Polmedics Ltd

Polmedics Limited - Allison Street

Inspection Report

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Ratings

Overall rating for this service

Overall summary

We carried out an announced comprehensive inspection on 9 November 2016, a further visit was carried out on the 30 November 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Summary of findings

Are services caring?

We were unable to assess whether this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

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 planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Polmedics Limited – Allison Street is an independent provider of gynaecology and dental services and treats both adults and children. Services are provided primarily to polish patients who reside in the United Kingdom (UK). Services are available to people on a pre-bookable appointment basis. The practice advertise a variety of other additional services on their website such as cardiology, dermatology, midwifery, psychiatry, paediatric and orthopaedic services however, we were advised at the time of our inspection that these additional services are no longer provided.

The practice is located within the city centre of Birmingham, West Midlands and is located on the first floor of a converted, terraced, commercial property. The property is leased by the provider and consists of a patient waiting room, reception area, an office, a kitchen and staff room, a decontamination room, and dental and consulting rooms which are all located on the first floor of the property. Access to the first floor is by a ground floor entrance and stairwell. There is limited on site car parking to the rear of the practice.

The provider which is Polmedics Ltd is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury from seven locations including Allison Street – Birmingham.

The practice holds a list of registered patients and offers services to patients who reside in Birmingham and surrounding areas but also to patients who live in other areas of England who require their services. The provider provides regulated activities from seven different locations. We were informed by the provider that there are approximately 33,000 registered patients across all Polmedics Limited locations.

At the time of our inspection, we were informed that the registered manager had left employment. The provider had not ensured that the registered manager had submitted an application to be removed. New applications had not been made to ensure a current registered manager was in place. (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).

At the time of our inspection, the practice employed seven dentists, three gynaecologists, four receptionists/ trainee dental nurses and one registered nurse who provides phlebotomy services. Staff were supported by an operational manager who was based from a different location. Some clinicians including dentists and gynaecologists working in the practice live in Poland and travel to England on a regular basis to carry out shifts at Polmedics Limited – Allison Street.

The practice provides appointment from 9am until 9pm Monday to Sunday. We were informed that the practice may close at short notice if there is no demand for appointments.

The provider is not required to offer an out of hours service. Patients who need emergency medical assistance out of corporate operating hours are requested to seek assistance from alternative services such as the NHS 111 telephone service or accident and emergency. This is detailed on the practice website.

Summary of findings

Our key findings were:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, those relating to Disclosure and Barring Service checks (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). Not all dentists and doctors had a current DBS check in place.
- The provider had not ensured that adequate medical indemnity insurance was in place or that appropriate checks of current insurance had been carried out on all clinicians upon commencement of employment.
- Paper based, hand written, patient care records were written mainly in Polish, some records written by individual clinicians were either illegible, not appropriately signed and did not always contain full and detailed information in relation to the consultation.
- There was not an effective system in place for obtaining written consent from patients for invasive procedures, not all consent forms were signed or dated.
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Not all doctors and dentists had completed up to date safeguarding training.
- There was not an effective system in place for the reporting and investigation of incidents or lessons learned as a result.
- The practice did not hold regular, formal multi-disciplinary or team meetings, meetings that did take place were ad-hoc and were not minuted.
- There was no formal process in place to ensure all members of staff received an appraisal. Doctors did not have a responsible officer in place.
- We were not assured that staff were supported by the provider in their continued professional development (CPD).
- There was no evidence of formal clinical supervision, mentorship and support in place for all members of staff including trainee dental nurses.
- Information about services and how to complain was available and easy to understand. Complaints were fully investigated and patients responded to with an apology and full explanation. Refunds were given to patients where the practice deemed appropriate to do so.
- Not all risks to patients were assessed and well managed. The practice did not have a risk register in place. The practice did not have risk assessments in place to monitor the safety of the premises. The practice did not always maintain appropriate standards of cleanliness and hygiene.
- There was very limited evidence that staff had received training appropriate to their roles, including update training in infection control, dental radiography, safeguarding and dealing with medical emergencies in the dental chair.
- The practice held medicines and life-saving equipment for dealing with medical emergencies in a primary care setting, although there were some gaps with respect to the recommended emergency medicines and equipment. Not all members of staff including doctors and dentists had completed basic life support training.
- The practice did not have an effective process in place to ensure patients were informed of their pathology results including those that were urgent or positive in a timely way.
- The practice had limited formal governance arrangements in place. The practice did not have an effective, documented business plan in place. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement.
- The practice had a number of policies and procedures in place to govern activity, but some of these required updating.
- The provider had not ensured that a registered manager was in place. It is a requirement of registration with the Care Quality Commission where regulated activities are provided to have a registered manager in place.

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

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2014, to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

- Ensure that a system is in place to ensure all clinicians have adequate medical indemnity insurance in place and that appropriate checks of clinicians own insurance is carried out upon commencement of employment.
- Ensure all staff complete all essential training requirements and that a system for collating the records of training, learning and development needs of staff members is established.
- Ensure there is effective clinical leadership in place and a system of clinical supervision/mentorship for all clinical staff.
- Ensure effective governance arrangements are in place in relation to information governance including systems to monitor patient care records to ensure that patient information is recorded in line with the 'Records Management Code of Practice for Health and Social Care 2016. Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant. Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure that there are appropriate systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control and emergency situations. Review the availability of a mercury spillage and bodily fluids spillage kit. Review procedures to ensure compliance with the practice annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Ensure a record is held of Hepatitis B status for clinical members of staff who have direct contact with patients' blood for example through contact with sharps.
- Ensure a review is undertaken of the availability of medicines, staff training and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. Specifically ensuring the availability of buccal Midazolam for dealing with epileptic seizures, a volumetric spacer for use with the recommended inhaler and child chest pads for the automated external defibrillator.
- Ensure a review is undertaken for the process of obtaining written consent ensuring consent is recorded appropriately and patients sign these forms when consent is required.
- Ensure appropriate systems are in place to meet health and safety regulations with respect to fire; including the maintenance of emergency lighting and fire alarm systems.
- Ensure a review is undertaken of chaperone arrangements and the policy in particular for gynaecology services, and in particular ensuring that chaperone training is undertaken by staff who perform chaperone duties.
- Ensure a review is undertaken for the process of informing patients of pathology results including those that are urgent or positive, so that results are given to patients in a timely way.

