Atlantic Clinic Ltd

Quality Report

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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Atlantic Clinic Ltd on 27 June 2016.

Our previous inspection in January 2016 had found the service was not providing safe, effective and well led care in accordance with the relevant regulations. It was providing caring and responsive care in accordance with the relevant regulations. As a result of the inspection there were requirement notices and a warning notice. The timescale given to meet the warning notice was 30 May 2016.

The warning notice was served related to regulation 17 Good governance.

Areas which did not meet the regulations in January 2016 were:

Summary of findings

- There were not effective systems or processes to assess monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities.
- There was not a maintenance of records in relation to persons employed in the carrying on of the regulated activity and the management of the regulated activity.
- There was a lack of sufficient clinical auditing within the service to ensure the regular monitoring of the quality of care and treatment provided and the implementation of changes to improve patient treatment outcomes.
- There was a lack of overarching governance arrangements within the service to support the delivery of good quality care and a lack of evidence of continual learning and improvement.
- There are no formal systems or processes in place to monitor the use of best practice guidance information to deliver care and treatment which meets patients' needs.
- Lack of formal systems and processes to review the on-going learning needs of staff.

The requirements notices were in relation to the need to make improvements. The provider was asked to:

- Ensure regular maintenance and servicing of all steam sterilisers within the service.
- Establish clear processes and procedures which ensure the effective cleaning, decontamination and tracking of all reusable instruments used within the service.
- Ensure systems are in place to monitor and manage risks associated with national patient safety alerts within the service.
- Ensure all necessary and relevant checks are undertaken for all staff prior to employment.
- Ensure all staff receives regular supervision and appraisal which reflects their full scope of work, including those doctors providing services to patients on a sessional basis.
- Ensure there are formal governance arrangements in place, including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure clinical audits are used to promote continuous improvement and improve patient outcomes, including auditing of dental x-rays.
- Ensure staff undertake training to enable them to undertake their role, including training in basic life support and chaperoning and where required, dental nurse training.

At our inspection on 27 June 2016 we found the service had complied with the warning notice and was now compliant with the regulations as set out both in the warning notice and the requirement notices. The service was now providing safe, effective and well led care.

Our Key findings were:

- There were regular maintenance and servicing of all steam sterilisers within the service.
- There were clear processes and procedures for effective cleaning, decontamination and tracking of all reusable instruments used within the service.
- There were systems are in place to monitor and manage risks associated with national patient safety alerts within the service.
- There were necessary and relevant checks are undertaken for all staff prior to employment.
- Staff received regular supervision and appraisal.
- Staff had undertaken training to enable them to undertake their role.
- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the service.
- The service had clearly defined and embedded systems, processes and clinics in place to keep patients safe and safeguarded from abuse.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- The service had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse
- Risks to patients were assessed and well managed

Are services effective?

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and training for all staff.

Are services well-led?

- The service had a vision and strategy to deliver quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The service encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a focus on continuous learning and improvement at all levels.

Atlantic Clinic Ltd

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a GP practice manager specialist adviser and a Dental specialist adviser.

Background to Atlantic Clinic Ltd

Atlantic Clinic provides private medical services predominantly to meet the needs of the local Polish population within the Southampton area. A range of services are provided which include obstetrics and gynaecology, orthopaedics, paediatrics, GP services, psychiatry, dermatology and dentistry. Dental services are provided from the first floor only.

The service employs six staff which includes receptionists, a trainee dental nurse, a phlebotomist and two managers. Doctors who provide services to patients are not employed by the service but are contracted to deliver services on a sessional basis.

The service is open from 09.00 to 20.30 from Monday to Sunday. The premises include several consulting rooms, treatment rooms and offices located over two floors of the building. The first floor is accessed via a flight of stairs only. There is no lift access to the first floor.

There is a responsible individual who represents the provider Atlantic Clinic Limited and there is a lead doctor within the service who 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.

Why we carried out this inspection

At the inspection carried out on 7 January 2016, we made a requirement to address shortfalls with;

Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

The registered provider had not always maintained records which are necessary to be kept in relation to the management of the regulated activity. We found that the registered provider had not always evaluated and improved their practice in respect of the processing of the information referred to above.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

The registered provider had not ensured that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.

Regulation 18 HSCA (RA) Regulations 2014 Staffing.

