Allpro Limited

Polska Przychodnia

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 06 December 2017 to ask the service the following key questions; are services safe, effective, caring, responsive and well-led? We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

This was a joint dental and medical inspection of an independent healthcare service.

Our findings were:

Are services safe?

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

Are services effective?

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

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 not 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. We have told the provider to take action (see full details of this action in the enforcement actions at the end of the 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 service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Polska Przychodnia is registered with the Care Quality Commission (CQC) as an independent provider of dental and medical services for children and adults and is located in Eccles, Greater Manchester. Patients are primarily Polish people with English as a second language who live in the United Kingdom and the service is accessed through pre-booked appointments.

Summary of findings

The clinic is registered with the CQC to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury
- Maternity and midwifery services
- Family Planning

The service mostly employs doctors, dentists and dental nurses on a sessional basis. However a physiotherapist also runs a clinic approximately once a month.

A full range of dental care including extractions is provided by the service.

The medical services includes:

- gynaecology;
- internal medicine defined as, dealing with the prevention, diagnosis, and treatment of adult diseases
- treatment for ear, nose and throat conditions;
- orthopaedics;
- Psychiatry and
- Diagnostic tests.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner. At Polska Przychodnia the private physiotherapy sessions provided are exempt by law from CQC regulations.

The medical health care team consists of:

- Four doctors: - an internal medical specialist, a gynaecologist, an ear, nose and throat (ENT) doctor and a psychiatrist.
- Five dentists.
- Four dental nurses (one is a trainee and another is a locum).
- All the doctors and dentists are registered with either the General Medical Council (GMC) or the General Dental Council (GDC).
- The doctors and dentists are supported by the registered manager who was also trained as a phlebotomist, a full-time receptionist and a full time administrator.

The Nominated Individual for the service is also the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received feedback about the service from six patients. All comments were positive and indicated the service was accessible; patients had confidence in the doctors and dentists and felt involved in planning their care and treatment. They told us the staff were caring and the clinic was always clean.

Our key findings were:

- Child protection and paediatric services were not provided in line with best practice guidance.
- There was no clinical governance oversight of the medical or dental services provided.
- The consulting rooms were clean and tidy. However cleanliness and infection control audits were not completed.
- Meetings to discuss patient outcomes did not take place and the doctors employed by the service did not meet with the registered manager to discuss the quality and development of the service.
- Patients' records were poorly written and did not provide sufficient detail about treatment and care provided.
- Processes for reporting incidents were not in place and systems for dealing with safety alerts were not reliable.
- Medicines for dealing with medical emergencies were not in place and vaccines were not correctly stored.
- Antibiotic prescribing and monitoring was not based on national guidance.
- A whistleblowing policy was in place.
- The provider could not demonstrate a clear understanding of responsibilities under the Duty of Candour regulation.
- Information about the range of services and fees was available.
- Systems were in place to inform patients about blood and other test results.
- Quality assurance was not embedded within the culture of the service.

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

- Ensure systems and processes are in place to provide safe care and treatment.

Summary of findings

- Ensure systems and processes are in place to safeguard service users from abuse and improper treatment.
- Ensure systems and processes are in place provide effective and good governance for the service.
- Ensure systems and processes are in place make sure suitably qualified, competent, skilled and experienced persons are continually employed by the service.

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 accessibility of key policies and procedures in relation to the main language read and spoken by staff.

Review the system for signposting patients to alternative services when the clinic is closed.

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. We have told the provider to take action (see full details of this action in the Enforcement Notices at the end of this report).

- Medicines needed to deal with a medical or dental emergency were not provided.
- Staff had not received basic life support training.
- All medicines, except vaccines, were provided from pharmacies local to the clinic or the patient, however the provider did not have a prescribing protocol in place. Antibiotics and other medicines were not always prescribed in line with best practice guidance.
- Vaccines were stored in a domestic refrigerator which is not in keeping with vaccination storage requirements.
- The provider did not routinely carry out checks to verify a patient's identity.
- The provider did not take steps to assure themselves that adults accompanying children had parental authority.
- The provider did not have a system in place to identify children at risk or vulnerable adults.
- The provider had not ensured appropriate health assessments were always completed or that patients care and treatment, including prescribed medicine, was always based on up-to-date best practice guidance.
- Medical records did not conform to the 'Records Management Code of Practice for Health and Social Care 2016'.
- A chaperone policy was not in place and staff who acted as a chaperone had not completed training to enable them to carry out the role safely and effectively.
- An incident reporting policy was not in place.
- Systems to ensure clean, well maintained and safe to use premises and equipment were not in place. Personal protective equipment (PPE) was not readily available for decontamination procedures.
- The provider had not ensured risks associated with fire or sharp instruments were managed appropriately.
- The provider had not ensured medical and dental equipment was fit for purpose because this equipment was not cleaned, maintained or calibrated in line with the manufacturer's instructions.
- Digital dental X-rays were not stored securely and these contained patient names and date of birth.