There were areas where the provider could make improvements and should:

- Review processes for ensuring fees are explained to patients prior to the procedure to enable patients to make informed decisions about their care.
- Review the availability of hearing loops for patients who are hard of hearing.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. The practice should also review the frequency of protein testing associated with the ultrasonic cleaning bath in line with HTM 01 05 guidelines so that these are carried out weekly rather than monthly.
- Ensure a system of appraisals is in place to ensure all members of staff receive an appraisal at least annually.
- Ensure appropriate policies and procedures are implemented, relevant to the practice ensuring all staff are aware of and understand them.
- Review the provision of translation services for service users and members of staff.

Summary of findings

- Review processes for collecting and acting upon patient and staff feedback.

On the 11 November 2016, the Commission served an urgent notice of decision to impose conditions upon the registration of this service provider in respect of a regulated activity. The following conditions were imposed:

- The registered person must not provide any services under the regulated activity of diagnostic and screening procedures, surgical procedures, maternity and midwifery and treatment of disease, disorder or injury until 11 January 2017.
- Submission of a written infection prevention and control action plan to include dates for completion of each action to be submitted to the Care Quality Commission by 10am on Friday 18 November 2016.
- Submission of a written record of all staff who work at Polmedics Limited – Allison Street including all clinicians, to include details of professional registrations and qualifications. To be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016.
- Submission of a written record of training undertaken by all staff working at Polmedics Limited – Allison Street to include infection control, safeguarding children and adults, chaperone and basic life support training. To be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016.
- Submission of a detailed written record of all services provided at Polmedics Limited – Allison Street and details of which clinicians are required to carry out these services. To be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016.
- Submission to the Care Quality Commission written evidence of disclosure and barring service checks (DBS) for all clinicians including phlebotomists and dental nurses. Submission of written evidence of the policy and processes in place in relation to either the application or verification of disclosure and barring service checks for new employees including the policy for DBS checks for non-clinical staff. To be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016.
- Submission of a written record to the Care Quality Commission of evidence of the completion of a check with relevant professional bodies including the General Medical Council, the General Dental Council and the Nursing and Midwifery Council of the registration status of all clinically qualified professionals. To be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016.
- Submission of a written action plan in relation to premises maintenance to include dates for completion of each action to be submitted to the Care Quality Commission by 10am on Friday 18 November 2016. Actions to include conformity with the Regulatory Reform (Fire Safety) Order 2005. How damaged ceiling tiles and areas of damaged flooring will be addressed and areas of damaged and unsuitable work surfaces in the decontamination room which present an infection control risk. Actions also to include trip hazards on the flooring within the doorway to the ultrasound room, exposed screws in the doorframe of the gynaecology room, and evidence of gas safety checks to be provided.
- Submission of a written action plan to ensure patient care records are compliant with the 'Records Management Code of Practice for Health and Social Care 2016' to be submitted to the Care Quality Commission by 10am on Friday 18 November 2016.
- Submission of your policy or protocol in relation to patient consent and a written action plan to address concerns found regarding incomplete consent forms during the Care Quality Commission inspection on 9 November 2016. Action plan to be submitted to the Care Quality Commission by 10am on Friday 18 November 2016.
- Submission to the Care Quality Commission evidence of your chaperone procedure including names of those who act as a chaperone including evidence of chaperone training for these members of staff. Evidence to be submitted to the Care Quality Commission by 10am on Tuesday 15 November 2016

On the 19 December 2016, the provider took actions to temporarily close all Polmedics Ltd locations which included Polmedics Limited – Allison Street until 31 January 2017.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. There was no process in place to ensure that staff received appropriate inductions, security and identification checks were carried out before commencement of employment.
- The practice did not have effective recruitment processes in place and had not ensured that all members of staff had received a Disclosure and Barring Service check (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).
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Not all doctors and dentists had completed up to date safeguarding training.
- There was not an effective system in place for the reporting and investigation of incidents or lessons learned as a result.
- The practice held evidence of Hepatitis B status and other immunisation records for some clinical staff members but not all who had direct contact with patients' blood for example through use of sharps. There was no process in place to ensure all clinical members of staff Hepatitis B status and other immunisations were checked or immunisation arrangements for staff were in place.
- Not all risks to patients were assessed and well managed. The practice did not have a risk register in place. The practice did not have risk assessments in place to monitor the safety of the premises. The practice did not always maintain appropriate standards of cleanliness and hygiene.
- The practice held medicines and life-saving equipment for dealing with medical emergencies in a primary care setting, although there were some gaps. Not all members of staff including clinicians had completed basic life support training.
- The practice had a safe and effective system in place for the collection of pathology samples such as blood and urine. The practice used the services of an accredited laboratory however, we were not assured that all patients received their results in a timely manner.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

- There was no formal process in place to ensure all members of staff received an appraisal.
- We were not assured that staff were supported by the provider in their continued professional development (CPD).
- There was no evidence of formal clinical supervision, mentorship and support in place for all members of staff including trainee dental nurses.
- There was very limited evidence that staff had received training appropriate to their roles, including update training in infection control, dental radiography, safeguarding and dealing with medical emergencies in the dental chair.

