# BG Medical Clinic

## Inspection report

48 North Street
Romford
RM1 1BH
Tel:

Date of inspection visit: 06 March 2023
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| Overall rating for this location | Inspected but not rated |
| --- | --- |
| Are services safe? | **Inspected but not rated** |

# Overall summary

**This was an un-rated inspection at this service.**

We carried out an announced inspection at BG Medical Clinic under Section 60 of the Health and Social Care Act 2008 to follow-up on concerns we found during our previous inspection on 19 January 2023. Following our previous inspection, we undertook urgent civil enforcement action to suspend the service for a six-weeks duration, by issuing a s.31 notice under the Health and Social Care Act 2008. In addition, we issued warning notices regarding Regulations 12 and 17 and the service was placed in 'special measures'.

At this inspection we took a primary medical services (PMS) team to check whether the service had made sufficient improvements since we imposed the six-weeks suspension under s.31 of the Health and Social Care Act 2008. This report includes evidence gathered by our PMS teams.

Following the inspection, we undertook further civil enforcement action, under the Health and Social Care Act 2008, by:

- **Imposing an urgent suspension, of 9-weeks duration, by issuing a s.31 notice under the Health and Social Care Act 2008.**

BG Medical Clinic Limited is an independent provider of medical services and offers a full range of private general practice services predominantly to the Bulgarian community.

Dr Andrean Damyanov 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.

**Our key findings were:**

- The provider did not have an adequate clinical system in place to enable safe prescribing and patient reviews.
- The provider had appropriate evidence in place of appropriate medical indemnity insurance for all clinical staff who worked at the service.
- The provider had made some improvements to their system to safely manage patient safety alerts and follow-up patients who may be affected by them.
- The provider did not have a system in place to safely manage patients who had been prescribed medicines.
- The provider did not have a system or policy in place to safely manage patients who had a long term condition.
- The provider did not have a safe system in place to safely manage laboratory test results for patients who attended the service.
- The provider had made improvements to enable them to safely manage recruitment, including disclosure and barring service (DBS) checks.
- The provider could not demonstrate they had appropriate oversight of their patient list and relative risk regarding their patient population group.
- The provider had made some improvements regarding their emergency equipment. However, we found some emergency medicines were missing and this had not been formally risk assessed.

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

- Care and treatment must be provided in a safe way for service users.

# Overall summary

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

**Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA**

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

## Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a member of the CQC medicines team.

## Background to BG Medical Clinic

BG Medical Clinic is located at 48 North Street, Romford, London, RM1 1BH, in the London borough of Havering.

The provider is registered with the Care Quality Commission (CQC) to deliver the regulated activities: treatment of disease, disorder or injury, diagnostic and screening procedures and family planning

Services provided include: general practitioner services; cardiology; orthopaedic; ENT (ear, nose and throat); paediatric; endocrinology; general surgery and gynaecology consultation services; ultrasound scans; dressings; blood and other laboratory tests. Patients can be referred to other services for diagnostic imaging and specialist care.

At the time of inspection the service was suspended. However, normally the service is open Monday to Friday from 9am to 6pm; Saturday 9am to 4pm and Sunday 10am to 2pm and does not offer out of hours care. The provider's website can be accessed at www.bgmedicalclinic.com

**How we inspected this service**

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

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

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

Inspected but not rated

# Are services safe?

**Safety systems and processes**

**The service had some systems to keep people safe and safeguarded from abuse.**

**At our previous inspection on 19 January 2023 we found:**

- It was not possible to undertake searches and recall of patients due to the severe limitation of the provider's clinical system.
- We reviewed eleven staff records and found they had completed DBS checks for seven out of nine medical staff, one phlebotomist and one receptionist/administrator. However, for two doctors the DBS checks were from different employers. Following our inspection on-site visit on 19 January 2023, the provider submitted evidence that they had initiated an enhanced DBS check for a further two doctors. They did not submit evidence for one newly recruited receptionist/administrator.
- We reviewed eleven staff recruitment records for nine medical staff, one phlebotomist and one receptionist/ administrator and found:
- No information was submitted in any staff records regarding a signed written employment contract or other form of employment 'terms of engagement' agreement.
- Eight out of ten staff records did not contain appropriate references, and one record contained references from 2007 and 2009.
- Nine out of ten staff records did not contain an application form or CV. One staff record contained an unexplained gap of 3.5 years.
- No staff records contained a signed confidentiality agreement.
- No information was submitted for a recently employed receptionist.