Are services effective?

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

- There was no evidence that staff were aware of current evidence based guidance in relation to medical practice. The provider stated clinical audit and quality improvement activity were not formalised and recorded.
- The dentists, however, did assess patients' needs and provided care and treatment in line with recognised dentistry guidance.
- The provider did not have any systems in place for monitoring the outcomes of care and treatment provided at the clinic.
- Recruitment and induction processes did not include seeking assurance that medical staff were fully competent to carry out the work they did at the clinic.
- The induction programme did not familiarise staff with where all equipment was stored.
- Employment records held at the service did not demonstrate that all the required pre- employment checks had been undertaken.
- We did not see evidence that the provider supported staff in their continuing professional development.

Summary of findings

- Systems were in place to inform patients of laboratory test results but this did not include informing the patient's NHS GP.
- There were no formal links with specialist NHS services such as mental health or learning disability services.

Are services caring?

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

- Patient feedback was positive and staff we spoke with were caring and knew how to be kind to patients.
- Privacy screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

A private room was available if patients appeared distressed or wanted to discuss sensitive issues.

Are services responsive to people's needs?

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

- Information about the services and how to complain was not readily available and verbal complaints were not recorded.
- Information was provided on line about procedures available at the clinic.
- Health promotion leaflets were not available at the clinic.
- Information sheets about the cost of each treatment and consultation was provided in Polish.
- The registered manager was accessible during opening times.
- All staff spoke Polish and English.
- The time allocated for patient consultations was flexible.

Are services well-led?

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

- There was an open culture and the registered manager was visible to staff.
- The registered manager held responsibility for all aspects of service delivery. Lead roles such as infection prevention and safeguarding had not been delegated to staff and the manager had not completed additional training to fully understand the expectations related to dealing with these matters.
- There was no continuous clinical audit or quality improvement activity.
- Formal team meetings were not held and there were no systems for clinical governance.
- There was no formal route of sharing information with doctors who worked for the service.
- There was no clinical leadership in place to drive quality improvement or ensure adherence to relevant best practice guidance.
- There was no evidence of local clinical supervision, mentorship, peer review or support for the doctors.
- There was no overarching risk assessment for identifying, recording and managing the risks and issues associated with running the business.
- A business continuity plan was not in place.
- There was a broad range of policies and procedures, however these were not bespoke to the location and there was no evidence that these had been shared with staff.
- Patient medical records were stored securely, however the area was not fireproof.
- Patient feedback was not actively sought and reviewed.

Polska Przychodnia

Detailed findings

Background to this inspection

We carried out an announced inspection on 06 December 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by a CQC Lead Inspector and included one dental inspector, a second CQC inspector, a CQC specialist GP advisor, a dental specialist advisor and a Polish-language interpreter.

During our inspection we spoke with the registered manager, two doctors, a dentist, one dental nurse and the receptionist. We received feedback from six patients. We reviewed personnel files, practice policies and procedures and other records concerned with running the service. We reviewed the full medical records available for 22 patients and reviewed doctors' letters for an additional five patients.

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

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

Safety systems and processes

The systems in place did not fully protect against abuse and arrangements for safeguarding did not fully reflect relevant legislation.