Are services caring?

We were unable to assess whether this service was providing caring services in accordance with the relevant regulations.

Summary of findings

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.

Are services responsive to people's needs?

We found that this service was not providing responsive care in accordance with the relevant regulations.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Access to the practice was not suitable for disabled persons or those with prams and pushchairs.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.
- Translation services were not available for patients or staff.
- The practice was open from 9am until 9pm Monday to Sunday. However, we were informed that the practice may close at short notice if there was no demand for appointments on particular days of the week. There did not appear to be alternatives for patients who may have required an urgent appointment when the practice was closed.
- Information for patients about the services available to them was easy to understand and accessible. However, information about fees was limited, details of fees was available on the practice website. There was no schedule of fees in the patient waiting area for medical services. A schedule of dental fees was available in a dental treatment room.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

- The provider had not ensured that adequate medical indemnity insurance was in place or that appropriate checks of current insurance had been carried out on all clinicians upon commencement of employment.
- The provider had not ensured that a registered manager was in place. It is a requirement of registration with the Care Quality Commission where regulated activities are provided to have a registered manager in place.
- The practice did not hold regular, formal multi-disciplinary or team meetings, meetings that did take place were ad-hoc and were not minuted.
- The practice had limited formal governance arrangements in place. The practice did not have an effective, documented business plan in place. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement.
- The practice had a number of policies and procedures in place to govern activity, but some of these required updating.
- The practice did not have an effective, overarching governance framework in place to support the delivery of the strategy and good quality care. There was a lack of effective systems and processes in place for assessing and monitoring risks and the quality of the service provision.
- There was not an effective leadership structure in place, there was a lack of day to management support in place on a daily basis and there was a lack of clinical leadership and oversight.
- Not all members of staff had completed all mandatory training requirements. There was no system for collating the records of training, learning and development needs of staff members.

Summary of findings

- There were no systems in place to monitor patient care records to ensure that patient information was recorded in line with the 'Records Management Code of Practice for Health and Social Care 2016. There was no system in place to ensure that an accurate, complete and contemporaneous record was maintained for every patient.
- Doctors did not have a current responsible officer in place. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice).
- The practice had a system in place to collect patient feedback however, there was no evidence that feedback results had been considered or acted upon.

Polmedics Limited - Allison Street

Detailed findings

Background to this inspection

The inspection was carried out on 9 November 2016. Our inspection team was led by a CQC Lead Inspector and was supported by a Clinical Specialist Advisor, Hospital Inspector and a Dental Specialist Advisor. The team was also supported by a Polish translator. Upon arrival, we were greeted by two members of staff who informed the inspection team that the provider had closed the practice to patients and that staff who were scheduled to be available during inspection were no longer able to attend. This inspection went ahead as scheduled.

A second announced visit was carried out on 30 November 2016. Our inspection team was led by a CQC Inspector and was supported by a Clinical Specialist Advisor and a second CQC Inspector. The team was supported by a Polish translator.

Prior to these inspections we had asked for information from the provider regarding the service they provide.

We carried out an announced, comprehensive inspection on 9 and 30 November 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

. During our visit we:

- Spoke with a dental nurse who was employed by Polmedics Limited – Allison Street and a manager who was normally based at another Polmedics Ltd location in London. During our second visit, we spoke with an operational manager, two company directors, a gynaecologist, a dental nurse and a newly employed dentist.
- Reviewed the personal care or treatment records of patients.
- The provider was provided with CQC comment cards prior to our inspection to allow patients and members of the public to share their views and experiences of the service.' However, we found that no cards had been completed prior to inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was not an effective system in place for reporting and recording significant events.

During our inspection, we observed that there was not an effective system in place to enable staff to report incidents, near misses or significant events.

- Formal meetings did not take place, there was no evidence of formal discussion in relation to any incidents which may have been required to be reported. There had been no incidents or significant events reported within the last 12 months. During our second visit on 30 November 2016, we spoke with staff members who were unable to explain whether incident report forms were available for staff or the location of these forms and a policy.
- We found that a number of complaints merited further investigation as a significant event in order to promote shared learning and prevent reoccurrence. The practice had not investigated these issues as significant events. We also found evidence of incidents and concerns identified during an internal inspection carried out by the provider in October 2016 which would have constituted further investigation and a significant event analysis. For example, staff were found to be using the decontamination sink in the dental area to clean domestic items such as drinking cups and plates used for food. The practice had also identified concerns relating to the legibility and language in which patient care records were written, as well as other concerns such as incomplete medical information contained within reports and lack of anaesthetic batch numbers or expiry dates being recorded in these records.

