Atlantic Clinic Ltd

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Inspection report

Unit 4, Mountbatten Business Centre,
Millbrook Road East,
Southampton
SO15 1HY
Tel: 02380 637374
Website: www.atlanticclinic.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 7 January 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.

Are services effective?

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

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

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

Background

Atlantic Clinic provides services predominantly to meet the needs of the local Polish population within the Southampton area. A range of services are provided which include obstetrics and gynaecology, orthopaedics, paediatrics, GP services, psychiatry, dermatology and dentistry. Dental services are provided from the first floor only. The practice employs six staff which includes receptionists, a trainee dental nurse, a phlebotomist and two managers. Doctors who provide services to patients are not employed by the practice but are contracted to deliver services on a sessional basis. The service is open from 09.00 to 20.30 from Monday to Sunday.

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

There is a responsible individual who represents the provider Atlantic Clinic Limited and there is a lead doctor within the service who is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection and we spoke to some patients on the day of our

Summary of findings

inspection. Nine patients provided feedback about the service. All of the comments were positive about the care they had received. Patients told us that staff acted in a professional manner and they felt they received good standards of care. Atlantic Clinic had not been subject to previous inspection by the Care Quality Commission.

Our key findings were:

- Services were provided from modern, well equipped and well maintained premises.
- Sterilisation equipment had not been adequately serviced and maintained to ensure the safety of patients. There was a lack of formal processes and procedures to ensure the effective decontamination of all reusable instruments used within the service.
- The service offered flexible opening hours over seven days each week and appointments to meet the needs of their patients.
- Dental services were provided on three days each week. Arrangements to provide emergency support to dental patients outside of those hours were not clearly defined.
- Patients received a comprehensive assessment of their health needs which included their medical history.
- Patients told us they were listened to, treated with respect and were involved in discussions about their treatment options.
- A range of information leaflets were available to patients, written in Polish and English, to enable them to make informed decisions about treatment options available to them.
- Staff had not received training in some key areas such as basic life support and chaperoning.
- There was a lack of systems in place to implement national patient safety alerts within the service.
- Appropriate recruitment checks on staff had not always been undertaken prior to their employment.
- The service did not have systems in place to monitor the ongoing training, continuous professional development and annual appraisal review of doctors working on a sessional basis. There was no system of supervision to provide support to sessional staff.
- There was a lack of formal governance arrangements and monitoring of patient outcomes. The service had not undertaken any clinical audits. They did not hold meetings to review clinical practice.
- There was a lack of review of and use of best practice guidance to implement changes to improve patients' treatment outcomes. Prescribing practices were sometimes outside of local formulary and NICE guidelines.
- The service regularly sought the views of patients. Feedback from patients was consistently positive about the care they received.

There were areas where the provider must make improvements and:

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

You can see full details of the regulations not being met at the end of this report.

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

- Review the service's supply of emergency medicines, to include medicines which support the fitting of intrauterine devices and epileptic seizures.

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- Ensure use of best practice guidance and NICE guidance in treatment and prescribing practices in order to ensure optimum treatment outcomes for patients.
- Provide clear information to patients on chaperoning services available.
- Provide clear information to patients about how to access emergency support outside of the service's opening hours and when specialist clinicians are unavailable.
- Ensure processes are in place to track and monitor the use of prescription pads.
- Implement a consistent approach to patient record keeping including consistency in the language used and ensuring all hard copy records are scanned into the electronic record in a timely manner.
- Review the service's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping and to include periodontal monitoring and soft tissue examination.
- Review policies and procedures to ensure they reflect current practices within the service.
- Review alarm systems within the service for alerting others in an emergency situation.

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.

Services were provided from modern, well equipped and well maintained premises. However, equipment for the sterilisation of instruments had not been adequately serviced and maintained to ensure the safety of patients. There was a lack of formal processes and procedures to ensure the effective decontamination of all reusable instruments used within the service. Staff providing care and treatment to patients sometimes worked outside of their scope of formal training which may have put patients at risk of harm. Staff had not received training in key areas such as basic life support and chaperoning. Prescribing practices were sometimes outside of local formulary and NICE guidelines. There were some systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. Staff had received training in safeguarding of children and vulnerable adults and knew the signs of abuse and to whom to report them. Appropriate recruitment checks on staff had not always been undertaken prior to their employment.

