Polmedics Ltd

Polmedics Limited - West Bromwich

Inspection Report

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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services responsive?	
Are services well-led?	

Overall summary

We carried out an unannounced focussed inspection on 16 December 2016 of Polmedics Limited - West Bromwich. This inspection was carried out because we had concerns in relation to the safety and overall governance of services provided at Polmedics Limited – West Bromwich following an inspection carried out at Polmedics Limited – Allison Street in Birmingham on 9 and 30 November 2016 where serious concerns were found.

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).

Are services responsive?

Summary of findings

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 - West Bromwich is an independent provider of dental and gynaecology services and also provides consultation services by a doctor who is referred to as an internist and treats both adults and children. This doctor provides consultation services including the prescribing of medicines and antibiotics to 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. Although we were informed by the provider that only dental and internist services were provided, we also found evidence that a psychotherapist provided consultations at this location.

The practice is located in a busy commercial area of West Bromwich in the West Midlands and is located on the first floor of a converted, commercial property. The property is leased by the provider and consists of a large patient waiting room which includes a reception desk, a decontamination room used for cleaning, sterilising and packing dental instruments, two dental treatment rooms and one medical consulting room used by a doctor. The practice is not accessible to wheelchair users, prams and patients with limited mobility. Car parking was available in the vicinity 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 Polmedics Limited - West Bromwich.

The practice holds a list of registered patients and offers services to patients who reside in West Bromwich and surrounding areas but also to patients who live in other areas of the UK 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 Ltd locations.

The provider had not ensured that a 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).

We were told that the practice employed five dentists, two gynaecologists, two receptionist/trainee dental nurses, one receptionist and one doctor who they referred to as an internist. A psychotherapist also provided services to patients at this practice. During our inspection, we were introduced to a trainee practice manager whom the provider had informed us was already in post however, during our inspection we were informed that this person had not yet ceased employment with their current employer and was not in fact in post. It was the intention of the provider that this manager would also apply to become the registered manager with the Commission. Staff were supported by an operational manager who was located at a different location. Some clinicians including dentists working in the practice live in Poland and travel to England on a regular basis to carry out shifts at Polmedics Limited – West Bromwich.

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

Summary of findings

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.

Our key findings were:

- 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 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 dentists and doctors were either illegible, not appropriately signed and did not always contain full and detailed information in relation to the consultation.
- Blank private prescriptions and medical statements (Med3 forms) were left unsecure, on a desk in an unlocked room, these prescriptions and forms had been pre-stamped with the name and GMC number of a doctor. Confidential clinical patient information was found unsecure on a desk in an unlocked room.
- 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. The practice did not have emergency medicines or equipment in line with the British National Formulary (BNF) and Resuscitation Council UK guidance or all that were recommended for medical emergencies in dental practice. Not all staff we spoke with were aware of the location of emergency medicines and equipment.
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. There was no assurance that all members of staff 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. A doctor 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). A doctor had not completed any CPD for approximately ten years.
- 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.
- Not all risks to patients were assessed and well managed. The practice did not always maintain appropriate standards of cleanliness and hygiene. Infection control procedures did not follow guidance issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- The dental treatment room was visibly clean and well maintained.
- There was very limited evidence that staff had received training appropriate to their roles, including update training in infection control and safeguarding.
- There was no evidence that the practice had implemented actions recommended from the critical examination test carried out in October 2013 for x-ray equipment.
- 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 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**:**

Summary of findings

- 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) 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 the safe storage and security of patient information, private prescriptions and medical statements.
- 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 dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice and the General Dental Council regarding clinical examinations and record keeping.
- Ensure audits of radiography are undertaken at regular intervals to help improve the quality of service.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant. Put systems in place to ensure all doctors 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 and legionella. 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, availability of glucagon, a volumetric spacer for use with the recommended inhaler and child chest pads for the automated external defibrillator.
- Ensure a review is undertaken of chaperone arrangements and the policy for ensuring chaperones are available and 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, ensuring 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

Summary of findings

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

On the 19 December 2016, the provider took actions to temporarily close all Polmedics Ltd locations which included Polmedics Limited – West Bromwich 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.