Reliable safety systems and processes (including safeguarding)

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, for example:

- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. We saw that a policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.
- During our inspection, we were unable to see evidence of safeguarding children or adults training for all members of staff. We requested evidence of up to date safeguarding training to be provided shortly after our inspection. We were provided with a spreadsheet which detailed dates of training which had been conducted by a manager who had previously been employed at the practice. This information also confirmed that one dentist and one registered nurse had not completed any safeguarding training. Formal meetings were not held and recorded to discuss and document safeguarding concerns which may have arisen.
- There was not an effective system in place to alert clinical staff of any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability. The practice did not have a register in place of vulnerable adults and children and did not actively review these patients. There was no evidence of multi-disciplinary meetings taking place or formal discussions and reviews of these patients.
- There were no notices on display in the waiting room to advise patients that chaperones were available if required. However, during our second visit notices had been displayed. The practice did have a chaperone policy in place however, not all staff who were required to act as chaperones were trained for the role. We were informed shortly after our inspection that two members of staff would have training arranged for them in December 2016, although further evidence of this training being undertaken had not been provided. We were provided with evidence of a chaperone training certificate for another dental nurse which had been carried out shortly after our inspection. We were not assured that trained chaperones were available during all gynaecology clinics.
- We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands

following administration of a local anaesthetic to a patient. The practice used a rubber protective device used by the dentist to cover the contaminated needle following administration of a local anaesthetic. Dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps however, we did observe some sharps boxes located in rooms used by doctors were stored on the floor, unlocked and open with used sharps visible.

- We also asked a dental nurse how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. This was confirmed when we observed the practices' rubber dam kit. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed as far as possible appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.
- The practice held a record of Hepatitis B status for some clinical staff members of staff who had direct contact with patients' blood for example through use of sharps. These records were not available for all clinicians. There was no process in place to ensure Hepatitis B status or other immunisation records was obtained for all clinical staff.
- The practice had a safe and effective system in place for the collection of pathology samples such as blood and urine.The practice used the services of an accredited laboratory which provided a daily collection service from the practice for all samples. During our second visit, we looked at numerous pathology results received and saw evidence that these patients had been contacted by a doctor in relation to their results. However, we were not assured that all patients received their results in a timely manner. We were informed that the doctor who requested the sample would contact the patient when they were next on duty. Doctors did not work every day and patients received their result by email, this included urgent or positive results such as for sexual health screening. We were informed that patients would receive a follow up telephone call from a doctor if a result was positive although we did not see evidence of these actions in patient care records.

Medical emergencies

The practice did not have adequate arrangements in place to respond to emergencies and major incidents. For example:

- We observed that there were some gaps with respect to the recommended emergency medicines and equipment. For example, the practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice except in one instance. The practice had in place ampoules of Diazepam instead of the recommended Buccal Midazolam format. We also noted that a volumetric spacer used in conjunction with the salbutamol inhaler was not available.
- The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We did note that the recommended chest pads for child patients was not available as part of the AED kit.
- The practice had access to oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and although the emergency kit was stored in a central location known to all staff. There were no records available that showed staff had received update training in dealing with medical emergencies in dental practice.
- Not all members of staff had received annual basic life support training. We were informed following inspection that training had been arranged for all staff in December 2016. Some staff we spoke with during our second visit were unable to explain the location of emergency equipment or medicines.
- A first aid kit was located in the reception office and and an accident book was available.

Are services safe?

- The practice had a comprehensive business continuity plan in place which had last been reviewed in July 2016 for major incidents such as power failure or building damage.

Staffing

There appeared to be adequate staffing levels in place to meet the demands of the service. However, most staff resided in Poland and travelled to England on a regular basis to carry out shifts at the practice and then returned to Poland following completion of their shift. We were informed that staff were recruited mainly through word of mouth and through friends and may also have had other employment in Poland.

All dentists and qualified dental nurses had current registration with the General Dental Council (GDC), the dental professionals' regulatory body. All doctors had current registration with the General Medical Council (GMC) the medical professionals' regulatory body. However, not all doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). We were unable to gain any assurance that all doctors working at the practice were following the required appraisal and revalidation processes.

We reviewed seven personnel files and found that appropriate recruitment checks had not always been undertaken prior to employment. For example, some personnel files did not contain employer references or applications for references, photographic identification, national insurance numbers or records of previous employment details. Appropriate checks through the Disclosure and Barring Service (DBS) had not been carried out for all members of staff which included two dentists and one gynaecologist. These are checks to 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. We were informed that these members of staff had been suspended from employment by Polmedics Ltd until appropriate checks had been carried out through the Disclosure and Barring Service. We observed that these recruitment records were stored securely.

There was not an effective process in place to ensure regular checks of GMC, GDC and other professional registrations were carried out. Immediately following our inspection, we were provided with a register which included professional registration numbers for all members of staff however, this record did not contain details of any checks undertaken.

There was no process in place to ensure trainee dental nurses or other nursing staff received regular clinical supervision during planned, face to face sessions. We did not see any written records of clinical supervision which may have taken place. During our second visit, we spoke with a dentist who prescribed medicines and had been employed for approximately one month prior to our second visit. They explained that there were no arrangements in place to ensure her clinical supervision. However, she explained that she would communicate with other clinical colleagues in Poland should she require any support.

Monitoring health & safety and responding to risks

Risks to patients were not assessed and well managed.