- A safeguarding lead was not formally identified and no processes were in place to share safeguarding concerns between clinicians.
- The registered manager and administration staff had not completed any level of safeguarding training and the registered manager had not assured themselves that visiting clinicians had completed level three adult safeguarding and child protection training in keeping with best practice guidance. Following the inspection visit, the registered manager reviewed the safeguarding policy, provided on-line safeguarding level one and two training for reception staff and completed level three training themselves. The provider also sent certificates to confirm the doctors had completed level three safeguarding and child protection. The provider also confirmed that a system of periodical checks had been put in place.
- A safeguarding policy was in place and included up to date information about PREVENT (the initiative for recognising and taking steps to deal with political or religious extremism) and protecting against female genital mutilation (FGM). Staff however did not know how to access the information, for example the policy was only held electronically but a member of staff thought it was in a folder behind the reception desk.
- We saw that an individual doctor had alerted the appropriate authorities when safeguarding concerns were raised. However the provider did not have processes in place to check the outcome of the referral or share this information with other doctors who worked at the service.
- A safeguarding vulnerable adults and child protection information flowchart was on display in the waiting area of the clinic. This included the contact details of the local adult and child protection units. This information was written in English, however the staff spoke English as a second language and a Polish version was not available.
- There was no chaperone policy and patients were not routinely offered a chaperone. Staff who would act as a chaperone if requested had not completed chaperone training.
- The policies and procedures in place did not include a lone working policy.
- The practice had a whistleblowing policy but this did not inform staff about which external organisations they could go to.
- None of the four staff recruitment files we viewed held evidence that Disclosure and Barring Service (DBS) checks had been completed. The registered manager could not provide assurance during the inspection that all the required employment checks and pre-employment vetting had been completed. This was discussed at the time of the inspection and information such as confirmation of DBS checks was provided after the inspection visit. The immunisation status of doctors and dentists was not recorded.
- The premises looked clean and tidy however a cleaning schedule was not in place for the different areas and rooms. Cleaning audits were not completed and staff in day to day control of the service had not completed infection prevention control training. The registered manager told us that a cleaning company was employed to carry out the general cleaning duties. This company did not, however, provide and store cleaning equipment in keeping with best practice. We observed that wet mops were stored in buckets with the head down, mops were not colour coded to make sure the same mop was always used for specific areas and cleaning equipment and fluids were not stored in a locked cupboard.
- Clinical waste and sharps bins were appropriately stored and collected by a specialist clinical waste company. We noted that sharps bins were not marked with the assembly and expiry date. This was discussed with the provider during the inspection.
- There was no hand washing facilities available in the physiotherapy room.
- A fire risk assessment had been completed in September 2013. We noted action had been taken to address issues identified and the fire service deemed the location safe at a follow up assessment in February 2014. On the day of inspection we noted the rear fire exit was locked with three bolts. There was also a fire extinguisher on the bottom step of a flight of stairs

which was not attached to the wall. There was no evidence of any regular testing of the fire detection system, emergency lighting or fire-fighting equipment. There was no evidence that any fire drills had been carried out.

- There was no sharps risk assessment. Staff told us the dental nurse was responsible for dismantling sharps and there were no needle re-sheathing devices available.
- We were told the dentist did not routinely use a rubber dam when providing root canal treatment. No other form of fixing root canal instruments was use.
- Control of Substances Hazardous to Health Regulations (COSHH) risk assessments had been completed but these did not provide enough information about the risk.
- The provider gave us access to the policies and procedures available to staff for the service however none, including the infection prevention and control policy, related specifically to the location.
- The provider had not ensured that equipment or medical machines were cleaned, calibrated and serviced in keeping with the manufacturer's instructions. Certificates for fixed electrical wiring checks were not available and information on the appliances was not accurate. For example the sticker on the baby weigh scale indicated it was tested in '2016' and due to be tested '2016'.
- Servicing documentation for the autoclave and compressor was not available on the day of inspection. We asked the registered manager to provide these. We have not received any evidence of servicing.
- We were told the X-ray machine in the surgery was new. We asked to be sent evidence of the installation check for this machine as it was not available on the day. This has not been provided.
- A Legionella risk assessment had not been completed. We saw a Legionella policy and procedure was available but this was not specific to the location. There was no evidence of monthly water temperature testing. A Legionella water sample had been taken in October 2017 which showed no Legionella was developing. The dental nurse described to us how they flushed the dental unit water lines to reduce the likelihood of Legionella developing.

Risks to patients

- The clinic did not have adequate arrangements in place to respond to medical emergencies and specific guidance about what to do in a medical emergency was not in place.
- None of the staff had completed first aid or basic life support training; and the registered manager had not assured themselves that all clinical staff working with children had completed paediatric life support training.
- A first aid kit was available and defibrillator was in place.
- Emergency medicines were not available. Oxygen with adult and children masks was in place, however the masks and tubing were out of date and there was no evidence that the oxygen tank was fit for purpose because it was not dated and no checks had been recorded to confirm it contained oxygen. These matters were discussed with the registered provider and emergency medicines were ordered during the inspection.
- Appropriate medical indemnity certificates were seen.
- The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing dental instruments in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). Records from the autoclave showed satisfactory completion of each sterilisation cycle.