**At this inspection on 06 March 2023 we found:**

- We saw the provider had made some improvements to their recruitment system, including:

We reviewed 8 staff records and found that all staff had completed recent DBS checks at the appropriate level.

We saw that all staff records contained photo ID and an employment contract.

We found that 1 out of 8 staff records contained appropriate professional references, to demonstrate satisfactory conduct in previous employment. The references in this staff records were dated 2007.

All staff records contained an application form or CV.

**Risks to patients**

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

**At our previous inspection on 19 January 2023 we found:**

- The provider could not demonstrate evidence that medical indemnity insurance was in place for four medical staff; one dentist and two dental nurses. A dental team of one dentist and two dental nurses was included in the current staff list provided to us during our inspection on 19 January 2023. The provider had offered to arrange interviews with dental staff during our on-site visit, however this did not materialise.

Inspected but not rated

# Are services safe?

- The provider could not demonstrate they had a failsafe system in place to ensure patients test results had been reviewed and actioned appropriately.
- The provider could not demonstrate they had a system in place to safely manage patient safety alerts, including historical alerts that remained clinically relevant. They could not demonstrate they had conducted and saved searches on the clinical system to identify patients who may be affected. In addition, the provider had a limited mechanism in place to disseminate relevant patient safety alerts to all clinicians who worked at the service.
- The provider could not demonstrate they had oversight of the patients on their list. For example, they did not know how many patients they had on their patient list. The service operated a dual system regarding patient record-keeping: a paper and clinical IT system. Staff told us that both systems hold identical information. However, we reviewed two random samples from patient records and could not find one patient at all on the clinical IT system. This patient's medical record information could potentially be lost to follow-up if the paper records were lost.
- The practice had a recruitment policy; however, we were unable to review recruitment records for dental staff. This was because the provider told us at the time of inspection there, were no dental staff employed. . This was not reflective of the staffing information provided to us by the practice which included a dentist and a dental nurse as part of the staff working at the practice.

**At this inspection on 06 March 2023 we found:**

- We found that appropriate medical indemnity insurance was in place for all clinical staff.

- We found there was limited capability to search or audit patient records regarding laboratory test results. The service did not operate a recall system for patients who may require blood and other monitoring related to medicines they are prescribed.

- Staff told us that laboratory results would be automatically downloaded into patient records, with changes that will be made to the practice IT system. The provider could not currently demonstrate how this would work.
- A dual system remained in place regarding paper-based records and the clinical IT system . For example, the patient's treatment plan will be issued on paper and then scanned into the patient's cloud-based record.
- Staff told us:

The provider had trained an administrator to review abnormal results. They have not provided evidence of this training and competency checking. Staff told us, the administrator would forward laboratory results to the relevant clinician and if that was not possible, patients results would be sent to the Registered Manager would then review any potentially abnormal results.

Medical staff will have the ability to log into the service's cloud based IT system to review test results at the end of their working day and they would then contact patients as necessary. The provider did not have a system in place to mitigate risk to patients if follow-up was not possible.

The provider did not have an audit or failsafe system in place to ensure when a test is requested, it gets done.