We found that the registered provider had not always ensured that staff received appropriate training, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform.

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed.

Detailed findings

The registered provider had not ensured that recruitment procedures were established and operated effectively to ensure that persons employed met the required conditions. We found that the registered provider had not ensured that information specified in Schedule 3 was available in relation to each person employed.

We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time.

We carried out this inspection to make sure that the necessary changes have been made. We found the provider was meeting the regulations included within this report. This report should be read in conjunction with the full inspection report.

How we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to look at the overall quality of the service.

We carried out an announced inspection visit on 7 January 2016 as part of the independent doctor consultation service inspection pilot. Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a dental specialist advisor, a CQC medicines inspector, a mental health specialist advisor and a practice manager specialist advisor.

Before this follow up inspection on 27 June 2016 we reviewed a range of information that we held about the service and asked other organisations to share what they knew. Prior to the inspection we reviewed information we had received from Southampton Clinical Commissioning Group prescribing team and the information provided in response to a pre-inspection information request to the provider. At this visit the team included a GP specialist advisor, a Dental specialist advisor, a Polish speaking practice manager and a CQC Inspector.

During our visit we:

- Reviewed reports and information sent to us by Atlantic Clinic Ltd
- Spoke with a range of staff including doctors, managers, a dental nurse and administration staff.
- Reviewed the personal care or treatment records of patients.
- Reviewed Policies and protocols.

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?

This inspection report should be read in conjunction with the original inspection report of January 2016.

Are services safe?

Our findings

Safe track record and learning.

There was an effective system in place for reporting and recording significant events.

The service told us that they see 5 to 20 patients' a day and had not reported any significant events since our last visit.

The service had revised and updated their policy and forms to raise a significant event and significant events were a subject discussed at staff meetings.

We saw that the service had an accident books and again they had not had any reported accidents on the premises.

Staff told us they would inform the service manager of any incidents and there was a recording form available on the computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

We saw a newsletter that was sent out to staff monthly, written in Polish, which also had a section for any significant event news.

Overview of safety systems and processes

The service had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Doctors were trained to child protection or child safeguarding level 3.

A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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 service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The service dental nurse was the infection control clinical lead who had received training to keep up to date with best practice. There was an infection control protocol in place dated March 2016 and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The service provided dental services on the first floor and we saw that there was a separate decontamination room in which infection control was carried out in line with dental guidelines HTM01/05. The service followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice about the prevention and control of infections and related guidance'. These documents and the services policy and procedures relating to infection prevention and control were accessible to staff. Posters about good hand hygiene, safe handling of sharps and the decontamination procedures were clearly displayed to support staff in following service procedures.

Since the previous inspection the service had purchased two new autoclaves for use in sterilisation of dental equipment and medical equipment. Both were labelled correctly to avoid confusion and we were told that the medical autoclave was not being used as the service was using disposable items. We saw that these were tested and inspected on 24 May 2016.

We saw that dental instruments were correctly pouched and dated after decontamination and sterilisation and all items inspected were in date.

The arrangements for managing medicines, including emergency medicines in the service kept patients safe. Processes were in place for handling prescriptions which included the review of high risk medicines.

The service carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

Are services safe?

The service used local clinical commissioning group guidelines and formulary and Wessex antibiotic guidelines and we saw evidence of use of NICE guidelines. We were told that the service did not import any medicines from abroad and always used the British National Formulary (BNF) when prescribing; we saw copies of the BNF in the consulting rooms. The service did not dispense any medicines.Blank private prescription forms were securely stored and there were systems in place to monitor their use.

We reviewed one personnel file of a member of staff employed since the previous inspection and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients.

Risks to patients were now properly assessed and managed.

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The service had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents.

The had adequate arrangements in place to respond to emergencies and major incidents.

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

All staff received annual basic life support training and there were emergency medicines available in the treatment room.

The service had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. All the medicines we checked were in date and stored securely.

The service had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people.

The service had systems and processes in place to ensure that standards of care were effectively monitored and maintained.

At our inspection in January 2016 we found that there was a lack of clinical auditing within the service to ensure the regular monitoring of the quality of care and treatment provided and the implementation of changes to improve patient treatment outcomes. This was in both the medical and dental services provided.

At this inspection we found that the registered manager had attended a course on auditing in May 2016 and audits were now being performed in the service.