- There were limited procedures in place for monitoring and managing risks to patient and staff safety. There was no health and safety policy available at the time of our inspection however, we were provided with a copy of this policy following our inspection. There was a poster in the patient waiting area which identified local health and safety representatives. Not all members of staff had received up to date health and safety training. The last fire risk assessment had been carried out in December 2015. We saw records of fire drills carried out in January and October 2016. We were informed that the fire alarm system was located in a shop next door to the practice and was shared by both parties. We did not see any evidence that regular testing of the fire alarm system or emergency lighting systems took place and there were no records that this was carried out. There was adequate fire protection equipment in place. Due to our concerns in relation to fire safety, CQC notified the local fire service who undertook a visit of the practice in December 2016.
- 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 practice did not have a risk register in place or risk assessments in place to monitor health and safety of the premises, staff and service users. The practice had in place a Control of Substances Hazardous to Health

(COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

- During our first inspection, we noted that although the practice had carried out an internal Legionella risk assessment, an assessment carried out by a competent person such as that carried out by a member of the Legionella Control Association had not been carried out. During our second visit, we were provided with a copy of a legionella risk assessment which had been carried out by an external specialist in March 2016. The dental water lines were maintained to prevent the growth and spread of Legionella bacteria they described the method they used which was in line with current HTM 01 05 guidelines. We also noted that water temperature testing was carried out.
- We observed a large, open shower cubicle located directly next to a kitchen sink in a staff area. There were no records available of regular flushing of the shower system and there were very high levels of dirt and residue in the shower basin. Upon our second visit on 30 November, this shower cubicle had been sectioned off to ensure it could not be used although the shower system was still in situ.

Infection control

There was inconsistency in relation to infection control processes in the practice. For example:

- We saw that the two dental treatment rooms, patient waiting area, reception area and patient toilets were visibly clean. Clear zoning demarking clean from dirty areas was apparent in all dental treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the dental treatment rooms. However, in a gynaecology room used for sexual health screening and ultrasound imaging, we noted that soap dispensers were empty.
- The practice had daily cleaning schedules in place which were on display in each area of the practice. All receptionists and dental nurses were responsible for cleaning the practice which included dental, decontamination and consultation rooms. Cleaning schedules had commenced on 8 November 2016. Cleaning schedules were not in place for specific clinical equipment.
- The systems and processes in place appeared to demonstrate that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. It was observed that audit of infection control processes in the dental areas only was carried out in October 2016 and confirmed compliance with HTM 01 05 guidelines.
- The practice did not have an overall infection control lead in place who would normally liaise with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place which had been reviewed in July 2016. We saw an infection control and prevention statement dated July 2016 which stated that audits would be carried out on a weekly and monthly basis to assess cleanliness of clinical equipment in the treatment rooms however, we found no evidence to support the requirements of this statement.
- Not all staff had received infection control or handwashing technique training. We spoke with a new member of staff during our second visit who explained that they had not received any type of infection control training or updates as part of their induction which had taken place approximately one month prior to our second visit. Annual infection control audits had not been undertaken for all areas of the practice, during our inspection, we saw an audit and action plan which had been carried out specifically for dental areas only. We were provided with a full infection control audit an action place following our inspection.
- We observed high levels of brown dirt on skirting boards in the stairwell upon entrance to the practice and also on window ledges in the patient waiting area.We also observed high levels of dirt and reside in the shower basin.
- Spillage kits were not provided to deal with the spillage of bodily fluids such as urine, blood and vomit.
- Each dental treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors. A dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment

room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

- The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.
- The practice used a system of manual scrubbing and ultrasonic bath for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date. We also noted that the essential validation checks for the ultrasonic bath including protein residue and foil tests were carried out and the results recorded. Although the practice should consider weekly protein testing rather than monthly testing in accordance with HTM 01 05.
- The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste in dental areas were properly maintained and was in accordance with current guidelines. However, sharps bins located in medical rooms used by doctors were not always maintained appropriately and were found to be left on a floor, unlocked and open with used sharps visible.
- The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored in a locked container prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Premises and equipment

During our inspection we conducted a tour of the premises which included consulting rooms, dental treatment rooms and patient areas. We observed areas of concern. For example:

- A room used for gynaecology and ultrasound appointments was poorly maintained.We observed numerous exposed screws protruding through the door frame. A large plank of wood was seen on the floor between the gynaecology and ultrasound room which posed a trip hazard in particular for pregnant patients. We observed broken ceiling tiles in staff and patient waiting areas, some tiles were seen to be hanging down through the ceiling. During our second visit, we observed that the practice areas of concern had been addressed and repaired.
- Areas of laminate flooring in the decontamination room were damaged and torn and we noted damaged work top surfaces which posed an infection control risk.We also observed a dental chair which was torn. During our second visit we observed that this dental chair had been replaced with a new chair, new flooring had been fitted and the work damaged work surfaces had been repaired.
- Shower curtains were in place as privacy curtains however, there were no records in place to evidence when curtains were either changed or cleaned. We also observed fabric seating and sofas within the patient waiting area and also in a room which was used by a phlebotomist. Some seating was stained and there were no records of cleaning or regular decontamination of fabric seating.

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in November 2016. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in November 2016. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records we saw. These medicines were stored securely in locked drawers for the protection of patients. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems.

Are services safe?

We were shown a radiation protection file that contained documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). Included in this file were the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. We also saw a copy of the local rules.

Patient records we looked at where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We were however unable to observe training records that appropriate staff had received update training in accordance with General Dental Council (the dental registrants governing body) recommendations.

Safe and effective use of medicines

During our inspection we looked at the systems in place for managing medicines.

- We noted that the practice had a system in place to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). However, the practice did not keep a record of alerts that were pertinent to dentistry or general medicine that had been issued by MHRA so that they could be discussed by members of the medical or dental team.
- Recent alerts relating to dental practice included those for Automated External Defibrillators, emergency medicines used in dentistry and electrical socket covering devices. There was no evidence that these alerts had been disseminated or were discussed in practice meetings as formal minuted meetings did not take place. Staff we spoke with were unable to explain the process for the receipt and dissemination of MHRA alerts or any alerts that had been acted upon.
- All prescriptions were issued on a private basis and we observed that all prescription pads were stored securely.
- The practice did not carry out audits of medicines or prescribing.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dental care records we looked at showed that dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Following the clinical assessment, it appeared that the diagnosis was then discussed with the patient and treatment options explained by the dentist.

