Polmedics Ltd

# Polmedics Limited - Rugby

## 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 focused inspection on 17 December 2016. This inspection was carried out because we had concerns in relation to the safety and overall governance of services provided at Polmedics Limited – Rugby following an inspection carried out at Polmedics Limited – Allison Street in Birmingham on 9 and 30 November 2016 and Polmedics Limited – West Bromwich on 16 December 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 requirement notice 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 requirement notice section at the end of this report).

**Are services responsive?**

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

**Are services well-led?**

# Summary of findings

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 requirement notice 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 - Rugby is an independent provider of dental services and also provides consultation services by a doctor who is referred to as an internist and treats both adults and children. This doctor provided consultation services including the prescribing of medicines 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 residential area of Rugby in Warwickshire and is located on the ground floor of a converted, terraced house property. The property is leased by the provider and consists of a patient waiting room which has a small reception desk, a decontamination room used for cleaning, sterilising and packing dental instruments, one dental treatment room and one medical consulting room used by a doctor. 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 - Rugby.

The practice holds a list of registered patients and offers services to patients who reside in Rugby 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 Limited 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).

Prior to our inspection we were told that the practice employed five dentists, one dental nurse, two trainee dental nurses and one doctor who they referred to as an internist. A psychotherapist also provided services to patients. There was a trainee practice manager who had been in post for approximately one month prior to our inspection and it was the intention of the provider that this manager would also apply to become the CQC registered manager. Staff were supported by an operational manager who was based 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 – Rugby.

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

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

**Our key findings were:**

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, those relating to Disclosure and Barring Service checks (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults

# Summary of findings

who may be vulnerable). We were not assured that all members of staff who had direct contact with vulnerable adults and children had a current DBS check in place.

- The provider had not ensured that adequate medical indemnity insurance was in place or that appropriate checks of current insurance had been carried out on all clinicians upon commencement of employment.
- Paper based, hand written, patient care records were written mainly in Polish, some records written by individual dentists and doctors were either illegible, not appropriately signed and did not always contain full and detailed information in relation to the consultation.
- 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.
- 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.
- The dental treatment room was visibly clean and well maintained.
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Not 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.
- Information about services and how to complain was available and easy to understand. Most 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. Clinical waste was not stored securely or appropriately.
- The provider had not ensured a five year fixed wire test of the electrical hard wiring system of the premises had taken place.
- 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 system for collating the records of training, learning and development needs of staff members.
- The practice did not have an effective process in place to ensure patients were informed of their pathology results including those that were urgent or positive in a timely way.
- The practice had limited formal governance arrangements in place. The practice did not have an effective, documented business plan in place. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement.
- The practice had a number of policies and procedures in place to govern activity, but some of these required updating.
- The provider had not ensured that a registered manager was in place. It is a requirement of registration with the Care Quality Commission where regulated activities are provided to have a registered manager in place.

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

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

# Summary of findings

- Ensured 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 care records.
- 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 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, decontamination of dental equipment, storage of clinical waste, 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 audits of radiography and infection control are undertaken at regular intervals to help improve the quality of service.
- 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 appropriate systems are in place to meet health and safety regulations with respect to fire and electrical hard wiring system checks of the premises.
- Ensure a review is undertaken of chaperone arrangements and the policy for ensuring 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 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.

# Summary of findings

- 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 – Rugby until 31 January 2017.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. There was no process in place to ensure that staff received appropriate inductions, security and identification checks were carried out before commencement of employment.
- The practice did not have effective recruitment processes in place to ensure that all members of staff had received a Disclosure and Barring Service check (DBS check) upon commencement of employment. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice did not ensure the safe storage and security of hand written patient records.
- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. Not 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 held evidence of Hepatitis B status and other immunisation records for some clinical staff members but not all who had direct contact with patients' blood for example through use of sharps. There was no process in place to ensure all clinical members of staff Hepatitis B status and other immunisations were checked or immunisation arrangements for staff were in place.
- Not all risks to patients were assessed and well managed.The practice did not always maintain appropriate standards of cleanliness and hygiene. Clinical waste was not stored securely. The lock on the external clinical waste bin was broken and there was a sharps bin inside which contained used sharps which was accessible by members of the public.
- Equipment involved in the decontamination process was regularly serviced and it was safe to use. However, staff were unclear about the process for the daily, weekly and quarterly validation of the autoclave and ultrasonic bath. Instruments were pouched prior to sterilisation in a non-vacuum autoclave.
- A Legionella risk assessment had been completed however, this had not been carried out by a competent person. We saw water temperatures were recorded on a monthly basis but on several occasions hot water temperatures had not reached 50 degrees Celsius. (hot water should be at least 50 degrees Celsius within one minute of running water to kill legionella bacteria).
- 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).