Are services effective?

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

Patients received a comprehensive assessment of their health needs which included their medical history. A range of information leaflets were available to patients, written in Polish and English, to enable them to make informed decisions about treatment options available to them. The service made some reference to evidence based guidance and standards within their policies and procedures. However, some aspects of best practice guidance were not always followed. There were no formal processes in place to monitor the consistent use of best practice guidance information to deliver care and treatment which met patients' needs. The service provided training and updating for staff in most key areas. However, some staff had not undertaken training in basic life support and chaperoning. The service did not have systems in place to monitor the on-going training, continuous professional development and annual appraisal review of doctors working on a sessional basis.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Feedback from patients spoken with and through completed comment cards was positive about their experience at the service. Patients told us they were listened to, treated with respect and were involved in discussions about their treatment options. Patients were contacted via email to provide feedback following consultations and treatment. We saw that patients provided consistently positive feedback. We observed staff to be caring, friendly and professional towards patients.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

The service offered flexible opening hours over seven days each week and appointments to meet the needs of their patients. However, appointment availability was dependent on the availability of the specialist clinicians, some of whom attended on only a few occasions each month. The service was not able to ensure that patients who required emergency dental treatment were responded to in a timely manner as dental services were only provided on a

Summary of findings

maximum of three days each week. Staff told us that patients would be directed to other dental services or emergency NHS services in the event of an emergency outside of their operating hours. There was no lift access to the first floor of the premises. Dental services were provided from the first floor only and therefore patients in a wheelchair or those with restricted mobility were unable to access those services.

Are services well-led?

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

There was a lack of overarching governance arrangements within the service to support the delivery of good quality care and a lack of evidence of continual learning and improvement. The service had some policies and procedures in place to govern activity which had been recently reviewed and these were available to staff. However, some of the policies did not reflect the processes which staff followed within the service and made reference to inaccurate processes. There was a lack of comprehensive understanding of the performance of the service. There was a lack of leadership to ensure continuous clinical and internal audit to monitor quality and to make improvements. Staff had not received regular performance reviews or supervision and had not attended staff meetings. The service regularly sought the views of patients.

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Detailed findings

Background to this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 and to look at the overall quality of the service.

We carried out an announced inspection visit on 7 January 2016 as part of the independent doctor consultation service inspection pilot.

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a dental specialist advisor, a CQC medicines inspector, a mental health specialist advisor and a practice manager specialist advisor.

Before visiting, we reviewed a range of information that we held about the service and asked other organisations to share what they knew. Prior to the inspection we reviewed information we had received from Southampton Clinical Commissioning Group prescribing team and the information provided in response to a pre-inspection information request to the provider.

During our visit we:

- Spoke with a range of staff including doctors, managers, a dental nurse and administration staff.
- Spoke with patients who used the service and observed how people were being cared for.
- Reviewed the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were some systems in place for reporting and recording incidents. Staff told us they would inform the service manager of any incidents and there was also a recording form available on the service's computer system. However, the service had only recorded one incident since their opening in 2014. We reviewed the one incident recorded and saw that some learning had been noted and lessons were shared to make sure action was taken to improve safety in the service.

There was a lack of systems in place to implement national patient safety alerts or alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) within the service. Staff lacked an understanding and awareness of alerting systems and told us they did not receive any correspondence about them.

Reliable safety systems and processes (including safeguarding)

The service had a named lead for patient safety and for the safeguarding of children and vulnerable adults. Arrangements were in place to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. The policies and contact information were accessible to all staff. The service's policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Staff demonstrated they understood their responsibilities and had received training relevant to their role. We found the doctors who provided services were trained to level 3 for safeguarding children.

Staff told us that patients were able to request a chaperone if required, however arrangements were not clearly defined. There were no signs or other information within the service advising patients of the chaperone service. Staff told us that receptionists or the practice manager would act as a chaperone if required. However, some of those staff members had not undertaken training to support the role.

We found the electronic patient record system was only accessible to staff with delegated authority which protected patient confidentiality. There were systems in place to back up patients records securely and a named lead for information governance and information technology systems.

