Allpro Limited

Polska Przychodnia

Inspection report

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Overall summary

We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

We carried out an announced focused follow-up inspection on 2 May 2018. CQC inspected the service on 6 December 2017 and asked the provider to make improvements regarding safe care and treatment; effective care and treatment and leadership. We checked these areas during this follow-up inspection and found improvements.

This was a joint dental and medical inspection of an independent healthcare service.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. Systems had improved since the previous inspection, however further improvement was needed and these systems were not fully tested because medical patients had not been treated at the clinic since February 2018 following publication of the report.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. Systems had improved since the previous inspection, however further improvement was needed and these systems were not fully tested because medical patients had not been treated at the clinic since February 2018 following publication of the report.

Are services well-led?

We found that this service was not providing a well-led service in accordance with the relevant regulations. Systems had improved since the previous inspection, however further improvement was needed and these systems were not fully tested because medical patients had not been treated at the clinic since February 2018 following publication of the report.

Background

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 an announced focused inspection, carried out on 2 May 2018 to confirm that the practice had completed their plan to meet the legal requirements in relation to the breaches in regulations we identified in our previous inspection on 6 December 2017. This report covers our findings in relation to those warning notices.

Polska Przychodnia is registered with the Care Quality Commission (CQC) as an independent provider of dental and medical services for children and adults and is

Summary of findings

located in Eccles, Greater Manchester. Patients are primarily Polish people with English as a second language who live in the United Kingdom and the service is accessed through pre-booked appointments.

The clinic is registered with the CQC to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury
- Maternity and midwifery services
- Family Planning

The service mostly employs doctors, dentists and dental nurses on a sessional basis. However a physiotherapist also runs a clinic approximately once a month.

A full range of dental care including extractions is provided by the service.

The medical services includes:

- gynaecology;
- internal medicine defined as, dealing with the prevention, diagnosis, and treatment of adult diseases;
- treatment for ear, nose and throat conditions;
- orthopaedics;
- Psychiatry and
- Diagnostic tests.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner. At Polska Przychodnia the private physiotherapy sessions provided are exempt by law from CQC regulations.

The medical health care team consists of:

- Four doctors: an internal medical specialist, a gynaecologist, an ear, nose and throat (ENT) doctor and a psychiatrist.
- Five dentists, four dental nurses (one whom is a trainee and another is a locum).
- All the doctors and dentists are registered with either the General Medical Council (GMC) or the General Dental Council (GDC).
- The doctors and dentists are supported by the registered manager who was also trained as a phlebotomist, one full-time receptionist and one full time administrator.

The nominated individual for the service is also the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a 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:

Over all, we found improvements at the service during this follow-up inspection.

- Child protection systems and processes had improved and systems were in place to check whether paediatric services were provided in line with best practice guidance.
- Cleanliness and infection control audits were now in place and completed.
- Regular staff meetings lead by the registered manager had been established. A system was in place to ensure medical and dental staff working for the service attended. The agenda included reviewing the quality and development of the service.
- Processes were in place to ensure patient records were well written and contained sufficient detail about treatment and care provided.
- Processes for reporting incidents were in place and systems for dealing with and sharing safety alerts were reliable.
- Systems were in place to monitor antibiotic prescribing.
- Policies and procedures were readily available.
- The provider could demonstrate a clear understanding of their responsibilities under the Duty of Candour regulation and this was supported by a Duty of candour policy.
- Quality assurance was to be discussed at all team meetings and the provider had started an audit programme to review the outcome of changes that had been made.
- There was now clinical governance oversight of the dental services provided, although clinical oversight for the medical service was not yet established.

Summary of findings

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

- Ensure that systems and processes are established and operated effectively to ensure good governance in accordance with the fundamental standards of care.
- Ensure staff have the correct support to demonstrate ongoing competency in their roles.

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 contents of the emergency medicines kit as this did not reflect current guidance.
- Review the emergency medicines risk assessment.
- Review the action taken in relation to making sure the x-ray machine was safe to use and used safely.
- Review the patient letters policy to ensure that letters are posted as required.
- Review the plan for organising a fixed wiring check so that a date is confirmed.
- Review whether a qualified engineer should also complete a legionella risk assessment for the building.
- Review a sample of care and treatment previously provided in order to set a baseline against which improvements can be measured.
- Review the accessibility of key policies and procedures in relation to the main language read and spoken by staff.
- Review the system for signposting patients to alternative services when the clinic is closed.