- The practice did not ensure the safe storage and security of hand written patient records, blank private prescriptions or medical statements.
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. We were unable to gain assurance that all members of staff 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 a record of Hepatitis B status and other immunisations for clinical staff members 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 always maintain appropriate standards of cleanliness and hygiene. Single use suction tubes were sterilised and used again. Blood samples were stored in a fridge in a decontamination room which also contained food, drinks and dental items.
- Equipment involved in the decontamination process was regularly serviced, it was safe to use. Staff were unclear about the process for the daily, weekly and quarterly validation of the autoclave and ultrasonic bath.
- The decontamination room was not secure and contained substances which were hazardous to health (cleaning fluids and medical emergency drugs and equipment).
- There was no evidence the provider had taken into account the recommendations from the critical examination of the x-ray machine completed in October 2016.
- A legionella risk assessment had been carried out. However, there was no evidence that monthly water temperature checks were being carried out as recommended in the risk assessment.
- The practice held medicines and life-saving equipment for dealing with medical emergencies in a primary care setting, although there were some gaps.
- 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, basic life support, chaperone and safeguarding.

Summary of findings

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 or dental 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 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 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. Audit was not embedded within the practice. For example, there was no evidence of an x-ray audit being completed.
- 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.
- 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 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 a number of policies and procedures in place to govern activity, but some of these required updating and some policies were not reflective of current practice.
- There was not an effective leadership structure in place and there was a lack of clinical leadership and oversight. There was not a system of appraisals in place for members of staff.
- There was no system for collating the records of training, learning and development needs of staff members. Not all members of staff had completed all mandatory training requirements.
- 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.
- A doctor did not have a current responsible officer in place. (All doctors working in the UK 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). This doctor carried out consultations and diagnosed treatment of disease to adults and children and prescribed medicines however, this doctor was not on the specialist register or the GP register.

Summary of findings

- 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 - West Bromwich

Detailed findings

Background to this inspection

The inspection was carried out on 16 December 2016. Our inspection team was led by a CQC Lead Inspector and was supported by a second CQC inspector, Clinical Specialist Advisor, Hospital Inspector and a Dental Inspector. The team was also supported by a Polish translator.

Prior to this inspection, an announced inspection had been carried out at Polmedics Limited – Allison Street in Birmingham on 9 and 30 November 2016. 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. This notice of decision included the following condition:

- 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.

Following the Commission's decision to impose conditions upon Polmedics Limited – Allison Street, due to the serious concerns identified, an unannounced focussed inspection was carried out at West Bromwich on 16 December 2016. Serious concerns were also found at this practice and on 16 December 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. This notice of decision included the following condition:

- 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 31 January 2017.

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

During our visit we:

- We conducted a tour of the practice. We were shown the decontamination procedures for dental instruments and the system that supported the patient dental care records.
- We looked at how medicines were managed and looked at the processes in place in relation to medicines management.
- Spoke with a doctor, a dental nurse, a receptionist, a dentist who was also a company director, a trainee manager who had been offered a position but was not officially in post at the time of our inspection, an operational manager and one other non-clinical company director.
- Reviewed the personal care or treatment records of patients.
- We looked at clinical equipment used by this service.
- We reviewed a range of information which included policies and procedures, patient care records and staff recruitment and training records.

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 visit 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 did observe that a policy was in place which was dated November 2016. The practice were aware of incidents which merited reporting for further investigation and urgent actions to be taken however, this had not been carried out.

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 gain assurance that all members of staff had completed safeguarding children or adults training for as the practice did not have that a system in place for collating the records of training, learning and development needs of staff. 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 notices on display in the waiting room to advise patients that chaperones were available if required. The practice did have a chaperone policy in place however, we were not assured that all staff who were required to act as chaperones were trained for the role. We were not assured that trained chaperones were available during all internist and gynaecology clinics.
- The practice did not hold a record of Hepatitis B status for clinical staff members or staff who had direct contact with patients' blood for example through use of sharps. There was no process in place to ensure Hepatitis B status or other immunisation records were obtained for all clinical staff.