Medical emergencies

The service had some arrangements in place to respond to emergencies and major incidents. There was a buzzer system which enabled reception staff to alert others in the first floor staff room to any emergency. However, there were no additional alarms in any of the clinical rooms which alerted staff to an emergency. Staff told us that they would call out if they required assistance and would be heard due to the close proximity of other rooms. Some staff, including receptionists, told us they had not received basic life support training.

The service had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automatic external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm) and oxygen with face masks for both adults and children. Emergency medicines were available and easily accessible to staff in secure areas of the service. Staff knew of the locations of the emergency medicines and equipment. Medicines for use in an emergency were stored in two locations at the service. These were within the upstairs dental room and also within a downstairs consultation and treatment area.

However, the range of emergency medicines stocked did not include all of those required. The medicines stocked did not include a supply of atropine to support the fitting of intrauterine devices or rectal diazepam to support patients experiencing epileptic seizures. The service had not undertaken a risk assessment to support the decision not to stock such medicines and provided care to both such groups of patients. We reviewed completed records which showed regular checks were undertaken to ensure the emergency equipment and medicines were safe to use. The service had first aid kits and an accident book available on site.

Staffing

There was a lack of arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' continuing needs. Systems were not in place

to ensure staff were always available to support patients following treatment within different service areas. For example, dental services were available on a maximum of three days each week and arrangements to provide emergency support to dental patients outside of those days were not clearly defined. Staff told us that general practitioner (GP) services were provided by one doctor on one day each week. We saw that this doctor was registered as a GP with the General Medical Council (GMC).

We reviewed seven personnel files and found that appropriate recruitment checks had not always been undertaken prior to employment or the commencement of a doctor providing services on a sessional basis. We found that proof of identification, details of qualifications and registration with the appropriate professional body had been obtained. However, references had not been obtained relating to three staff members. The practice manager told us that it was the service's policy to request a Disclosure and Barring Services (DBS) check for all staff. However, we found that some staff files contained DBS checks which applied to previous positions of employment held by staff and did not relate to an application made by the provider.

Monitoring health & safety and responding to risks

There were procedures in place for monitoring and managing risks to patient and staff safety. We saw that the service had undertaken a range of documented risk assessments, including for example relating to health and safety of the environment, first aid, information technology and associated information governance. All of the staff team had received health and safety awareness and fire safety training as part of their induction. Some staff members had further delegated responsibilities for implementing health and safety at work. For example, we found the service had been subject to a fire risk assessment and one director was the named lead for fire safety. Fire safety equipment had been regularly serviced and records demonstrated staff had been involved in regular fire drills. The lead receptionist and practice manager held responsibility for first aid.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks to patients, staff and visitors, associated with substances hazardous to health had been identified and actions taken to minimise them.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the service.

Infection control

There was a lack of effective systems in place to reduce the risk and spread of infection in some areas of the service. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The service had followed some of the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)'. The service's policy and procedures for infection prevention and control were accessible to staff and made reference to this guidance.

We saw the facilities for cleaning and decontaminating dental instruments. We found there was a dedicated decontamination room with a clear flow from 'dirty' to 'clean.' The dental nurse demonstrated to us how instruments were decontaminated and sterilised. This was in accordance with the procedure for decontamination of instruments written by the service. We observed instruments were placed in pouches after autoclave sterilisation and dated to indicate when they should be reprocessed if left unused. We saw that the practice undertook daily checks to confirm the steriliser was working correctly and we saw the use of test strips to verify the effectiveness of each sterilisation cycle; however we noted that the logbook used to record those checks was incomplete.

The service had two autoclave sterilisers on the premises. One steriliser was in use and used regularly in the sterilisation of dental instruments and other instruments, including those used for gynaecological treatments such as cryotherapy. Staff told us that cryotherapy tips were the only instruments which were sterilised other than dental instruments. However, we found forceps and tweezers within the treatment room used for colposcopy treatments which had been packaged and sterilised within the clinic.