The dentists were performing radiography audits to ensure the quality of x rays and necessity and infection control audits had taken place in June 2016. We saw that action plans had been produced and actions implemented. There had also been dental clinical records audited for three dentists in April 2016 and each had been reported on and any action plans implemented.

The doctors had completed a simple audit of medical records to ensure that they had been completed correctly and this audit was being repeated. We looked at 10 random patient records and found that they were complete with reasonable consultations and displayed relatively good record keeping.

There had been an infection control audit of the medical areas of the service in January 2016 after the first inspection and any actions had been implemented. There had also been an audit of medicine prescribing as advised by Wessex guidelines which showed that the service was adhering to those guidelines.

Governance arrangements.

We reviewed a number of policies, for example, complaints handling protocol and recruitment policy in place to support staff. Staff told us they knew where to find these policies if required.

At this inspection we saw that policies had been updated for example the Health and Safety policy was reviewed and updated in January 2016 detailing the responsible person for health and safety as well as a clinical governance lead. The policy was comprehensive and had risk assessments covering such things as accidents and emergencies, manual handling, safe use of X-Ray, clinical waste and work place safety. The medicines management policy had been reviewed and re written to reflect the processes that took place at the service.

Other policies such as for safeguarding of adults and children, infection control and complaints had all been reviewed and updated where required.

The service had also produced an induction policy for all new staff, with details of how to access the policies via the computer systems thus avoiding the need for paper copies. This also fully documents the new staff induction process with check lists that record details of the frequency of one to one meetings in the first six weeks of employment, at the half way point and two weeks prior to end of probation period.

We also saw that since our last visit the service had improved the number of meetings held. We saw minutes of meetings from March 2016 and May 2016. They were clearly written with details of any actions that were required. All actions were listed as requiring immediate responses.

Clinical Meetings (All doctors and nurses as available) had been held twice since the previous inspection and a monthly newsletter had been sent out to all staff and doctors. All the doctors working at the service were registered with the General Medical Council and received annual appraisals.

The service had completed four patient surveys and after every visit the patient was sent a feedback form, also the service used social media platforms for patient's to write opinions. The results of the patient surveys were positive. The service website which is written in Polish shows 15 patient reviews with a 4.6 star rating out of 5.

Are services well-led?

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

Our findings

Governance Arrangements.

At our inspection of 27 June 2016 we saw that improvement had been made.

The service had updated its policies, introduced new policies, such as induction policy, and re written other policies.The service had continued to review and develop policies since our last inspection. The provider now reviewed, reflected and discussed evidence based guidance and results within the service team by means of meetings, discussion and any actions required to improve the service. The service also asked patients for feedback to monitor that the service was providing care to the requirements of its patients.

Leadership, openness and transparency.

There was a clear leadership structure in place and staff felt supported by management. The registered manager had responsibility for the day to day running of the service. They worked closely with one Director who was responsible for operations and the service manager. The lead receptionist was also training to undertake a management role. Named members of staff held lead roles. For example, there were named leads for patient safety, the safeguarding of children and vulnerable adults and information governance. The registered manager told us they held regular meetings with individual staff on a two monthly basis. Doctors providing services on a sessional basis attended clinical, governance or supervisory meetings when they were available and team meetings were held within the service. The service produced a monthly news sheet that was circulated to all doctors and staff for them to be kept up to date with clinical matters and new processes within the service.

Staff told us management were approachable and took the time to listen to them. The lead receptionist who was training to undertake a management role told us they had been involved in discussions about how to run and develop the service, and to identify opportunities to improve the service. The registered manager had some awareness of and complied with the requirements of the Duty of Candour. The service was trying to encourage a culture of openness and honesty such as for complaints management and responding to incidents or events in the service.

Learning and improvement.

The service provided training and updating for all staff in key areas such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality via a comprehensive series of e-learning training modules. There was now a formal process to review the on-going learning needs of staff. The service now conducted an annual appraisal review of doctors working on a sessional basis. There was formal supervision or peer review processes through the new clinical audits that the service had undertaken.

Provider seeks and acts on feedback from its patients, the public and staff.

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback following consultation about the delivery of the service. Staff told us and we saw evidence that each patient was actively encouraged via email to provide feedback on the service they had received following consultation and treatment. Staff we spoke with told us how they were asked to contribute suggestions for improving services for patients and had recently been involved in developing promotional Polish literature.