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. There were no needles or syringes available to administer adrenaline in the event of anaphylactic shock. We noted the glucagon was not stored in the fridge and the expiry date had not been adjusted accordingly. We also noted that a volumetric spacer used in conjunction with the salbutamol inhaler was not available.
- We observed the emergency resuscitation equipment and found that it was not in line with the Resuscitation Council UK guidelines. There was no self-inflating bag, no portable suction device and only one size of oropharyngeal airway was available. we noted the oxygen cylinder was broken. It was not capable of administering oxygen. The oxygen mask was attached

and was left draped on the floor of the decontamination room and was visibly dirty. We were told this had broken the day before and a new one would be sourced. We saw evidence that another oxygen cylinder was sourced during our inspection.

- 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 noted that the recommended chest pads for child patients were not available as part of the AED kit. Two dentists we spoke with were not aware of the location of emergency equipment and medicines.
- Not all members of staff had received annual basic life support training. However, following our inspection, we were provided with evidence of this training which had been carried out in December 2016.
- A first aid kit was located in the reception area and an accident book was available.
- 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. The doctor had current registration with the General Medical Council (GMC) the medical professionals' regulatory body. However, this doctor did not have a current responsible officer. (All doctors working in the UK 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 saw evidence that this doctor was providing consultation services which including the prescribing of medicines to both adults and children. Prior to our inspection, the provider informed us that this doctor carried out diagnosis and treatment of disease in adults and children which included administering vaccinations and healthcare advice. This doctor was not on the specialist register and not on the GP register. We had been informed prior to this inspection that this doctor had not completed any continuous professional development (CPD) for approximately ten years. We did request evidence of any CPD records for this doctor to be provided immediately following our inspection however, we did not receive any of this information.

We spoke to a newly recruited member of staff regarding recruitment and induction processes. They informed us that references had not been obtained from their previous employer prior to an offer of employment being made due to being dismissed from employment.

There was not an effective process in place to ensure regular checks of GMC, GDC and other professional registrations were carried out.

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 written records of clinical supervision which may have taken place. We noted that there were limited written protocols in place for trainee dental nurses to follow.

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 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 did not see any evidence that regular fire drills took place. We did see evidence that the last test of the fire alarm system had taken place on 1 February 2016. There was adequate fire protection equipment in place.
- 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 had some risk assessments in place to monitor health and safety of the premises, staff and

service users. For example, we saw a risk assessment which had been carried out of the decontamination room however, this had last been carried out in August 2013 and required review. A Legionella risk assessment had been carried out in March 2016. This assessment advised that monthly water temperatures should be recorded at the sentinel outlets. This had not been done by the practice.

- We asked a dentist 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.

Infection control

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

- We saw that the dental treatment rooms, patient waiting area, reception area and patient toilets were visibly clean. Clear zoning demarking clean from dirty areas was apparent in the dental treatment room. Hand washing facilities were available including liquid soap and paper towel dispensers.
- 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 the consultation room. Cleaning schedules were not in place for specific clinical equipment.
- The practice had an overall infection control lead in place. There was an infection control protocol in place however it was not reflective of processes in place at the time of our inspection.
- During our inspection, we observed that blood samples were stored with teeth whitening gel, food items and alcohol in a fridge in the decontamination room which is used for the sterilisation and decontamination of dental equipment. The decontamination room was not secure and was accessible by patients from the waiting room and contained substances which were hazardous to health (cleaning fluids and medical emergency drugs). We observed a small child freely walking around this room during our inspection. We informed the provider of this immediately to ensure the safety of the child.
- We were unable to locate any update training records for staff in respect of infection prevention control. We asked the practice to submit this evidence immediately following our inspection however, this was not provided when requested.
- Spillage kits were not provided to deal with the spillage of bodily fluids such as urine, blood and vomit. We did note that the practice did not have a mercury spillage kit.
- The dental treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors. A dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again.
- We observed that single use suction tubes which should be disposed after first use were sterilised and used again. During the inspection we noted several plastic saliva ejectors in the dirty box. We asked a dental nurse if these were to be sterilised. They confirmed they were due to be sterilised. These instruments are single patient use only and should not be sterilised and re-used.
- We spoke with staff and reviewed records relating to the validation and testing of the equipment used in the decontamination and sterilisation of used instruments. There were many gaps in the validation and testing processes. Staff were unclear about the daily automatic control test for the autoclave. There was a checklist which indicated this test was carried out even though staff were unaware of how to conduct the test. The weekly protein residue test on the ultrasonic bath had last been completed in June 2016. The ultrasonic activity test had last been completed in May 2016. This test should be carried out on a quarterly basis.