The provider did not hold records to demonstrate the validation of the steriliser at the point of installation or any ongoing servicing records related to the steriliser. The

provider was unable to demonstrate the suitability and effectiveness of the steriliser to decontaminate instruments used in gynaecological and other procedures. The provider had not assessed or identified the risks associated with the use of a steriliser that had not been regularly serviced by a suitably qualified professional which may have placed patients at risk of harm and health care associated infections. Following our inspection we asked the provider to take urgent action to ensure the steriliser was serviced. The provider had recently taken delivery of a second steriliser which was not in use at the time of our inspection. The service could not demonstrate that this steriliser had been subject to the required validation checks upon installation.

There was a lack of formal processes to ensure the effective decontamination of reusable instruments used within the service other than dental instruments. The provider had not implemented processes and procedures which defined the competency requirements of staff involved in the cleaning and decontamination of those instruments. Written records were not maintained for every element of the decontamination cycle. There was a lack of a complete audit trail which would enable the provider to confirm adequate decontamination in the event of a decontamination incident or outbreak investigation. The service did not maintain track and traceability records which included unique identification numbers for each device or instrument used; the date and time decontamination procedures were carried out; the name of the person undertaking each stage of the decontamination process and the patient identity on whom the instrument was used. There was no internal or external auditing of processes to monitor and ensure their robustness.

The service had an on-going contract with a clinical waste contractor. We saw that a clinical waste audit had been undertaken in January 2016. We saw the differing types of waste were appropriately segregated and stored within the service. This included clinical waste and safe disposal of sharps. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance. There was clear guidance within the service detailing the process for dealing with a needle stick injury which included local emergency contact numbers. Staff we spoke with had a good level of understanding of this process.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near to sinks to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members. Environmental and equipment cleaning schedules were in place for all areas and services provided, including dentistry. We saw daily checklists had been completed to confirm cleaning had taken place.

The service had undertaken an audit of their infection control procedures in August 2015 and also undertook regular documented checks of the environment and infection control processes on a quarterly basis.

Records showed a risk assessment process for Legionella with appropriate processes in place to prevent contamination, such as flushing of dental unit water lines. This process ensured the

risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Premises and equipment

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The service also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health.

The provider did not hold records to demonstrate the validation of the autoclave steriliser at the point of installation or any ongoing servicing records related to the steriliser. Information about the steriliser was limited to systems checks. Other equipment had been serviced regularly, including the air compressor, fire extinguishers and the X-ray equipment. We were shown the annual servicing certificates which showed the service had systems in place to ensure most equipment in use was safe and in good working order.

Records showed and staff confirmed repairs were carried out promptly which ensured there was no disruption in the delivery of care and treatment to patients. We checked the provider's radiation protection file as X-rays were taken at

the centre. We also looked at X-ray equipment at the service and talked with staff about its use. We found there were suitable arrangements in place to ensure the safety of the equipment. We saw local rules relating to the X-ray machine were displayed. We found procedures and equipment had been assessed by an independent expert within the recommended timescales. The organisation had a radiation protection adviser and had appointed a radiation protection supervisor.

The service had undertaken some auditing of dental x-rays and had maintained a log of the x-rays taken and their grading. However, no reporting of the findings or actions taken had been completed.

Safe and effective use of medicines

We reviewed the arrangements and systems in place for managing medicines. The registered manager and lead doctor was the named lead for medicines management. We saw that policies were in place for the management of medicines and the prescribing of repeat medicines. However, these did not always reflect current practices within the service and contained contradictions within the same policy. For example, the medicines management policy stated that medicines were administered by the service to patients on site, but were not dispensed to be taken away. Staff we spoke with confirmed that medicines were not dispensed for patients to take away. However, the policy then described the labelling of medicines to be administered with patient name, dosage instructions and the clinic name. The policy stated that keys to the medicines cupboards were only available to authorised prescribers, but we were told that the receptionist and practice manager had access to the keys to those cupboards.

We looked at medicines kept in the treatment rooms and medicine refrigerators and found they were stored securely. Records showed fridge temperature checks were carried out which ensured medicines and vaccines were stored at the correct temperature. We were told that there was no written policy in place for ensuring that medicines were kept at the required temperatures or describing the action to be taken in the event of a potential failure.

Patients were issued with prescriptions for dispensing at a community pharmacy. All prescriptions were written and signed by a doctor following a face-to-face consultation with the patient. We saw that prescribing was only carried out by medical professionals. Staff told us that there were no non-medical prescribers within the service. Doctors told us they relied upon the information provided by patients to make safe prescribing decisions, and did not regularly access other patient records.