# Summary of findings

- 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.

**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 suitable for disabled persons or those with prams and pushchairs.
- A consulting room which was accessible from the patient waiting room did not lock to ensure the dignity and privacy of patients during consultations and examinations.
- 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 adequate medical indemnity insurance was in place or that appropriate checks of current insurance had been carried out on all clinicians upon commencement of employment.
- The provider had not ensured that a registered manager was in place. It is a requirement of registration with the Care Quality Commission where regulated activities are provided to have a registered manager in place.
- The practice did not hold regular, formal multi-disciplinary or team meetings, meetings that did take place were ad-hoc and were not minuted.
- The practice had limited formal governance arrangements in place. The practice did not have an effective, documented business plan in place. Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement. Audit was not embedded within the practice. For example, there was no evidence of an x-ray or infection prevention and control audit being completed.
- The practice had a number of policies and procedures in place to govern activity, but some of these required updating.
- The practice did not have an effective, overarching governance framework in place to support the delivery of the strategy and good quality care. There was a lack of effective systems and processes in place for assessing and monitoring risks and the quality of the service provision.
- There was not an effective leadership structure in place and there was a lack of clinical leadership and oversight. There was not a system of appraisals in place for members of staff.
- Not all members of staff had completed all mandatory training requirements. There was no system for collating the records of training, learning and development needs of staff members.

# Summary of findings

- There were no systems in place to monitor patient care records to ensure that patient information was recorded in line with the 'Records Management Code of Practice for Health and Social Care 2016. There was no system in place to ensure that an accurate, complete and contemporaneous record was maintained for every patient.
- 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 either a specialist or GP register.
- 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 - Rugby

**Detailed findings**

## Background to this inspection

The inspection was carried out on 17 December 2016. Our inspection team was led by a CQC Lead Inspector and was supported by a Clinical Specialist Advisor, Hospital Inspector and a Dental Inspector. The team was also supported by a Polish translator. Upon arrival, we were greeted by a dental nurse who informed the inspection team that the provider had closed the practice to patients due to dental x-ray equipment failure. A director of the company attended the practice shortly after our arrival who explained that a clinic had been scheduled for patients to commence at midday. This inspection went ahead as planned.

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 focused inspection was carried out at West Bromwich on 16 December 2016. Serious concerns were also found at West Polmedics Limited – West Bromwich 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 – Rugby 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 the storage of clinical waste.
- We looked at how medicines were managed and looked at the processes in place in relation to medicines management.
- Spoke with a dental nurse, a receptionist, a trainee dental nurse, a dentist, a trainee manager, an operational manager and one 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. During our inspection, we observed serious concerns regarding the storage of clinical waste. We were informed by a member of the management team that they had previously been aware of these concerns but they had not reported this incident or acted upon it due to lack of time.
- We found that a number of complaints merited further investigation as a significant event in order to promote shared learning and prevent reoccurrence. The practice had not investigated these issues as significant events.

**Reliable safety systems and processes (including safeguarding)**

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

- Arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and local requirements. We saw that a policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.
- During our inspection, we were unable to see evidence of safeguarding children or adults training for all members of staff. 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 clinics.
- The practice held a record of Hepatitis B status on personnel files for some clinical staff members of staff who had direct contact with patients' blood for example through use of sharps. These records were not available for all clinicians. There was no process in place to ensure Hepatitis B status or other immunisation records were obtained for all clinical staff.
- We observed hand written patient care records were stored in a consulting room which was not lockable and was accessible from the patient waiting area. This consulting room was not in use at all times by a member of staff. Records were stored in filing cabinet next to a single pane glass window at the front of the building on the ground floor, we observed keys had been left in these cabinets and another cabinet had a key missing and were accessible by anyone who entered this room. There were no security measures in place to ensure the safe storage of patient identifiable information.