Are services safe?

- The segregation and storage of clinical waste was not always followed in line with current guidelines laid down by the Department of Health. We observed that clinical waste bags and municipal waste in the dental area were properly maintained and was in accordance with current guidelines. However, we observed one sharps bins located in a gynaecology consulting room used by doctors which was left unlocked and open with used sharps visible and was dated as September 2015. We observed another sharps bin which had not been dated upon assembly.
- We noted that sanitary waste bins were not provided in a female patient toilet located near to the gynaecology treatment room.Domestic waste bins were provided in this toilet and there was a strong unpleasant odour in this room.

Premises and equipment

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

- X-ray equipment was located in one of the dental surgeries. We saw a critical examination and acceptance test had been carried out on 8 October 2013. Within this there were two actions which had been highlighted to ensure the x-ray equipment was safe to use. One of these actions related to the position of the operator whilst taking an x-ray. This stated "the operator stands inside the decontamination room and views the patients and warning lights through a viewing panel provided in the wall. If the viewing panel is made of conventional glass, it should be replaced with lead glass in order to provide adequate protection to the operator. The practice should consult its RPA regarding this matter". During the inspection we observed an x-ray being taken. The dentist did not follow the guidance from the report and did not observe the patient whilst the x-ray was being taken. We also did not see any evidence the radiation protection advisor (RPA) had been consulted and lead glass had been put in the viewing panel. The report also stated the practice should review the use of self-developing x-rays. This will reduce the dose to patients. The practice was still using self-developing x-rays.
- We were unable to observe training records that appropriate staff had received update training in dental radiography in accordance with General Dental Council (the dental registrants governing body) recommendations.
- We observed clinical items such as bags of vacutest tubes which are used for the collection of pathology samples such as blood which had expired. We observed open condoms with the wrapper removed amongst a box of condoms supplies in a gynaecology treatment room. These condoms were used during use of the ultrasound equipment and we were told by a member of staff that they were not required to be sterile.
- We found out of date swab collection and transport kits for use in sexual health screening which had expired in November 2016. These kits should not be used after the date of expiry.

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave and ultrasonic bath had been serviced and calibrated within 12 months. Portable appliance testing (PAT) had been carried out in December 2016. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records we saw.

Safe and effective use of medicines

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

- We noted that the practice did not have a system in place to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). At the time of our inspection, there was no evidence of alerts received 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.

Are services safe?

- All prescriptions were issued on a private basis and we observed that all prescription pads were not always stored securely. Blank private prescriptions were left unsecure, on a desk in an unlocked room, these prescriptions had been pre-stamped with the name and GMC number of a doctor.
- 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

Medical records we looked at which were completed primarily by both dentists and doctors were inconsistent. Some records were illegible, we observed that some records did not always contain details of basic observations, patient history, follow up advice given or referral information to secondary care providers. Not all care records were signed or dated appropriately and some records were written in Polish and were illegible. 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 prior to our inspection. However, during our inspection, we noted that some patient care records were still written in Polish and were illegible.

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.

Staff training and experience

The practice did not have a comprehensive induction and training programme in place for newly appointed staff.

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. We asked the provider to forward details of staff training however, this was not been provided for all members of staff.

The practice did not have a system of appraisals in place to ensure the learning needs of staff were identified. There were no formal processes in place for clinical supervision of trainee dental nurses.

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. 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 told us they 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

Are services effective?