We reviewed the records of ten patients who had visited the service and found prescribing of antibiotics outside of local formulary and NICE guidelines. The service had not carried out any audits of prescribing in order to ensure monitoring of the quality of care and treatment provided or the implementation of necessary changes to improve patient treatment outcomes.

Prescription pads were stored securely in the practice to ensure that only authorised prescribers could use them. However, there were no formal systems in place to monitor their use. We were shown where pre-printed prescription forms, containing prescriber details such as name, GMC number and serial numbers, were kept within a lockable filing cabinet or printer in a lockable room. We were told that these prescription forms were pre-prepared by the receptionist and practice manager. However, there were no records kept of when and by whom these forms were later used. Staff told us that controlled drugs were not prescribed from the service.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

We reviewed dental patient records and noted that the service did not use a dental specific system for maintaining treatment records. Records lacked some components of assessment recommended by the Faculty of General Dental Practice, such as periodontal monitoring and soft tissue examination. The dentists did not always use current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Records were of sufficient detail to reflect the treatment provided. All records we examined included completed medical history forms. Details of x-rays taken, evidence of written consent, local anaesthetic administered and treatments provided, were all clearly recorded.

Treatment plans explained the treatment required the options available and outlined the costs involved. This allowed patients to consider the options, risks, benefits and costs of treatment before making a decision to proceed.

A range of information leaflets were available to patients to enable them to make informed decisions about treatment options available to them. For example, we saw information was available relating to dental extractions and root canal treatments for dental patients. Other information reflected the mental health and gynaecological treatments provided by the service. Information leaflets were written in English and Polish.

We reviewed patient records relating to other services provided by sessional doctors within the service. We undertook a review of patient records due to information we had received about prescribing practices within the service prior to our inspection. We found that medical histories had been recorded when patients registered with the service. Some patient records were held as hard copies where there had been delays in scanning them into the patients' electronic records. For example, we noted that where investigation requests had been recorded in a patient's electronic records, results had been received in hard copy format and had not always been scanned into the electronic records. The provider told us that they aimed to record all patient records in English; however we found that some written records had been made in Polish. The provider told us they had recently undertaken a review of some patient records. We saw that as a result, some feedback had been provided to doctors via a team newsletter. The registered manager told us they occasionally observed some consultations undertaken by other doctors with the purpose of quality monitoring and provided verbal feedback in this regard. The service did not hold written records to reflect this activity.

We saw some reference to evidence based guidance and standards within the service's policies and procedures, including those issued by National Institute for Health and Care Excellence (NICE) and the General Dental Council. However, there were no formal processes in place to monitor the use of best practice guidance information to deliver care and treatment which met patients' needs. There were no formal processes in place to review, reflect and discuss evidence based guidance within the service team. The service did not have evidence of clinical audits which had been used to implement change and improve treatment outcomes for patients.

Staff training and experience

The service had a basic induction programme for newly appointed staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There was also role specific induction training which ensured staff were competent for the role to which they had been appointed.

The service demonstrated how they provided training and updating for all staff in key areas. Staff had access to and made use of a comprehensive series of e-learning training modules. Completion of the modules was recorded within each personnel file. However we found that some staff had not undertaken training in basic life support and those staff who may be required to act as chaperones had not received training to support this role. Doctors who provided services on a sessional basis were required to present evidence of training, professional qualifications and experience at the point of recruitment. We saw this information was held in their personnel files.

However, there was a lack of formal processes to review the ongoing learning needs of staff. The service did not monitor the continuous professional development of doctors who provided services on a sessional basis. The service did not conduct an annual appraisal review of doctors working on a sessional basis and did not hold details of external

Are services effective?

(for example, treatment is effective)

appraisal reviews for those doctors. There were no other systems in place to support the coaching, mentoring, and clinical supervision of doctors. The service was therefore unable to ensure that staff had access to appropriate training and support to meet their learning needs and to cover the scope of their work within the service.

We noted that a trainee dental nurse received supervision and support from a dentist within the service. The nurse was registered to undertake a national examination in dental nursing in the future but had not been registered to access any formal dental nurse training in preparation for the examination.