**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 some instances. The practice had in place ampoules of

Diazepam instead of the recommended buccal Midazolam format. There was no glucagon available. 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.
- 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. However, we noted that the battery was not installed into the AED, this would have caused a delay in attempting to restore a normal heart rhythm in the event of a medical emergency. The practice staff were not aware that this battery had not been fitted correctly. We installed the battery and ensured it was charged. We also noted that the recommended chest pads for child patients were not available as part of the AED kit.
- 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**

Due to the inconsistency of evidence provided prior to, during and following the inspection visit it was impossible to be assured who was employed and scheduled to work at this location**.**

On the day of the inspection 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 included 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 providing healthcare advice. This doctor was not on either a specialist or GP register. We had been informed prior to this inspection that this doctor had not completed any continuous professional development for approximately ten years.

We reviewed seven personnel files and found that appropriate recruitment checks had not always been undertaken prior to employment. For example, some personnel files did not contain employer references or applications for references, photographic identification, national insurance numbers or records of previous employment details.

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 with the exception of one competency based assessment which took place for a dentist in October 2015. During our visit, we spoke with a trainee dental nurse who explained that there were no formal arrangements in place to ensure her clinical supervision. However, she explained that she would communicate verbally with a dentist on duty should any support be required. We noted

that there were limited written protocols in place for trainee dental nurses to follow for example, there were no protocols in place in relation to decontamination procedures.

**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 October 2016 by an external specialist. We noted that there was an action item in this risk assessment that a five yearly fixed wire testing of the electrical hard wiring system in the premises was required. The provider had recorded an action item to contact the landlord of the property as the landlord was responsible. We were unable to see evidence that this had been carried out. The provider informed us that the certificate was in a health and safety folder, we were unable to find this. We requested a copy of this to be provided to the Commission immediately following our inspection however, this was not provided. We saw a record of a fire drill which had been carried out in December 2016. We did see evidence that testing of the fire alarm system and emergency lighting system had taken place in December 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. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. We observed a health and safety file which had been produced by an external specialist.
- A legionella risk assessment had been carried out. This had been carried out internally, an assessment carried out by a competent person such as that carried out by a member of the Legionella Control Association had not been carried out.
- 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 had commenced on 1 December 2016. Cleaning schedules were not in place for specific clinical equipment.
- The practice did not have an overall infection control lead in place who would normally liaise with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place however this policy did not refer to the practice infection control lead. This policy was not reflective of processes in place at the time of our inspection.

# Are services safe?

- Not all staff had received infection control or handwashing technique training. Annual infection control audits had not been undertaken for all areas of the practice.
- 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 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 protein residue test on the ultrasonic bath had last been completed in April 2016. Prior to this it had only been completed on a quarterly basis.
- The dental nurse told us that after decontaminating the instruments these were bagged prior to going into the autoclave. The type of autoclave used was a non-vacuum autoclave. HTM 01-05 states that instruments should not be bagged prior to sterilisation in a non-vacuum autoclave. This is because the bag becomes wet and will compromise the storage of the instruments.
- The segregation and storage of clinical waste was not followed in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste in the dental area were properly maintained and was in accordance with current guidelines. However, we observed in the medical consulting room a sharps bin which had been left unlocked and contained used sharps, this room was easily accessible by patients when the room was not in use as the door did not lock. We also observed a clinical waste bin was stored outside to the rear of the property in a shared garden which was accessible by other properties. This bin was awaiting collection from an appropriate contractor to remove clinical waste from the practice. We also noted children's play equipment near to the clinical waste bin. We observed the lock was broken on this bin and a full sharps bin had been left inside this bin on top of the clinical waste and was accessible by members of the public. The trainee manager arranged for the lock to be repaired during our inspection and the sharps bin was removed.

**Premises and equipment**

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

- X-ray equipment was located in the dental treatment room. We were told that a critical examination and acceptance test had been carried out in December 2013. There was no evidence of this report on the day of inspection. We asked for this to be sought and sent to us immediately following our inspection. This had not been provided as requested. We were however sent evidence that a routine inspection had been carried out on 21 December 2016.
- 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 and urine which had expired in December 2015 and September 2016.

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.

**Safe and effective use of medicines**

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

- We noted that the practice had a system in place to receive national patient safety alerts such as those

issued by the Medicines and Healthcare Regulatory Authority (MHRA). This system had been implemented on 2 December 2016. 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.
- All prescriptions were issued on a private basis and we observed that all prescription pads were stored securely.
- The practice did not carry out audits of medicines or prescribing.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

Medical records we looked at which were completed primarily by both dentists and a doctor 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.

One consultation we looked at was in relation to a patient who was diagnosed with a urinary tract infection, the doctor had not recorded in the care record that a urine sample had been dip tested in the practice or sent to for pathology screening however, the doctor had prescribed antibiotics to this patient.