(for example, treatment is effective)

Staff sought patients' consent to care and treatment in line with legislation and guidance however there was inconsistency in relation to the explanation of fees and patients consent to these fees.

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.
- The practice did have a consent policy in place. Patients were required to sign a written consent form which detailed the fees required.
- 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.
- 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 patient waiting room. Fees were recorded on the patient consent form which they were required to sign during consultation.
- 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.

Health promotion & prevention

Dental staff we spoke to during our inspection demonstrated that dentists gave 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 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 converted commercial property.
- 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.

Tackling inequity and promoting equality

The practice offered appointments primarily to eastern European patients who lived in the UK however, the practice did offer appointments to anyone who requested one and did not discriminate against any client group. During our inspection we did speak with a British patient who had attended the practice on a regular basis for dentistry services. At the time of our inspection, the practice website was available in Polish only.

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.
- We were informed that the practice manager would normally be the designated responsible person who handled all complaints in the practice however, at the time of our inspection there was no manager in post. We met a prospective trainee practice manager who had not formally commenced employment at the time of our inspection. We were informed that the operational manager would deal with any complaints received until a permanent practice manager was in post.
- The practice held records of all formal complaints received. The practice did not keep a record of informal complaints received.
- There was information on how to complain in the patient waiting area on the practice website.

We looked at one complaint which was the only complaint received within the last 12 months. We found that this complaint was satisfactorily handled and dealt with in a timely way. We saw evidence of a written acknowledgement sent to the patient which included an apology and a refund of fees.

Are services well-led?

Our findings

Governance arrangements

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 suitably trained and experienced management support in place on a daily basis and there was a lack of clinical leadership and oversight.
- 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 that adequate medical indemnity insurance was in place for all staff who required this.
- 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, most records were written in Polish and did not always contain detailed information of the consultation or treatment that had taken place. The provider had previously been made aware that patient 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 prior to our inspection that this responsible officer (RO) had withdrawn from acting as RO for medical 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 evidence that staff had read and understood all of these policies. We looked at various policies during our inspection which included infection control and decontamination policies. Not all policies we looked at had been reviewed and updated. Policies did not deliver consistency across the practice and were not always being implemented and followed, for example in relation to infection control. The practice did not have a medicines management policy in place.
- The practice did not have effective arrangements in place for identifying, recording and managing risks, issues or implementing mitigating actions. The practice had not ensured health and safety risk assessments had been carried out in relation to the premises to ensure the safety of staff, patients and visitors.
- The practice did not hold formal, structured, minuted meetings. Meetings were either held informally or were ad-hoc.
- The practice did not have a robust strategy or supporting business plans in place.
- 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 present told us they were aware of areas of concern which required addressing and discussed their plans to improve. We were not assured of the leadership, openness and transparency of the directors as no learning had been shared following concerns raised during previous inspections of other Polmedics Ltd locations. For example, the Commission had inspected another three locations all of which had multiple breaches.

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

Learning and improvement

The directors present during our inspection did not give any assurance that there was a focus on continuous learning and improvement at all levels within the practice. For example, the provider had not acted upon the same serious concerns which had already been raised during inspections of other locations where regulated activity was provided from. For example, concerns in relation to gaps in emergency medicines and equipment.

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

Are services well-led?

with a revised policy dated 15 November 2016 in relation to patient care records. However, during our inspection, 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 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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 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 legionella. 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 members of staff had completed upto date safeguarding training. The practice had not ensured the availability of trained chaperones at all times for patients who attended for medical consultation services when an examination may be required. 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 had not ensured the safe storage of paper patient care records.

This section is primarily information for the provider

Enforcement actions

The practice did not have an effective process in place to ensure patients received pathology results in a timely way.

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 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 that Doctors who carried out medical consultations with adults and children was on a specialist or GP register.

The practice had not ensured all staff received training required to carry out their roles for example, safeguarding, chaperone, infection control and dental radiography.

The practice had not acted upon the outcome and actions required following a critical examination report for x-ray equipment.

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 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:**

This section is primarily information for the provider

Enforcement actions

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.

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 system in place for collating the records of training, learning and development needs of staff.

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.