Other staff working within the service such as reception staff had not yet been employed for a 12 month period and had therefore not yet received an appraisal. We spoke with the lead receptionist who told us they had undergone a performance review three months after the start of their employment and had been confirmed in their post.

Working with other services

The service had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from other services, to be saved in the system for future reference. We found that there were sometimes delays in hard copy records such as test results being scanned onto the electronic system.

The service shared relevant information with the patient's permission with other services, for example, when referring patients to other services or informing the patient's own GP of any matters. The service requested permission to share information with the patient's GP at the point of registration.

Staff worked with other health care professionals to meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to, or after they were discharged from hospital.

Consent to care and treatment

We found staff sought patients consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance (Gillick). We saw the service obtained written consent before undertaking procedures. Information about fees was transparent and available in the waiting room and on the service's website. The process for seeking consent was demonstrated through records and showed the service met its responsibilities within legislation and followed relevant national guidance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. Staff we spoke with were aware of the importance of protecting patient confidentiality and providing reassurance. They told us they could access an empty room away from the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

We observed curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

The provider and staff explained to us how they ensured information about patients using the service was kept confidential. The service had electronic records for all patients which were held securely. The day to day operation of the service used computerised systems and the service had an external backup for this system. Staff members demonstrated to us their knowledge of data protection and how to maintain confidentiality.

Involvement in decisions about care and treatment

Staff told us a patient's medical status was discussed with them in respect of decisions about the care and treatment they received. We reviewed some examples of written treatment plans for dental treatments and found they explained the treatment required, the options available and outlined the costs involved. This allowed patients to consider the options, risks, benefits and costs of treatment before making a decision to proceed.

We saw a range of information available on the service's website and within the service which were written in both Polish and English and which explained the services and treatments available to patients. Comments we received from patients indicated they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision.

Patients completed CQC comment cards to tell us what they thought about the service. All of the comments were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were efficient, helpful, caring and knowledgeable. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Staff told us that the service had been established to meet the needs of the local Polish population within the Southampton area. The service offered flexible opening hours over seven days each week and appointments to meet the needs of their patients. The range of services was kept under review to meet demand. Staff reported the service scheduled enough time to assess and undertake patients' care and treatment needs.

The premises and facilities were modern, well maintained and welcoming for patients, with a manned reception area and comfortable waiting room. The treatment and consultation areas were well designed and well equipped.

The service had effective systems in place to ensure the equipment and materials needed were in stock or received well in advance of the patient's appointment.

Tackling inequity and promoting equality

The service was offered on a fee basis only and was accessible to people who chose to use it. We asked staff to explain how they communicated with patients who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Staff knew how to access language translation services if these were required.

The building was accessed through manual doors and there was ramp access into the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the ground floor treatment and consultation rooms. Toilet facilities were available for all patients. The toilet for disabled patients contained grab rails for those with limited mobility and an emergency pull cord. However, patient services were located over two floors of the building. The first floor was accessed via a flight of stairs only and there was no lift access. Dental services were provided from the first floor only and therefore patients in a wheelchair or those with restricted mobility were unable to access dental services.

Access to the service

Appointments were available at varied times between 09.00 and 20.30 from Monday to Sunday but were dependent on the availability of the specialist clinicians. For example, patients who required emergency dental treatment were not able to be responded to in a timely manner as dental services were only provided on a maximum of three days each week. Staff told us that patients would be directed to other local dental services or emergency NHS services in the event of a dental emergency outside of those operating hours. Patients were provided with email and text reminders of their appointments.

The length of appointment was specific to the patient and their needs. Staff told us that all patients who needed to access care in an emergency or outside of normal opening hours were directed to the NHS 111 service. However, there was no information available to patients on the service's website or patient information brochure in this regard.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal and informal complaints from patients. Information for patients about how to make a complaint was available in the service waiting room and in the service information brochure. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the service investigation into their complaint. The registered manager handled all complaints.

We reviewed the complaints system and noted that all comments and complaints made to the service were recorded. We read the service procedure for acknowledging, recording, investigating and responding to complainants and found all of the five patient complaints which had been received over the past 12 months had received an appropriate investigation and response. We noted that three of the complaints related to paediatric prescribing practices which had been monitored by Southampton clinical commissioning group prescribing team. Two complaints related to dermatology services and we saw that appropriate responses had been provided to those patients.