Where relevant, preventative dental information was given to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. We saw that a treatment plan was drawn up and this included the costs involved.

Dental care records that we looked at demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out where appropriate during a dental health assessment.

Medical records we looked at which were completed primarily by gynaecologists were inconsistent. Some records were illegible, we observed that some records did not always contain details of basic observations, follow up advice given or referral information to secondary care providers. One care record we looked at was in relation to a patient who had been signed off work for a period of two weeks for depression, however, there was no follow up advice given, no referral to other specialist services and no other form of treatment offered to the patient.

Assessment and treatment

We were unable to gain assurance that the practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice did not have a comprehensive induction and training programme in place for newly appointed staff. We were unable to see evidence of comprehensive, written induction plans or records in personnel files for all members of staff. We spoke with a clinical member of staff during our second visit who had recently been employed by the practice. They told us that they had a basic induction carried out by a manager however; this induction did not include any infection control training. They were unable to explain the full process for reporting significant events and serious incidents and were not able to explain the location of emergency medicines and equipment.

The practice did not have comprehensive records of training in place and we were unable to locate any training records in the recommended core subject areas by the General Dental Council including, infection control, dental radiography, safeguarding and dealing with medical emergencies in the dental chair.

The practice did not have a system of appraisals in place to ensure the learning needs of staff were identified. The practice had identified the need for appraisal processes in their own internal audit report and action plan. There were no formal processes in place for clinical supervision of trainee dental nurses and other members of the nursing team. One newly appointed dentist we spoke to during our second visit told us that there were no formal arrangements in place for her clinical supervision.

During our inspection we looked at an employment and induction policy dated 1 July 2016. Current employment and induction processes were not reflective of this policy. For example, this policy stated that all staff would undergo an annual appraisal and also that the practice aimed to comply with all current employment legislation. We were not assured of this during our inspection.

Working with other services

Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral

criteria and referral forms developed by other primary and secondary care providers such as oral surgery and oral medicine. This ensured that patients were seen by the right person at the right time.

The information needed to plan and deliver care and treatment was available to relevant staff through hand written paper patient care records only. The practice did not have an electronic patient record system in place.

The practice told us that they ensured sharing of information with NHS GP services and general NHS hospital services when necessary and with the consent of the patient. Due to restrictions in communication links with NHS stakeholders, the provider did not have access to a full medical history from medical or hospital records and relied solely on the patient offering their history freely during a consultation. If an NHS service required any information, the practice would write to the service to provide details required about the patient's medical history. As the practice did not have an electronic patient record system in place they were unable to print a list of medicines and diseases/disorders for the patient to take with them.

There was no assurance that staff worked together as a multi-disciplinary team to meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. There was no formal meeting structure in place and there were no meeting minutes available to evidence any discussions that may have taken place.

The provider told us if a patient attended an OOH service or accident and emergency departments, the patient was responsible for advising them that a consultation had occurred and for providing information relating to the consultation.

Consent to care and treatment

There was inconsistency in individual clinicians approach to seek patients' consent to care and treatment in line with legislation and guidance. For example:

- Dental care records we looked at showed that dentists understood the principle of informed consent. Records indicated that individual treatment options, risks, benefits and costs were documented in a written treatment plan.
- On the day of our inspection, because no dentists were working, we were unable to check if staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. (Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We were also unable to check how they would obtain consent from a patient who suffered with any mental impairment who may be unable to fully understand the implications of their treatment.
- Dental care records we looked at showed that dentists provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. We saw that written information was available detailing the cost of dental treatment.
- The practice did have a consent policy in place. Patients were required to sign a written consent form. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, we did see evidence of some consent forms during our inspection in relation to gynaecology consultations in which consent forms were not always signed by the patient and some consent forms were not dated and were incomplete.
- The practice did not offer interpreter or translation services as an additional method to ensure that patients understood the information provided to them prior to treatment. However, most patients and staff were Polish and so the practice did not feel there was a need for interpreter services.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care. However, the practice did not offer a pre-consultation process to ensure fees were explained and that patients had a 'cooling off' period before committing to the required fee, attending for an appointment or commencing treatment. We saw examples of complaints which related to patients being charged for services that they did not request or that the fees were not explained to them prior to consultation or services being delivered.
- Standard information about fees were detailed on the practice website however, there was no information regarding fees or a schedule of fees displayed in the

Are services effective?

(for example, treatment is effective)

patient waiting room. Fees were recorded on the patient consent form which they were required to sign during consultation. We did observe a book in a dental treatment room which detailed dental fees.

Health promotion & prevention

Although on the day of our inspection we were unable to speak to dentists about the preventative interventions that were provided to patients, dental care records we observed demonstrated that dentists had given oral health advice to patients to help maintain healthy teeth and gums. We also observed various health promotion advice on display in the patient waiting area.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were unable to observe whether members of staff were courteous and helpful to patients and treated them with dignity and respect as there were no patients present during our inspection.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.
- Staff we spoke with understood the importance of confidentiality and the need for speaking with patients in private when discussing services they required.