- The provider could not demonstrate evidence that they had made sufficient improvements and had an effective system in place to collate and respond to patient safety alerts, for example on receipt of information indicating certain medicines are unsafe for use. In particular:

Inspected but not rated

# Are services safe?

The provider told us they had created a proposed new system for receiving patient safety alerts and logging them. However, due to the limitations as a result of the clinical system not having a functioning search facility, it was not possible to identify patients in the clinical system who could be affected by a particular alert. Nor was the provider able to demonstrate how this process would work.

The provider could not demonstrate they had completed audits of the system to identify relevant patients, who are prescribed medicines which have been the subject of patient safety alerts and would require review or follow-up. This included for historical alerts that remain relevant.

**Information to deliver safe care and treatment**

**Staff did not have the information they needed to deliver safe care and treatment to patients.**

**At our previous inspection on 19 January 2023 we found:**

- Due to the limitations of the clinical IT system, we could not be assured that all care records for patients were appropriately managed. We reviewed 17 randomly chosen individual care records and saw that care for 11 patients had been managed in a way that kept patients safe.
- However, the provider could not demonstrate that care records for patients who did not have access to NHS care, were managed in a safe and effective way.

**At this inspection on 06 March 2023 we found:**

- Following our last inspection, the provider submitted an action plan regarding improvements they planned to make regarding their clinical system. They told us they had consulted with their clinical system supplier and assured CQC that the required improvements would be made by the end of January 2023. If that was not possible, the provider told us a new clinical system would be installed and this would be completed by end of January 2023. At the time of this reinspection, this had not been implemented.

- The provider could not demonstrate that care records for patients who did not have access to NHS care, were managed in a safe and effective way.

**Safe and appropriate use of medicines**

**The service did not have reliable systems for appropriate and safe handling of medicines.**

**At our previous inspection on 19 January 2023 we found:**

- During our inspection on 06 March 2023, we identified that it was not possible to undertake safe medicine prescribing, free text searches of patient records or recall of patients for consultation due to the severe limitation of the provider's clinical system. This limitation is a significant risk, contributing to several of the further concerns contained in this report.
- The provider did not have a system or process in place to safely manage patients who were prescribed high risk medicines, to ensure they receive appropriate blood monitoring and were regularly reviewed.
- The provider could not demonstrate they had carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

Inspected but not rated

# Are services safe?

- The provider did not have an overarching system to manage emergency medicines and equipment. For example, we found some medicines and equipment had expired for example, a medicine used to treat croup in young children which expired on 30/04/2022. In addition, there were some items of emergency equipment which were missing, for example airways. We saw paediatric and adult masks were absent from the resuscitation kit.
- We saw that some emergency medicines stored in the vaccine fridge had expired, for example, glucagon as used in a diabetic emergency.
- There were two syringes filled (1.5mls in each syringe) with a clear fluid. These were not labelled as to the name of the medicine or contents of the syringes; when these were drawn up and when these would expire. They were not labelled with any patient-identifiable information.

- Emergency equipment and medicines were not available and checked in accordance with national guidance. The provider did not have oropharyngeal airways or a portable suction. We also found the provider did not have Buccal Midazolam (Oromucosal Midazolam) as part of their standard emergency drugs instead they held rectal diazepam. (Buccal midazolam has been tested and approved for seizure management and is now the NICE recommended drug of choice for emergency treatment for prolonged convulsive seizures). The provider told us this would be replaced.

- The provider could not demonstrate that primary medical service (PMS) and dental staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

**At this inspection on 06 March 2023 we found:**

- The provider could not provide an appropriate formulary of medicines. On request, the provider submitted evidence, during our inspection, of a basic formulary of groups of medicines against each prescriber at the service (which had been implemented since the last inspection).

- The provider told us their dermatologist, for example, was only allowed to prescribe certain medicines. When we asked if clinicians would be allowed to prescribe other medicines if required, the provider told us that they could. This meant that this particular checklist was not fit for purpose for future scenarios because it did not consider the scope of prescribing; disease management and any monitoring that may be required for patients who presented to the service.