Information to deliver safe care and treatment

- There was no system in place to verify the identification of patients (adult or children) and the provider did not take steps to assure themselves that adults accompanying a child had parental authority. The provider did not check whether a child was on a risk register. There were no systems in place for shared care with statutory services in keeping with child protection best practice. Following the inspection the provider put in place systems for verifying the identity of adult patients and agreed to signpost all patients under 18 years to NHS GPs or other NHS services until their child protection protocols met best practice.
- The medical patient records did not contain a detailed medical history and doctors did not take action in relation to patients who gave permission to liaise with their NHS GP before or after a consultation to make sure care was based on up to date information.

Are services safe?

- Paper records were held in a locked cupboard; however this was not fire proof. The practice had a digital X-ray system. These were saved on a laptop computer in the surgery. This computer was not password protected but held personal information such as the name, address and date of birth of patients.

Safe and appropriate use of medicines

We checked the arrangements for the management of medicines at the clinic.

- Vaccines were stored in an ordinary domestic fridge. This is not in keeping with national requirements for vaccine storage because the temperature could not be monitored. The registered manager destroyed the vaccines that were held and ordered a medicine fridge on the day of the inspection.
- The clinic did not have a prescribing protocol and doctors did not use national antibiotic prescribing protocols, for example we saw that antibiotics were used as first line treatment and a risk assessment or rational for their use was not documented. The registered managers told us medicine audits to monitor the quality of prescribing were not completed.
- The clinic issued private prescriptions, these were stored securely however, these were not monitored for use.

Track record on safety

- The registered manager stated there had been no incidents reported in the service since registration in August 2016.
- There was a clinical incident reporting policy which stated staff must report incidents, however this was not supported by service specific guidance and reporting protocols related to Polska Przychodnia. The provider and staff did not understand the range of events that could constitute an incident.

Lessons learned and improvements made

- The provider was not aware of the requirements of the Duty of Candour regulations; however, they explained they would contact the patient if a serious incident came to light.
- Systems for dealing with feedback from stakeholders such as pharmacists or patients were informal and a review process so that trends and areas for improvement could be identified was not in place.
- A system was in place to receive national patient safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). However a formal system of sharing the information and checking that instructions had been followed was not in place.
- Processes were not in place to identify patients who may have received care which needed to be reviewed in response to safety alerts. The types of treatment provided were not audited.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

- The medical service was unable to provide evidence of assessing needs and delivering care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) best practice guidelines for care and treatment provided. Records made about patient consultations did not include an up to date medical history or information about the guidance provided to the patient.
- We reviewed the medical records and consultation notes for 19 children and none of the information documented confirmed that they had been examined or treated in accordance with best practice guidance. For example, we saw that prescriptions were not based on weight for very young small children and specific care pathways were not followed in relation to febrile children. In response to these findings the provider agreed to signpost children aged 0-18 to NHS GP or out of hours services until improvements were made and verified.
- Arrangements were not in place to refer patients who required additional support if they were experiencing poor mental health. There was inconsistent evidence regarding advice offered, monitoring arrangements and follow-up arrangements for all patients.
- The dentist assessed patients' treatment needs in line with recognised guidance.
- The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this was an appropriate treatment plan.
- The dentist told us they discussed smoking, alcohol consumption and diet with patients during appointments.

Monitoring care and treatment

- The registered provider did not collect and monitor information on the outcomes of care and treatment provided by the service.
- There were no clinical audits or clinical quality improvement activity in relation to the medical or dental sides of the operation.
- The provider had not ensured that a clinician took responsibility for medical oversight of the service and the decisions made by doctors were not discussed or reviewed.

Effective staffing

- Revalidation for medical staff was not effectively managed because the provider did not seek assurance that doctors were competent to work with specific patient groups at the clinic. Following the inspection the provider put systems in place to liaise with responsible officers and review the skills of doctors in relation to the patient groups they treated.
- There was no formal induction provided to agency staff. Staff were shown around the surgery however there was no evidence that specific topics were covered such as where equipment was stored, fire safety, safeguarding, confidentiality or infection prevention and control. This meant the correct equipment was not always used. For example agency staff did not know where find thick rubber gloves used to prevent sharps injuries when cleaning instruments. We were told by the registered manager that agency staff knew to request items they needed. However we observed that staff did not always make a request.
- Mandatory training programmes were not in place, the registered manager did not provide formal appraisal to staff and had not assured themselves that visiting doctors were competent in the scope of practice they undertook at the clinic.