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 improvements in safe care in accordance with the relevant regulations; however, there are areas where we have told the provider to take additional action (see full details of this action in the Requirement Notices at the end of this report).

The areas of improvement were:

- All staff had received basic life support training.
- Systems were in place to monitor antimicrobial prescribing and other medicines to ensure best practice guidance was followed or risk assessed when this was not the case.
- A specialist medicines fridge had been purchased and monitored in keeping with best practice guidance.
- The provider carried out checks to verify a patient's identity in keeping with best practice protocol.
- The provider had introduced processes to assure themselves that adults accompanying children had parental authority.
- Processes were in place to ensure health assessments were completed and patients care and treatment, including prescribed medication, was always based on up-to-date best practice guidance.
- Processes were in place to ensure medical records conformed to the 'Records Management Code of Practice for Health and Social Care 2016'.
- An incident reporting policy was now in place.
- Systems to ensure clean, well maintained and safe to use premises and equipment were in place and personal protective equipment (PPE) was available for decontamination procedures.
- The provider had ensured risks associated with fire or sharp instruments were managed appropriately.

The provider had taken steps to ensure medical and dental equipment was fit for purpose. Equipment was now cleaned and maintained in line with the manufacturer's instructions. However more urgent action was needed in respect of managing the x-ray machine.

Are services effective?

We found improvement in the service providing effective care in accordance with the relevant regulations, however, we have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The provider has introduced systems to monitor the outcomes of care and treatment provided at the clinic.
- Recruitment and induction processes have been reviewed and includes seeking assurance that medical staff are fully competent to carry out the work they do at the clinic.
- The induction programme has been reviewed and includes familiarising staff with where all equipment is stored.
- Employment records held at the service demonstrated that all the required pre-employment checks were undertaken.
- Systems were in place to inform patients of laboratory test results included informing the patient's NHS GP unless the patient had opted out or refused to provide the GPs details.

A staff training programme has been introduced and clinical supervision in place for the dentists, however, there continues to be a need for more evidence of local clinical supervision, mentorship, peer review and support in place for the medical doctors and psychiatrist.

Summary of findings

Are services well-led?

We found improvement in providing well-led care in accordance with the relevant regulations, however additional improvements were needed.

- Systems for quality improvement such as formal checks and audits had been introduced and risk assessments completed, however, risk assessments had not ensured the management of x-rays and radiation met the full legal requirements in a timely manner; checks on emergency medicines did not identify that some items were missing or inappropriate and, aspects of the service had not been benchmarked to help measure the effectiveness of improvement plans and intervention in those areas.
- The provider had delegated some lead roles such as infection prevention and control and provided appropriate training as required.
- Formal team meetings were held and clinical governance for the dentists had been introduced.
- A formal route of sharing information with doctors who worked for the service had been put in place.
- Clinical leadership for the dental teams was now in place to drive quality improvement and ensure adherence to relevant best practice guidance.
- Clinical leadership for doctors was not yet established.
- Although improvements were needed, risk assessments for identifying, recording and managing the risks and issues associated with running the business had been developed.
- There was evidence that a selection of the policies and procedures had been updated to relate to the service and shared with all staff.
- Records were securely stored and the area where patient medical records were stored had been fireproofed.

Polska Przychodnia

Detailed findings

Background to this inspection

We carried out an announced inspection on 6 December 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to follow-up on whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by a CQC Lead Inspector and included one dental inspector, a second CQC inspector, a CQC specialist GP advisor and a dental specialist advisor.

During our inspection we spoke with the registered manager, one doctor and one administrator.

We reviewed personnel files, practice policies and procedures and other records concerned with running the service. We reviewed the full medical records available for 12 patients and reviewed doctor's letters and medical test results for an additional number of patients.

Are services safe?

Our findings

At our previous inspection on 6 December 2017, we saw that the service needed to improve as the arrangements in respect of safeguarding; risk assessments; medicines management and managing a medical or dental emergency were not adequate. These arrangements had improved when we undertook a follow up inspection on 2 May 2018.