Are services well-led?

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

Our findings

Governance arrangements

There was a lack of overarching governance arrangements within the service to support the delivery of good quality care and a lack of evidence of continual learning and improvement.

The service had some policies and procedures in place to govern activity and these were available to all staff. Many of the policies and procedures we saw had been reviewed or developed in the weeks prior to our inspection. Some reflected current good practice guidance from sources such as the General Dental Council (GDC).

There were no formal processes in place to monitor the use of best practice guidance information to deliver care and treatment which met patients' needs. There were no formal processes in place to review, reflect and discuss evidence based guidance within the service team. The registered manager told us they held telephone conversations to discuss governance arrangements with individual sessional doctors but there were no records of those discussions.

The provider did not have governance arrangements to ensure clinical audits had been used to implement change and improve treatment outcomes for patients. Governance arrangements had not identified prescribing practices that were sometimes outside of local formulary and NICE guidelines and not ensured audits of prescribing practices had been carried out.

Leadership, openness and transparency

There was a clear leadership structure in place and staff felt supported by management. The registered manager had responsibility for the day to day running of the service. They worked closely with one Director who was responsible for operations and the practice manager. The lead receptionist was also training to undertake a practice management role.

Named members of staff held lead roles. For example, there were named leads for patient safety, the safeguarding of children and vulnerable adults and information governance. The registered manager told us they held regular meetings with individual staff on a monthly basis but there were no records held to confirm those meetings.

Staff told us that team meetings were not held. Informal meetings were held with some individual members of staff but these were not documented. Doctors providing services on a sessional basis did not attend clinical, governance or supervisory meetings and there were no team meetings held within the service.

Staff told us management were approachable and took the time to listen to them. The lead receptionist who was training to undertake a practice management role told us they had been involved in discussions about how to run and develop the service, and to identify opportunities to improve the service.

The registered manager had some awareness of and complied with the requirements of the Duty of Candour. However, there was a lack of formal arrangements in place to ensure that the organisation encouraged a culture of openness and honesty such as for complaints management and responding to incidents or events in the service.

Learning and improvement

The service provided training and updating for all staff in key areas such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality via a comprehensive series of e-learning training modules.

However, there was a lack of formal processes to review the ongoing learning needs of staff. The service did not monitor the continuous professional development of doctors who provided services on a sessional basis. The service did not conduct an annual appraisal review of doctors working on a sessional basis and did not hold details of external appraisal reviews for those doctors. There was a lack of formal supervision or peer review processes. The service was therefore unable to ensure that staff had access to appropriate training and support to meet their learning needs and to cover the scope of their work within the service.

There was a lack of clinical auditing within the service to ensure the regular monitoring of the quality of care and treatment provided and the implementation of changes to improve patient treatment outcomes. The service had undertaken a limited review of clinical records and we also saw the initial stages of auditing of dental x-rays taken but this had not been completed. The service had not carried out any audits of prescribing practices or treatments undertaken.

Are services well-led?

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

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

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered provider had not assessed the risks to the health and safety of service users of receiving care and treatment and had not done all that is reasonably practicable to mitigate any such risks.** **We found that the registered provider had not ensured that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.** **This was in breach of regulation 12 (1) (2) (a) (b) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered provider had not always ensured that staff received appropriate training, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform.** **This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

We found that the registered provider had not ensured that persons employed for the purposes of carrying on a regulated activity were of good character and had the necessary qualifications, competence, skills and experience necessary for the work to be performed.

We found that the registered provider had not ensured that recruitment procedures were established and operated effectively to ensure that persons employed met the required conditions.

We found that the registered provider had not ensured that information specified in Schedule 3 was available in relation to each person employed.

This was in breach of regulation 19 (1) (a) (b) (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not always assessed, monitored and improved the quality and safety of services provided. We found that the registered provider had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and staff. We found that the registered provider had not always maintained records which are necessary to be kept in relation to the management of the regulated activity. We found that the registered provider had not always evaluated and improved their practice in respect of the processing of the information referred to above. This was in breach of regulation 17 (1) (2) (a) (b) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.