Coordinating patient care and information sharing

- Patients completed a medical history form that included patient consent to share information with the patients' registered GP. Records showed that information was not routinely shared and this was confirmed by the registered manager. This was not in accordance with General Medical Council (GMC) guidance on sharing information.
- Arrangements for receiving laboratory tests results were effective. A service level agreement was in place with a laboratory. Specimens were collected daily and a 24 hour turnaround for results was expected. Results were reviewed by the doctor and given directly to the patient. The results were not, however, routinely shared with the patient's NHS GP.

Supporting patients to live healthier lives

Are services effective?

(for example, treatment is effective)

- The service did not identify patients who needed support and consultation records did not indicate that advice on healthy living was given.

Consent to care and treatment

- Consent to care and treatment was sought. We saw evidence that consent could be verbal or written. The consent policy was generalised and not specific to the service. However information was based on best practice in relation to the Mental Capacity Act and Gillick competency in relation to children and young people.
- We saw that treatment fees were explained to the patient prior to the procedure and the schedule of fees was available in Polish in the waiting room.

Are services caring?

Our findings

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

Kindness, respect and compassion

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- All staff spoke English and Polish.
- We noted that staff treated patients respectfully, appropriately and with kindness.
- Patients had access to information about the clinicians working for the service and could book a consultation with a doctor or dentist of their choice.
- We received feedback from six patients and all were positive about the service. Social media feedback was also positive in respect of kindness and compassion.

Involvement in decisions about care and treatment

- Health promotion information was available in Polish on the company's website.
- The website also included details of the doctors and dentists available and the scope of services offered.
- Patients were also able to access information on a social media site; however were no health promotion information leaflets at the clinic.

Privacy and Dignity

- Consulting rooms were private to maintain patients' privacy and dignity during examinations, investigations and treatments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- The provider did not collect information about ethnicity; however anyone could access the service.
- Baby changing facilities were available and there were play tables for children in the reception area. However the safety of this area needed to be risk assessed.
- Staff told us that the majority of patients attending the clinic were either Polish or English speaking. We were told translation services were not necessary as staff spoke both Polish and English.
- There were no patient information leaflets about healthy living or describing the benefits or risks of the services provided. However this information was available on the services website.
- Information about dealing with complaints or requesting a chaperone was not readily available.

Timely access to the service

- Clinic opening hours were displayed at the premises.
- Services were pre-bookable and available Monday to Saturday. Doctors and dental appointments were available at different times. There were no time limits to the length of consultations.
- Urgent medical appointments were not provided however this was not made clear to patients and a system to provide automatic signposting was not in place.

Listening and learning from concerns and complaints

- There was no formal system for dealing with complaints.
- Complaints were dealt with by the registered manager as they arose and were not documented. A record of action taken to resolve concerns was not kept. The registered manager could not demonstrate any learning or changes made in the service as a result of complaints.

Are services well-led?

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

Our findings

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

Leadership capacity and capability

- The registered manager was the nominated individual and responsible for the day to day running of the service. The registered manager appeared open to new ideas and staff told us there was a positive culture. Staff said they enjoyed working at the service and the manager listened to their opinions and was approachable.
- Staff generally approached the registered manager for advice; however, there were no arrangements in place if the registered manager was unavailable.
- Formal systems were not in place to ensure continual learning and professional development and staff employed were not provided with the processes and guidance to carry out their responsibilities.

Vision and strategy

- The registered manager stated the vision of the service was to provide the best possible clinical care to the Polish community. However there were no formal systems in place to benchmark and check the quality of the service or assess patient satisfaction.
- There were no formal meetings to discuss the vision and strategy of the clinic. The doctors who worked for the service were not involved in the informal meetings which we were told took place.

Culture

- The provider did not have a separate Duty of Candour policy and this topic was not included in any other policy such as the complaints policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. However the registered manager and staff stated any incident would be discussed openly and support given to the patient concerned.
- Staff described an open culture and felt confident about reporting any issues to the registered manager or the senior dentist. However this was not underpinned by clear policies and processes which could be checked and monitored for effectiveness.