The systems in place protected against abuse and arrangements for safeguarding reflected relevant legislation.

- Processes were in place to ensure adults accompanying children under 18 years of age had parental responsibility. The protocol included requesting a selection of the following items as proof of identity: photographic identification of the adult and child; request for a birth certificate; the attendance of both parents if possible; the child's NHS immunisation book; proof of address for the accompanying adult and name and address of the child's GP.
- The provider had provided training and guidance to assist staff in identifying children at risk and vulnerable adults.
- A safeguarding lead had been identified and this person had completed appropriate training and made links with the local safeguarding team. Processes were in place to share safeguarding concerns between clinicians.
- The registered manager and administration staff had completed the appropriate level one, safeguarding training and the registered manager had processes in place to check and confirm that visiting clinicians had completed adult safeguarding and child protection level three training in keeping with best practice guidance.
- A safeguarding policy was in place and included up to date information about PREVENT (the initiative for recognising and taking steps to deal with political or religious extremism) and protecting against female genital mutilation (FGM). This was available in both electronic and hard copy. Staff had signed to confirm they knew how to access the policy.
- The provider had developed a process which included regular updates from staff, and team meetings, in order to check on the outcome of the safeguarding referrals or other incidents.
- A safeguarding vulnerable adults and child protection information flowchart was on display in the waiting area of the clinic. This included the contact details of the local adult and child protection units.
- The provider had developed a lone working policy for staff working at the clinic.
- The whistleblowing policy had been updated to include information about external organisations staff could approach if they had concerns.
- Processes were in place to ensure all the required checks were completed for new recruits. We reviewed the files of the newest recruits and these were complete and held all of the required information to promote safe staff recruitment, including Disclosure and Barring Service (DBS) information. (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.)
- The premises were clean and tidy and a cleaning schedule was in place for the different areas and rooms. Cleaning audits had been completed and staff in day to day control of the service had completed infection prevention control training.
- The cleaning company employed to carry out the general cleaning duties stored cleaning equipment in keeping with best practice. We observed that mops were properly stored and coded to make sure the same mop was always used for specific areas. Cleaning equipment and fluids were stored in a locked cupboard. Control of substances hazardous to health (COSHH) risk assessments had been completed and these provided information for staff concerning risks and risk mitigation.
- Clinical waste and sharp bins were appropriately stored and collected by a specialist clinical waste company. Boxes which had been assembled were marked with the assembly and expiry date.
- An up-to-date fire risk assessment had been completed in March 2018 and action had been taken to address the issues identified at that time. On the day of inspection we noted the rear fire exit was unlocked and free of obstructions. The fire extinguisher was attached to the wall and we saw evidence that the fire detection systems and fire-fighting equipment had been regularly tested or checked. Records also indicated that fire drills had been carried out and all staff had completed fire safety training. The fire risk assessment identified that

Are services safe?

an up to date fixed wiring check was not in place and this was on the action plan being followed by the provider, however a date for completion was not identified.

- Infection prevention and control policies and protocols were specific to the location and provided staff with enough information about how to protect against cross infection.
- The provider had taken steps to ensure equipment and medical devices were cleaned, calibrated and serviced in keeping with the manufacturer's instructions. However more action was needed in respect of managing the x-ray machine.
- A radiation protection file was in place.
- The provider had taken appropriate steps to register the X-ray machine with Public Health England and the Health and Safety Executive. Radiation test packs had been sent to Public Health England for analysis the results indicated that the machine was operating within safe parameters. There was no evidence available on the day of inspection that a qualified person had examined the X-ray machine in situ.
- We requested that the provider review the installation of the x-ray machine to ensure staff are provided with clear diagrams and instructions in how to prevent inadvertent radiation exposure.
- Servicing documentation for the autoclave and compressor was available on the day of inspection.
- An in-house Legionella risk assessment had been completed and a Legionella prevention policy and procedure for the clinic was in place. This risk assessment did not have a schematic drawing of the location and had not identified the sentinel outlets. We saw that water temperatures were now checked monthly and records indicated that water reached a safe temperature. However, the provider was not aware which taps were the sentinel outlets which needed to be checked. A Legionella water sample had been taken in October 2017 which showed no Legionella was developing.

