Lithium who was identified at our previous inspection when we reviewed patient records. The patient prescribed Lithium had not at that time received a blood test in the previous five months. At this inspection, we looked at the patient's record and saw the provider had ensured the patient had done a blood test to check levels of Lithium, before issuing a further prescription to the patient.
- There was limited evidence that the provider acted on and learned from external safety events as well as patient and medicine safety alerts. We asked the provider to tell us how they are informed of alerts. We saw evidence of email alerts received by the provider from the Independent Doctors Federation (IDF) and the Department of Health (DOH) but there was no system to show these had been read and acted on. The provider did not routinely do searches following a safety alert. The provider was able to tell us about how many the MHRA alert for Sodium Valproate. Although we did not see a record of a search, the provider, Dr O'Connell, told us this alert was not relevant to any of his patients. The provider created a safety alert action plan template during our inspection to monitor and follow up on alerts received.
- Processes were in place at the host clinic for checking medicines and staff kept accurate records of medicines. However, the provider did not have a system to monitor medicines stored off site. At this inspection, we saw the provider stored medicines in a drawer off site at another location. It was not clear how the provider was able to account for the medicines. The provider did not have an effective system to account for the number of medicines used or have a system in place to record expiry dates. The provider was not able to tell us how he would know if any medicines went missing.
- The service did not have a system of quality improvement measures to monitor whether medical assessment and prescribing is carried out in line with evidence-based guidance and standards.

Track record on safety

We found that the safety systems in place at previous inspections had not been maintained. For example, management of fire risk was not safe and there were no systems to ensure the safe management of prescribing of controlled drugs. The provider, Dr O'Connell relied on the host clinic to manage safety aspects of the service environment. However, there was no record of any written agreement to this effect.

- At this inspection we found the provider, Dr O'Connell, had no formal arrangements in place with the host clinic to monitor and review health and safety activity. The provider had not ensured that all risks were accurately identified and effectively addressed. For example, there was minimal quality improvement activity carried out at the host clinic and no record of prescribing audits for the provider who prescribed controlled drugs.

Are services safe?

- There was a system of risk assessments in relation to safety issues including fire safety, infection control and legionella.
- There was a fire risk assessment process in place and recorded actions identified. However, we saw the provider relied on the host clinic to review actions and follow up on issues identified.

Lessons learned and improvements made

There was minimal evidence the provider learned and made improvements when things went wrong. The provider Dr O'Connell, did not follow the host service's protocols to assess significant events. The provider told us that they included such events as part of their annual Independent Doctors Federation (IDF) appraisal module. However, we saw no evidence of lessons learned or improvements made as a result of these annual appraisals.

- There was a lack of evidence that the provider acted on and learned from external safety events as well as patient and medicine safety alerts. Dr O'Connell's service relied on the host clinic to keep a record of safety alerts received with a record of action required. We saw evidence of email alerts received by the provider, Dr O'Connell, from the Independent Doctors Federation (IDF) and the Department of Health but there was no system to show these had been acted on or how the provider shared alerts with members of the team including sessional and agency staff.

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 in December 2018, we found leadership and oversight had not been sufficient to ensure that safety was consistently managed. At this inspection, we found that this provider was not providing a well-led service in accordance with the relevant regulations although improvement had been identified.

Leadership capacity and capability

Leaders had the clinical capacity and skills to deliver the service, however, the structure, lines of responsibility and leadership within the host clinic and provider remained unclear. There was no information for patients about the registered provider's role in the leadership of the service. It was not clear where responsibility for policies, governance and oversight lay, which meant there was insufficient assurance that these were being addressed.

- At our previous inspection, safety aspects of the provider were not clearly known or prioritised to ensure high quality care was delivered. There was insufficient leadership focus on adequate systems of governance and management of risks. Since the previous inspection the leadership focus on management of risks had improved in some areas. There was a risk management lead at the host clinic and the provider followed the host clinic's lead to manage most risks safely.
- At our previous inspection, there were insufficient systems and processes relating to the management of medicines and prescribing of controlled drugs. At this inspection oversight of medicines management in relation to the storage of prescriptions for controlled drugs had improved. The provider had acted on safety concerns which were raised during the previous inspection. For example, the provider had taken action to secure controlled drug prescription pads in a lockable drawer.
- We saw a new controlled drugs policy in place at the host clinic, followed by Dr O'Connell's service, which reflected national guidance for prescribing controlled drugs. The provider Dr O'Connell had started to implement a system for controlling and recording controlled drug prescription form movement, including recording the serial numbers.
- At the time of our inspection the provider Dr O Connell, had not ensured that the employee working off site had been DBS checked. The provider told us that the administrator was employed through an agency. We were invited to meet the administrator who showed us evidence of their DBS disclosure application from the agency.
- There was minimal evidence of a programme of quality improvement measures to improve the care and treatment for patients.

Vision and strategy

- The host clinic had a vision to deliver high-quality care and an overall positive patient experience and an associated strategy. This provider had not developed its own vision or strategy and there was little evidence that they were working toward the host service's vision and strategy. There was a mission statement and service staff were aware of this.
- There was a formal business plan. However, it was not clear how the provider monitored progress against delivery of the strategy. One of the host clinic's doctors was the clinical governance lead.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

Dr O'Connell's service demonstrated a positive culture. There were positive relationships between managers and teams.