The provider had also previously 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.

**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. We were unable to see evidence of comprehensive, written induction plans or records in personnel files for all members of 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 immediately following our inspection however, this has 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.

**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 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**

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.

# Are services effective?

## (for example, treatment is effective)

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. Fees were recorded on the patient consent form which they were required to sign during consultation.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care. However, the practice did not offer a pre-consultation process to ensure fees were explained and that patients had a 'cooling off' period before committing to the required fee, attending for an appointment or commencing treatment. We saw examples of complaints which suggested that fees were not explained to them prior to consultation or services being delivered and that patients were being misled regarding fees.
- 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.
- 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 suitable for disabled persons or those with prams and pushchairs. The practice was located on the ground floor of a converted terraced house Patient toilet facilities were available on the ground floor, the practice did not have a designated disabled toilet.
- The reception desk was a small desk situated in the corner of the waiting room and was not suitable for patients in wheelchairs.
- Translation services were not available for patients or staff.
- There was a practice leaflet which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also the treatment options and services available. Information was also available on the practice website.

**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. 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.
- The practice manager was the designated responsible person who handled all complaints in the practice however, at the time of our inspection there was a trainee practice manager in place who had began employment approximately one month prior to our inspection.
- The practice held records of all complaints received.
- There was information on how to complain in the patient waiting area on the practice website.

We looked at four complaints received within the last 12 months. We found that most of these complaints were satisfactorily handled and dealt with in a timely way however, one complaint we looked at was in relation to the dental treatment provided by a dentist. The provider gave an apology to the patient but informed the patient to write to the Dentists address in Poland with their complaint as the provider had dismissed this Dentist. We saw evidence of a written acknowledgement sent to the patient following other complaints we looked at which included full details of investigations carried out and an apology given where necessary. The practice had not identified trends as a result of complaints received for example, three of the complaints we looked at were in relation to poor care and treatment from the dental team. Another complaint suggested that patients were being misled regarding fees and that the provider was dishonest and unethical.

# Are services responsive to people's needs?

## (for example, to feedback?)

We found that a number of these complaints merited further investigation as a significant event in order to promote shared learning and prevent reoccurrence. The practice had not investigated any of these issues as significant events.

# 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.
- Following our inspection, the Commission carried out a referral of a dentist to the GDC following concerns relating to concerns found during our inspection in relation to the recording of patient care records.
- 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 however, we did observe that some members of staff had singed that they had read and understood a health and safety policy. 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, not all policies were dated. 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 environmental audits had been carried out in relation to infection control for all areas of the practice or other health and safety risk assessments in relation to the premises with the exception of those relating to COSHH 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. However, we were informed during our inspection that the trainee manager had recently submitted an application to the Commission to be the registered manager for this location. 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 has been shared following concerns raised during previous inspections of other Polmedics Ltd locations. For example, the Commission had inspected another four 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.

# Are services well-led?

**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 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.

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

The practice had gathered feedback from patients through surveys and complaints received. We saw evidence of a patient feedback form which encouraged patients to give feedback about the service they had received which included their views on the ease of booking an appointment, level of satisfaction by the practice, how clearly treatment choices were explained to them and customer service and an opportunity to give any other feedback. The practice had not collated these results and there was no evidence that the practice had considered or acted upon any feedback received from patients. The practice had not identified trends from complaints received for example, numerous complaints received were in relation to either care and treatment delivered to patients or the explanation of fees for services provided.

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

# 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<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment<br><br>**How the regulation was not being met:**<br><br>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:<br><br>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.<br><br>There was a lack of systems and processes in place in relation to emergency medicines and equipment.<br><br>The practice did not ensure arrangements to safeguard children and vulnerable adults from abuse reflected relevant legislation and local requirements. Not all clinicians had completed upto date safeguarding training.<br><br>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.<br><br>The practice did not ensure a system of clinical supervision/mentorship for all clinical staff including trainee dental nurses.<br><br>The practice did not ensure patient care records were factually accurate, legible and represented the actual care and treatment of patients.<br><br>The practice had not ensured the safe storage of paper patient care records. |

This section is primarily information for the provider

# Requirement notices

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 those who had direct contact with patients had a DBS check in place upon commencement of employment. The practice had not ensured that Doctors who carried out medical consultations with adults and children were on either a specialist or GP register.

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

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

## Regulated activity

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

## Regulation

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

# Requirement notices

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 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.