Risks to patients

- At our previous inspection on 6 December 2017, we saw that the clinic did not have adequate arrangements in place to respond to medical emergencies and specific guidance about what to do in a medical emergency was not in place. These arrangements had improved when we undertook follow-up inspection on 2 May 2018 however additional action was needed.
- Emergency medicines were now provided, however these were incomplete as they did not include all of the medicines detailed in resuscitation best practice guidance. The medicines were not readily accessible because both medical and dental emergency medicines were stored in the same box.
- In date emergency oxygen and adult and paediatric sized masks was available, however the oxygen tank was not large enough to provide oxygen until emergency services could arrive at the clinic. These matters were discussed with the provider at the time of the inspection and the provider ordered the correct size tank and agreed to review the way in which emergency medicines were managed.
- A risk assessment had not been completed to ensure emergency medicines were managed safely.
- All staff had now completed first aid and basic life support training; and processes were in place to ensure that all clinical staff working with children had completed paediatric life support training.

Information to deliver safe care and treatment

- The provider had introduced protocols to verify the identification of patients both adults and children. Additional processes were in place to ensure adults accompanying a child had parental authority. The safeguarding lead had completed safeguarding adults and child protection level three training. Liaison with the local safeguarding team had taken place to ensure systems in place were in line with child protection best practice. Processes were in place to ensure a child's GP was always updated about care and treatment provided at the clinic.
- Process had been put in place to audit patient records to ensure these contained a detailed medical history. The process for contacting the patients GP had been updated to meet best practice guidance. This meant the patient's NHS GP would have up-to-date information about ongoing care and treatment whenever possible.
- Paper patient records were stored in a safe and secure area and fire retardant treatment applied to the door leading to this room. Electronic records were stored on encrypted laptops which were password protected.

Are services safe?

Safe and appropriate use of medicines

We checked the arrangements for the management of medicines at the clinic.

- The provider had purchased specialist medicines fridge which included a temperature logger so that highest and lowest temperature range within a given period could be observed and recorded. Guidance was provided about the action to be taken if the temperature was outside the required parameters. All medication on site had been stored correctly.
- The clinic had introduced checks to monitor the medicines prescribed by dentists and doctors. The process included checking whether medicines were prescribed in keeping with best practice guidance and local and national antibiotic prescribing protocols. The clinic issued private prescriptions, these were stored securely and their use was now monitored.

Track record on safety

- There was a clear and detailed reporting incidents policy and incidents would be discussed at team meetings. The registered manager initiated the incident protocol in response to feedback provided during the inspection process.

Lessons learned and improvements made

- The provider was aware of the requirements of the Duty of Candour regulations and this was supported by clear policies and procedures.
- Systems for reviewing information received by the service had been formalised so that trends and areas for improvement could be identified.
- A system was in place to receive national patient safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and this information was shared with each dentist and doctor at the beginning of each shift.

Processes were now in place to identify patients who may have received care which needed to be reviewed in response to safety alerts. Systems were now in place to audit the type of treatment provided at the clinic.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 6 December 2017, we saw that the service needed to improve the arrangements in respect of providing effective care and treatment. These arrangements had improved when we undertook a follow up inspection on 2 May 2018.

- The clinic had introduced processes to check whether practitioners delivered care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) best practice guidelines. Checks were in place to monitor records to ensure information include an up to date medical history and information about the guidance provided to the patient.
- Records had not been reviewed retrospectively to identify the areas of priority in relation to improving outcomes for patients.

Monitoring care and treatment

- Monitoring and follow-up arrangements and other processes had been put in place to support good practice and ensure consistently effective and appropriate care and treatment was offered going forward.
- Clinical and quality improvement audits were now in place so that treatments could be reviewed against best practice guidance.
- A dental clinician was in place to have oversight of dental care and treatment, however a clinician to have oversight of medical care was not yet place. The provider was in the process of seeking a medical practitioner to take responsibility for oversight of medical care. We noted that checks and processes were in place to promote effective care and treatment until this role was filled.

Effective staffing

- The provider now had systems in place to check the competency of new employees, this included contacting and receiving written reassurance from responsible officers for doctors. A formal induction programme was now in place. Topics covered included an orientation around the building; fire safety; safeguarding; confidentiality and infection prevention and control.
- A mandatory training programme was now in place and an appraisal system had been introduced.