Involvement in decisions about care and treatment

- The provider was provided with CQC comment cards prior to our inspection to allow patients and members of the public to share their views and experiences of the service.'However, we found that no cards had been completed prior to inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- Access to the practice was not suitable for disabled persons or those with prams and pushchairs. The practice was located on the first floor of a terraced, commercial property which was accessed by a wide, two level staircase only. Patient toilet facilities were available on the first floor, the practice did not have a designated disabled toilet.
- The reception desk was of a lower level suitable for patients in wheelchairs.
- Translation services were not available for patients or staff.
- There was a practice leaflet which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also the treatment options and services available. Information was also available on the practice website.
- The practice used the services of an accredited laboratory which provided a daily collection service from the practice for all samples. However, we were not assured that all patients received their results in a timely manner. We were informed that the doctor who requested the sample would contact the patient when they were next on duty. Doctors did not work every day and patients received their result by email, this included urgent or positive results such as for sexual health screening. We were informed that patients would receive a follow up telephone call from a doctor if a result was urgent or positive however this would be dependent upon when a doctor was next on duty. We did not see evidence of these actions in patient care records.

Tackling inequity and promoting equality

The practice offered appointments primarily to eastern European patients however, the practice did offer appointments to anyone who requested one and did not discriminate against any client group. At the time of our inspection, the practice website was available in both Polish and English language.

The practice provided patients with written information in a language they could understand. We found there were areas where the practice could assist with the needs of the more disabled members of society including the use of hearing loops for the hard of hearing.

Access to the service

We were informed that the practice was open from 9am until 9pm Monday to Sunday. Appointments were available on a pre-bookable basis. Generally, patients could access the service in a timely way by making their appointment either in person or over the telephone. When treatment was urgent, patients would be seen on the same day except on a Wednesday when we were informed that the practice may close dependent on demand for appointments. There did not appear to be alternatives for patients who presented on days when the practice may be closed apart from being seen the following day. Appointment diaries showed that clinics were held on Saturday's and Sunday's.

Concerns & complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance for Dentists in England and gave patients details of the General Dental Council (GDC) should they wish to have their complaint reviewed. The policy did not give patients details of the Health Service Ombudsmen) for patients who may be unhappy with the outcome of their complaint in relation to a medical consultation with a doctor or gynaecologists..
- The practice manager was the designated responsible person who handled all complaints in the practice however, at the time of our inspection there was no practice manager in place.
- The practice held records of all complaints received.
- There was information on how to complain in the patient waiting area on the practice website.

We looked at 12 complaints received within the last 12 months. We found they were satisfactorily handled and dealt with in a timely way. We saw evidence of a written acknowledgement sent to the patient which included full details of investigations carried out and an apology given where necessary. Some written responses to complaints

Are services responsive to people's needs?

(for example, to feedback?)

also included confirmation of a refund of fees to the complainant. The practice demonstrated an open and transparent approach in dealing with complaints. The practice had not identified trends as a result of complaints received for example, three of the complaints we looked at suggested that fees had either not been explained to them or that they were charged inappropriately for services not requested.

We found that a number of complaints merited further investigation as a significant event in order to promote shared learning and prevent reoccurrence. For example, two complaints we looked at suggested that a gynaecologist performed unnecessary invasive tests such as a cervical smear test and an ultrasound scan. The practice had not investigated these issues as significant events.

Are services well-led?

Our findings

During our inspection, we found major flaws in the leadership and governance of this practice. The practice did not have an effective, overarching governance framework in place to support the delivery of the strategy and good quality care. There was a lack of effective systems and processes in place for assessing and monitoring risks and the quality of the service provision. For example:

- There was not an effective leadership structure in place, there was a lack of day to management support in place on a daily basis and there was a lack of clinical leadership and oversight. The practice manager had left employment in recent months and during our second visit, we were informed that the trainee practice manager had also resigned. An operational manager was in place however this manager was based at a different location and provided remote support.
- The provider had not ensured that adequate medical indemnity insurance was in place or that appropriate checks of current insurance had been carried out on all clinicians upon commencement of employment. We were unable to gain assurance during both visits that adequate medical indemnity insurance was in place. During our second visit on 30 November 2016, we were informed by two company directors that they had recently suspended a clinician from working in the practice due to lack of medical indemnity insurance. We had also been informed that a dentist had left due to issues regarding medical indemnity. Both directors present explained that doctors and dentists who lived and worked primarily in Poland but travelled to England to carry out regular shifts at the practice faced expensive medical indemnity insurance charges to enable them to work in England which was causing recruitment problems for the provider.
- We requested evidence to be provided immediately following our second visit of all clinicians insurance. Evidence was provided for all clinicians and we were informed that the provider had given notice of termination of employment to one gynaecologist due to no medical indemnity insurance being in place. We also observed that another gynaecologist had limited cover in place and was only insured for two hours per week however, we saw evidence that this gynaecologist was providing more than two hours of consultations per week.
- Patient care records were in written format only. We looked at numerous examples of these records during our inspection and found concerns in relation to specific doctors and dentists. For example, some records were illegible. Most records were written in Polish. Following our first visit, we were informed by the provider that immediate action would be taken to address this issue and we were provided with evidence of a new policy dated 15 November 2016 which would ensure all patient care records were written in English and were legible. During our second visit on 30 November 2016, we looked at further patient records which still appeared to be written in Polish. It was also unclear which clinician had written entries on these records, there was not always a signature or full written name. Some records for individual gynaecologists did not always contain full detailed information about the consultation or information about any advice given in the event of a possible emergency or deterioration in health or referrals to secondary care providers. The provider had previously been made aware that patients care records did not meet the fundamental standards of GMC requirements by their responsible officer however, the provider had not acted upon this. We were advised shortly after our inspection that this responsible officer (RO) had withdrawn from acting as RO for doctors employed by Polmedics Ltd and that the clinical leadership team had been notified of this.
- Practice specific policies were implemented and were available to all staff. We were unable to see any evidence that staff had read and understood these policies. We looked at 13 policies during our inspection which included infection control, safe use of sharps, decontamination, chaperone, fire, recruitment and safeguarding policies. Policies did not deliver consistency across the practice and were not always being implemented and followed, for example in relation to infection control and safeguarding. The complaint policy required further review and update. The practice did not have a medicines management policy in place.