Governance arrangements

- Appropriate arrangements for identifying, recording and managing non clinical risks, were not place.
- Policies and procedures were mostly generic and did not relate specifically to the service. During the inspection we noted that staff did not know how to access policies and procedures.
- A clinical incident policy which related to the service was not in place and no significant events had been reported since the service opened in 2016. There were no formal processes in place to report, record or learn from incidents or significant events.
- Team meetings were not held. Meetings with doctors did not take place. There were no clinical governance arrangements in place. There was no formal process of sharing information with doctors or staff.
- A quality improvement programme or continuous clinical and internal audit process was not in place. Monitoring systems to drive improvements were not in place. There were no audits to improve the quality of prescribing, X-rays, infection prevention and control, or to check outcomes for patients.

Managing risks, issues and performance

- An organisational risk assessment had not been developed.
- A business continuity plan was not in place though staff understood that they could contact the registered manager in most eventualities. Staff were not provided with any contingency plan if the registered manager was not available.
- The doctors provided a wide variety of services on a sessional basis and there was no formal clinical leadership or oversight of the activities they undertook. We saw no evidence that clinical leadership was provided or external expertise sought to drive quality improvement.

Appropriate and accurate information

- Patients' medical records were held electronically and also handwritten. Patients' medical records were stored in a cupboard however the area was not fire retardant.

Are services well-led?

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

The practice had a digital X-ray system. These were saved on a laptop computer in the surgery. This computer was not password protected and there were patient's names and date of birth stored with the X-rays. This was discussed with the registered manager.

- Medical records were not audited and checked to make sure the information provided met best practice guidance and standards. We reviewed 22 medical records and important information was missing in all 22 records. Missing information included baseline clinical observations and the patient's previous medical history. There was no system of clinical peer review of records; cases were not discussed and considered in respect of possible improvements in care and treatment.

Engagement with patients, the public, staff and external partners

- The was no system in place to periodically engage with patients, the public, staff and external partners in order to seek their opinions on what the service did well and how the service could be improved.

Continuous improvement and innovation

- The provider identified the engagement with regulatory bodies was an important component in improving the standard of the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.** **Why you are failing to comply with this regulation**: 1. We found that none of the medical records reviewed included a detailed medical history on which to base additional treatment. 2. We found that none of the records reviewed contained sufficient information to confirm that care and treatment at the clinic was in accordance with best practice at all times. We found evidence of treatment contrary to practice (for example treatment first line treatment for conjunctivitis). 3. We found that none of the records reviewed indicated that the service communicated with the patient's NHS GP, in accordance with best practice. We saw that a staff member recorded the patients GP would be consulted but there was no evidence of contact. 4. We found that the service did not routinely update the patient's NHS GP about the patient's test results. 5. Medicines were not always prescribed in accordance British National Formula guidance. For example the medicine doses for children were not based on age or weight when appropriate. 6. You failed to ensure that medicines were managed safely. We found that doctors did not use a prescribing protocol for antibiotics. For example antibiotics were prescribed as first line treatment for conjunctivitis. 7. We found that information about medicines prescribed by doctors privately was not routinely shared with the patient's NHS GP so that effective continuity of care was promoted.

This section is primarily information for the provider

Enforcement actions

8. You did not ensure that vaccines were stored safely. We found that vaccines were stored in an ordinary domestic fridge this was not in keeping with national best practice requirements.
9. You did not provide medicines required for medical and dental emergencies in keeping with best practice guidance and emergency equipment such as masks and airways was not within the use by date.
10. We found that environmental risk assessments had not been completed and that regular fire equipment safety checks had not been undertaken. We found that one of the fire exits was bolted shut.
11. We found that staff had not completed fire safety training and that no fire drills had been recorded.
12. You did not ensure that equipment such as x-ray machines and ultrasound scans were kept in good working order and fit for purpose. We found that you had not taken steps to have equipment checked and calibrated in accordance with the manufacturer's recommendation. For example, the GE Vivid 3 ultrasound scan should have been wiped down with antistatic wipes weekly and the filters cleaned weekly. This had not been done since the equipment was purchased. This meant the provider could not guarantee that diagnostic readings were accurate.
13. You did not ensure that appropriate risk assessments were completed in full. For example control of substances hazardous to health (COSHH) risk assessments were not completed for all substances.
14. You did had not ensure that a legionella risk assessment and plan was in place
15. We could find no evidence of a formal cleaning schedule for the premises. We found that cleaning audits were not completed to ensure all areas were clean and safe to use. We found that cleaning material was not stored in keeping with best practice. For example, we observed that cleaning mops were stored wet and head down in buckets and mops were not colour coded to ensure that they were used to clean specific areas.