Coordinating patient care and information sharing

- Patients completed a medical history form that included consent to share information with their registered GP. Records now indicated that information was shared with the patients GP unless a refusal was documented. This was now in keeping with the General Medical Council (GMC) guidance on sharing information. We noted that the provider was monitoring each doctor's compliance with this procedure and letters posted by the administration staff were logged. Doctors sometimes took responsibility for posting their own letters and these letters were not logged.
- Laboratory tests results were also routinely shared with the patients NHS GP.

Supporting patients to live healthier lives

- The auditing process which had been introduced included reviewing whether patients were given advice on healthy living; however, this was a new process and had not been tested in relation to medical patients.

Are services well-led?

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

Our findings

At our previous inspection on 6 December 2017, we saw that the service needed to improve as the arrangements in respect of providing a well-led service. These arrangements had improved when we undertook a follow up inspection on 2 May 2018.

Leadership capacity and capability

- The registered manager was the nominated individual and responsible for the day to day running of the service. The registered manager appeared open to new ideas and learning.
- Since the previous inspection formal systems had been put in place to ensure continual learning and professional development this included an induction process, mandatory training, clear job descriptions and an appraisal system.
- The registered manager had also completed additional management skill courses.

Vision and strategy

- The registered manager stated the vision of the service was to provide the best possible clinical care to the Polish community. Since the previous inspection formal systems had been introduced to benchmark and check the quality of the service and assess patient satisfaction.
- Formal meetings to discuss the vision and strategy of the clinic had been introduced and records kept so that ideas and planned actions could be reviewed. These meetings were open to all staff including the doctors and dentists. Systems were in place to ensure those who could not attend were updated about changes and developments.

Culture

- A Duty of Candour policy was now in place. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Governance arrangements

- Arrangements for identifying, recording and managing non-clinical risks were now in place and monitored.
- Policies and procedures had been updated to relate specifically to the service and policies were now available in the main reception area.
- An incident and significant event policy had been introduced and this included formal processes to report, record or learn from incidents or significant events. This policy had not been used at the time of this follow-up inspection; however, the provider initiated the policy during the inspection process in response to an area of feedback.
- Quality improvement programmes and internal audit processes had been introduced since the previous inspection. These included quality of prescribing, X-rays, infection prevention and control and a review of care and treatment against the relevant best practice guidance.

Managing risks, issues and performance

- An overarching organisational risk assessment still needed to be developed.
- A business continuity plan was now in place and staff had the contact number for the provider if the registered manager was not on the premises.
- The provider had started to put processes in place to provide clinical leadership and monitor doctors who provided a wide variety of services on a sessional basis. The provider was seeking additional clinical leadership and external expertise to drive quality improvement. The provider was investigating how to introduce a system of clinical peer review so that cases were periodically discussed and considered in respect of possible improvements in care and treatment.
- There were however still gaps in relation to managing risks and performance, for example the ionising risk assessment was not adequate because it did not identify the urgency needed in relation to dealing with particular risks; ensuring the x-ray machine was safe to use and operated in keeping with legal requirements; the checks had not identified that emergency medication was incorrect and current performance was not benchmarked in order to identify improvements in future performance.

Appropriate and accurate information

- All patients' medical records were held safe and secure. Paper records were stored in locked cabinets within a

Are services well-led?

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

locked room protected by fire proofed door and electronic records were held on a suitably secure computer system which was encrypted and each file was password protected.

- An audit of medical records had been introduced to check and make sure the information provided met best practice guidance and standards.

Engagement with patients, the public, staff and external partners

- A system to periodically engage with patients, the public and external partners in order to seek their opinions on what the service did well and how the service could be improved remained under development, however systems were in place to receive feedback for staff.

Continuous improvement and innovation

- The provider had commenced engagement with regulatory bodies in order to improve the standard of the service.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Systems and processes established were not always operated effectively to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, because the system did not always identify when best practice was not followed for example: • The provider did not have systems in place to ensure emergency medicines met best practice guidance. **The system did not prompt the provider into taking sufficient and timely action to ensure the x-ray machine was completely safe to use.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was limited clinical oversight to review the treatment provided by doctors working at the practice.**