Are services well-led?

- We saw evidence that some clinical audits were being carried out such as infection prevention and control in relation to dental areas, quality of dental x-rays and record keeping in relation to dental care records. However, we did not see evidence of other clinical audits or effective audits of patient care records for medical staff that were driving improvement in performance to monitor and improve patient outcomes.
- The practice did not have effective arrangements in place for identifying, recording and managing risks, issues or implementing mitigating actions.
- The practice did not hold formal, structured, minuted meetings. Meetings were either held informally or were ad-hoc.
- The practice had not ensured that all members of staff received an appraisal within the last 12 months.
- The provider had not ensured that a registered manager was in place. It is a requirement of registration with the Care Quality Commission where regulated activities are provided to have a registered manager in place.

Leadership, openness and transparency

On the day of inspection, the directors told us they were aware of areas of concern which required addressing and discussed their plans to improve.

The practice did not hold regular, formal, minuted practice or team meetings for all practice staff to attend.

An operational manager was in post who was based at a different location. This manager had been in post for approximately six months and had taken steps to address concerns. For example, an internal audit had been carried out in October 2016 to identify actions which required to be addressed. We saw evidence of this report and action plan during our inspection however, despite concerns being identified within this audit and action plan, we did not see sufficient evidence of actions taken to address these concerns.

Learning and improvement

The provider did not give any assurance that there was a focus on continuous learning and improvement at all levels within the practice.

Following our first visit on 9 November 2016, the practice did not take necessary actions to ensure immediate actions were taken in respect of concerns raised regarding emergency medicines and equipment. For example, the practice had been informed that buccal Midazolam was required urgently. During our second visit on 30 November 2016, this emergency medicine had still not been ordered. There were also no child defibrillator pads in stock or volumetric spacer device used in conjunction with the salbutamol inhaler.

The provider had also been made aware of concerns in relation to the legibility of patient care records and the language in which they were written. We were provided with a revised policy dated 15 November 2016 in relation to patient care records. However, during our second visit on 30 November 2016 we noted that some patient care records were still written in Polish and were illegible.

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

The practice had gathered feedback from patients through surveys and complaints received. We saw evidence of a patient feedback form which encouraged patients to give feedback about the service they had received which included their views on the ease of booking an appointment, level of satisfaction by the practice, how clearly treatment choices were explained to them and customer service and an opportunity to give any other feedback. The practice had not collated these results and there was no evidence that the practice had considered or acted upon any feedback received from patients. The practice had not identified trends from complaints received for example, numerous complaints received were in relation to the explanation of fees for services provided. Patients had suggested that fees had either not been explained to them or they had been charged for services they did not require. During our inspection, we were unable to find a schedule of fees for medical or dental services within the patient waiting area.

The practice did not provide a formal mechanism to gather feedback from staff and there were no formal staff meetings structures in place to encourage discussion.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. For example: The practice did not have systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control, fire and health and safety. There was a lack of systems and processes in place in relation to emergency medicines and equipment. The practice did not ensure arrangements to safeguard children and vulnerable adults from abuse reflected relevant legislation and local requirements. Not all clinicians had completed upto date safeguarding training. The practice had not ensured the availability of trained chaperones at all times for patients who attended for gynaecology services. The practice did not ensure a system of clinical supervision/mentorship for all clinical staff including trainee dental nurses. The practice did not ensure patient care records were factually accurate, legible and represented the actual care and treatment of patients. The practice did not ensure there was an effective system in place for obtaining written consent from patients for invasive procedures, not all consent forms were signed or dated. The practice did not have an effective process in place to ensure patients received pathology results in a timely way.

This section is primarily information for the provider

Enforcement actions

There was no process in place for acting on and monitoring significant events, incidents and near misses.

The practice did not have effective recruitment processes in place to ensure necessary employment checks were carried out for all staff and the required specified information in respect of persons employed by the practice is held. The practice did not ensure medical indemnity insurance was in place for all clinicians or that an appropriate level of cover was in place. The practice had not ensured those who had direct contact with patients had a DBS check in place.

The practice had not ensured all staff received training required to carry out their roles for example, safeguarding, chaperone, basic life support and dealing with medical emergencies in the dental chair.

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

Regulated activity

Diagnostic and screening procedures

Family planning services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity.

How the regulation was not being met:

The practice had limited formal governance arrangements in place and did not have a programme of regular audit or quality improvement methods to assess, monitor and improve the quality and safety of the services provided.

The provider had not ensured that a registered manager was in place.

The practice had a lack of management and clinical oversight in place on a daily basis.

This section is primarily information for the provider

Enforcement actions

Policies and procedures were not effective or consistently implemented and followed across the practice.

The practice did not ensure that an accurate, complete and contemporaneous record is maintained for every patient.

Not all members of staff had received an appraisal within the last 12 months.

There was no evidence of a system being in place for dissemination, reviewing and actioning NICE and MHRA alerts or evidence of any actions taken.

The practice did not ensure a record was held of Hepatitis B status for clinical members of staff who had direct contact with patients' blood for example through contact with sharps.

There was no formal meeting structure in place for multi-disciplinary or practice meetings.

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