For the above reasons you are failing to provide care and treatment in a safe way for service users.

This section is primarily information for the provider

Enforcement actions

You are required to become compliant with Regulation 12, section (1) (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 11 April 2018.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service was failing to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. **Why you are failing to comply with this regulation:** 1. We found that the registered manager and other frontline staff such as the receptionist had not completed training on safeguarding vulnerable adults or child protection. 2. We could find no evidence that independent doctors had received appropriate levels of training on safeguarding adults and children. 3. We found that staff did not know where to find the service's safeguarding policy. For example staff stated the policy was in a folder behind the reception area, we checked and this was not the case. 4. We found that there were no formal processes in place to confirm that adults accompanying child patients had parental responsibility. This was confirmed by staff. 5. We found that there was no system in place to check whether a child patient was on a child protection register. 6. We could find no evidence of follow-up for safeguarding referrals. For the above reasons, you are failing to have effective systems in place to prevent abuse of service users. **You are required to become compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 11 April 2018.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

Why you were failing to comply with this regulation:

1. You did not have systems in place to enable you to assess, monitor and improve the quality and safety of the service being provided.
2. Policies and procedures to set standards and guidance about how to complete tasks was not specific to the location and were not shared with staff. For example the infection control policy did not provide instructions about how to clean different rooms or surfaces.
3. You did not provide all of the policies required. For example, we could find no evidence of a duty of candour policy at the practice.
4. We could find no evidence of any internal audits or checks for processes.
5. We noted that there was no clinical oversight to review the treatment provided by doctors working at the practice. We noted that clinical audits to look at the effectiveness of care and treatment provided were not undertaken.
6. We noted that information was not gathered to review complaints, incidents, medication prescribing, type of treatment given and outcomes for patients.
7. You did not put systems in place to ensure paper records were complete and in good condition. We noted that none of the 22 hand written records reviewed were legible.
8. You did not ensure that electronic records were securely stored. For example, the laptop computer in the dental surgery was not password protected. We noted that this computer held personal information about patients at the practice, including names, dates of birth and x-ray results.
9. The registered manager did not ensure that safety checks were effective. For example; we were told that the oxygen cylinders were checked. However, we noted that date stickers were not placed on the oxygen tanks and that no visual checks had been

This section is primarily information for the provider

Enforcement actions

recorded by staff. We were also told that emergency equipment was checked. However, we noted that adult and paediatric oxygen masks and tubing were out of date.

10. We did not receive any assurance that risks associated with providing the regulated activities had been sufficiently planned for and mitigated. Examples of failure to mitigate risks included: a legionella risk assessment had been completed but a legionella risk mitigation plan had not been developed and fire safety checks were incomplete because emergency lighting was not checked and there was no process to ensure the fire escape door was unbolted when the building was occupied.
11. We noted that there were no formal and effective systems for communicating or sharing learning from patient safety alerts, significant events, or complaints.
12. We could find no evidence of any formalised meetings to discuss areas of risk or improvements for the service.
13. We could find no evidence that the registered provider held regular meetings with staff or the doctors and we could find no evidence of formal communication between any staff or doctors who worked at the service.

For the above reasons, you are failing to have effective systems in place to ensure effective governance of the service provided.

You are required to become compliant with Regulation 17 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 11 April 2018.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service was failing to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

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Enforcement actions

Why you are failing to comply with this regulation:

1. We found that you had not taken steps to ensure that the staff induction programme prepared staff members for their respective roles.
2. We found that you had not taken steps to satisfy yourself that doctors at the practice could demonstrate on-going competencies to provide care and treatment to different patient groups especially in relation to children under the age of 18 years.
3. We found that you did not ensure staff received clinical supervision or other means of supervision to ensure competency in their role.
4. We found that permanent members of staff had not completed relevant training. For example, we noted that the practice administrator acted as the first point of contact for patients, was responsible for triaging patients in relation to accepting the patient or signposting them to urgent care, and also acted as the chaperone. However, we were concerned to note that the practice administrator had not received training in these topics.
5. We found that there was no annual appraisal system, to ensure that members of staff remained appropriately skilled and experienced.

For the above reasons, you are failing to have effective systems in place to provide suitable staff to carry on the service.

You are required to become compliant with Regulation 18, section (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 11 April 2018.