- We reviewed the prescribing policy for the service and this contained information confirming that clinicians could prescribe controlled drugs. However the provider told us that the clinicians working at the service would be unable to do so. This contradicts the service policy. Upon asking further questions around length of prescribing, long terms conditions and defined limits for prescribing, the provider was unable to demonstrate that they had a robust system in place to ensure patients remained safe from the prescribing of certain high risk medicines.

- The provider told us that unlicensed medicines would not be prescribed. For example, a medicine used to treat poly-cystic ovarian syndrome, however this was not reflected in their prescribing policy.

- When we asked how patients who are prescribed specific medicines can be searched on the clinical IT system retrospectively, the provider told us that conditions had been 'tagged' on the system and can be searched against this to identify a list of patients. However, due to the limited capability of the clinical IT system this meant that searches and audits could not be completed for patients who are prescribed different medicines than those specified, including the absence of a free text search from patient records, laboratory results and other relevant information. The provider was unable to demonstrate the proposed new system they described.

Inspected but not rated

# Are services safe?

- Although we saw that some improvements had been made regarding emergency equipment and that appropriate equipment was now in place, we found some medicines were missing from the emergency medicines kit. For example, medicines used to treat anaphylactic reactions and appropriate risk assessments had not been completed.

- The provider could demonstrate that primary medical service (PMS) staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support within the previous year.

**Safe care and treatment**

**Management of long term conditions**

**At our previous inspection on 19 January 2023 we found:**

- Due to the limitations we found regarding the provider's clinical system and other concerns found during our inspection on 19 January 2023, the provider could not demonstrate that care and treatment was consistently delivered in line with national guidance. When we spoke with the provider, they told us they were aware of national guidance regarding patient care and treatment. However, we reviewed evidence from eleven patient records that national guidance had not been followed; an appropriate plan of care had been documented or contained appropriate information, for example ultrasound scan images.

**At this inspection on 06 March 2023 we found:**

- Since our last inspection on 19 January 2023, the provider had made a small improvement regarding safe care and treatment for patients who may have a long term condition. Specifically, they had added a 'tagging' facility to their clinical IT system, for patients who may have a long term condition. For example, for patients who have type 2 diabetes. It was possible to run a search of patients who had been tagged with 'type 2 diabetes'. However, there remained no coding system in place and it is not possible to undertake a free text search in the clinical IT system to identify and to provide a failsafe for all patients who may have been diagnosed with a long term condition, in line with national guidance. These patients may be lost to follow-up

- In addition, if a doctor had not manually tagged a condition on the system, the only way to identify patients with a certain condition was to print out the whole patient list and manually identify those patients. This meant at the time of inspection the provider was unable to undertake effective searches on the clinical system to identify patients with a specific long term health condition.

- The provider could not demonstrate they had completed audits of their system to identify relevant patients with long-term conditions effectively who would require review or follow-up.

- The provider demonstrated limited knowledge regarding the management of patients who may have a long-term condition. They provided inconsistent responses regarding the management of long term conditions. This was inconsistent with national guidance.

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.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**We imposed an urgent suspension under s.31 of the HSCA 2008.**<br>**Care and treatment must be provided in a safe way for service users**<br>• The provider failed to have an effective clinical IT system in place to safely manage searches and recall of patients.<br>• The provider failed to have a safe and effective system to monitor and manage patient safety alerts.<br>• The provider failed to have an effective system to place to safely manage prescribing and medicines management.<br>• The provider failed to have an effective system in place to safely manage patients who may have a long term health condition.<br>• The provider failed to operate a recall system for patients who may require blood and other monitoring related to medicines that are prescribed, including a failsafe system.<br>• The provider failed to operate a safe and effective recruitment system.<br>• The provider failed to monitor and manage a safe system to their patient list and records.<br>• The provider failed to have a safe and effective system to monitor and manage emergency medicines and equipment, in line with UK national resuscitation guidance. |

This section is primarily information for the provider

# Enforcement actions

**This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**