- Staff felt respected, supported and valued. They were proud to work for the service.
- Staff at the service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Staff were supported to meet the requirements of professional revalidation where necessary. There was a structure of inductions for new staff. There was an equality and diversity policy in place at the host clinic,

Are services well-led?

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followed by Dr O'Connell's service. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

- There was insufficient emphasis on the safety and well-being of all staff. The provider had not completed all actions identified in the fire safety assessment carried out in May 2018.

Governance arrangements

There was evidence of systems to support good governance although some systems continued to lack clear governance arrangements and accountability.

- In some areas governance arrangements to ensure effective oversight of risk had improved. Safety assessments for the premises and equipment had been undertaken. For example, there was an annual fire risk assessment carried out and actions identified had been reviewed. At our previous inspection, one of the high priority fire safety actions identified had not been completed. The provider had failed to install a manual call point within the basement. There was no reasonable method of raising the alarm in the basement. At this inspection we saw the manual call point had been installed and tested.
- At the previous inspection we found there was no effective governance meetings structure in place. One of the host clinic's doctors was the clinical governance lead. At this inspection a clinical governance policy was in place however, there was minimal evidence that governance within the Dr O'Connell service was formally monitored.
- Dr O'Connell's service was following the host clinic's policies and procedures which followed guidance from a quality compliance company. However, the provider had not assured themselves that all policies and activities were operating as intended.
- At our previous inspection, we found that some policies were not always reflective of day to day activities, for example, medicines management protocol and safety and security of patient records. At this inspection, we found the medicines management policy in use by all services at the host clinic, including Dr O'Connell's service, had still not been updated to include specific guidance about high risk medicines prescribing. There was no suitable service protocol available for staff which reflected national guidance on prescribing high risk medicines. We spoke to the host clinic who showed us a print out of suggestions for drug monitoring adults in primary care, but they did not have a policy in place. The host clinic told us the policy is to be produced following a clinical governance meeting on 10 February 2019. The host clinic told us they had reviewed the medicine management policy with the provider and that he would follow the policy procedure.

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance, although some areas were identified for improvement.

- The process for effectively identifying, understanding, monitoring and addressing current and future risks, including risks to patient safety, had improved in some areas. For example, the provider had started to implement a protocol to ensure the safe management of prescribing of controlled drugs.
- The host clinic had a process to manage patient safety alerts. There was a record kept of the action taken in response to patient safety alerts, and staff were able to demonstrate that they had an effective process to manage these. However, there was limited evidence that the provider acted on and learned from external safety events as well as patient and medicine safety alerts. We asked the provider to tell us how they are informed of alerts. We saw evidence of email alerts received by the provider from the Independent Doctors Federation and the Department of Health but there was no system to show these had been read and acted on. The provider did not routinely do searches following a safety alert. The provider was able to tell us about the MHRA alert for sodium valproate. Although we did not see a record of a search, the provider Dr O'Connell told us this alert was not relevant to any of his patients. The provider created a safety alert action plan template during our inspection to monitor and follow up on alerts received.
- There was minimal evidence of measures to improve and address quality. The provider had commenced one clinical audit in November 2018, to measure blood pressure taken in consultations but there was little evidence of actions taken to improve clinical service.

Are services well-led?

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

- At our previous inspection We saw CCTV in the ceiling inside two consulting rooms. There were no signs up warning people about CCTV recording in the clinic. The service had not sought consent from patients and there was no guidance in the service's consent policy about cameras operating inside the consultation rooms. At this inspection the host clinic had removed the cameras in the ceilings of the two consultation rooms. We saw there was still CCTV camera in the reception area. The service had not put up any signs warning patients of video recordings. The host clinic staff put up notices in the reception area during our visit.

Appropriate and accurate information

Overall, the provider acted on appropriate and accurate information; however, in some areas there was a lack of information gathered and maintained. There was minimal evidence that quality and sustainability were discussed and acted on.

- Individual care records were not always written and managed in a way that kept patients safe. The provider Dr O'Connell did not use the service's electronic patient management record system to record consultation notes. At our previous inspection we found the provider only kept hand-written notes which were not scanned into the electronic patient record system. At this inspection, we found the provider had started to scan in his handwritten patient notes on to the electronic patient record system. We saw 44 patient notes had been scanned into the electronic system. The provider was not able to support sharing of patient information with other clinicians in an effective and timely way.
- At this inspection we were invited to inspect the patient notes stored off site. The provider had started to scan in patient records but most patient notes we saw were paper based and stored in folders on open shelves. The provider still did not have an effective system to search patient records or share patient information from his handwritten notes with other staff and services. Patient notes were not easily accessible in an emergency and the provider did not keep a contemporaneous record for each service user. We spoke to the provider who told us that he only saw approximately 15 patients a week.
- Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not consistently in line with data security standards.

Engagement with patients, the public, staff and external partners

There was minimal evidence the provider Dr O'Connell involved patients and external colleagues to improve the service delivered.

- Dr O'Connell's service had comment forms available in reception for patients to complete. There was no evidence that the provider used patient feedback to improve and develop the service.

Continuous improvement and innovation

There were some processes and opportunities for learning, continuous improvement and innovation.

This section is primarily information for the provider

Requirement notices

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider could not show that safety alerts had been monitored and actioned. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider Dr O'Connell had adopted the medicines management policy in place at the host clinic however it had still not been updated to include high risk medicines prescribing. There was no suitable service protocol available for staff which reflected national guidance on prescribing high risk medicines. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.