Ortho-Tek Limited

Maidenhead Orthodontic Centre

Inspection report

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Overall summary

We carried out this announced inspection on 13 September 2022 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 in the Health and Social Care Act 2008 and associated regulations.

The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

• Is it safe?

• Is it effective?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Background

Maidenhead Orthodontic Centre is in Maidenhead, Berkshire, and provides NHS and private orthodontic care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

Summary of findings

The dental team includes three orthodontists, one of whom is also the practice manager, three orthodontic nurses, a receptionist, and a trainee orthodontic therapist. The practice has two treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager.

Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Maidenhead Orthodontic Centre is an orthodontist and practice director.

On the day of inspection, spoke with 3 patients, and all staff members except an orthodontist and an orthodontic nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open

- Monday to Friday from 9am to 5.30pm.

Our key findings were:

- The practice appeared to be visibly clean.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had information governance arrangements.
- The provider had staff recruitment procedures which reflected current legislation for all but one member of staff.
- Close circuit television recording (CCTV) arrangements did not suitably protect people's privacy and personal information.
- The provider had ineffective systems to help them manage risk to patients and staff.
- The provider demonstrated ineffective leadership in areas and did not demonstrate a culture of continuous improvement.
- The provider had infection control procedures, but these did not reflect published guidance in some areas.
- Appropriate medicines and life-saving equipment were available, but one had passed its expiry date.
- Staff knew how to deal with emergencies, but we were not assured that all staff were suitably trained and confident in using firefighting equipment.

We identified regulations the provider was not complying with. Full details of the regulations the provider is not meeting are at the end of this report.

There were areas where the provider could make improvements.
They should:

Summary of findings

- Implement a system to ensure non-electronic patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.
- Implement practice protocols and procedures to ensure staff are up to date with training in relation to sepsis awareness.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** ✓
Are services effective?	**No action** ✓
Are services well-led?	**Requirements notice** ✗

Are services safe?

Our findings

We found this practice was providing safe care in accordance with the relevant regulations.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. However, they did not follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care in all areas. We observed the following:

- Autoclave test cycles were not correctly validated. Staff used a vacuum cycle on their autoclave at the end of the day; they used a self-devised system of a Time Steam and Temperature (TST) strip placed in a sealed pouch which is not effective or appropriate for validating vacuum autoclave cycles. This self-devised system was used instead of a Helix test; Helix tests are designed to check the ability of an autoclave to sterilise hollow objects.
- There was no running water supply to the handwashing sink in the decontamination room. Staff who had completed manual disinfection of contaminated instruments in the decontamination room washed their hands in the same sink they had used to scrub the instruments. Shortly after the inspection, the registered manager informed us that the water supply to the tap had been reconnected and sent us evidence of this via a photograph. We asked why the water had been disconnected and how long it had been disconnected for, but we did not receive a response.
- We observed staff re-using a single-use item (plastic dappens pots used to hold materials). The manufacturer's instruction's packaging for this item clearly stated it is single use only.
- One out of two staff did not wear eye protection while scrubbing contaminated instruments, and both members of staff used the light from the illuminated magnifier but not the magnifier itself to check whether they had cleaned the instruments effectively.
- The most recent infection control audit was two months overdue and was not appropriately completed or practice specific. The audit had been completed by the practice's infection control lead. For example, sections regarding sedation were answered 'yes' but the practice did not provide sedation, and ticks were entered in some sections that requested entry of a number. This audit and the one completed eight months prior found that the practice was meeting the required standards; neither had identified the issues we highlighted during the inspection.
- There were no suitable processes in place for the disinfection of dental appliances. Incoming patient-specific dental appliances from dental laboratories, such as orthodontic retainers, were disinfected in same solution as contaminated mouth mirrors and radiograph scanner heads before being given to patients to take home.
- Some equipment required replacing; chairs in the waiting room were fabric-covered and some were visibly soiled; pedals for a waste disposal bin in the toilet and a clinical waste disposal bin in the decontamination room were not functioning. The registered manager showed us an invoice to show that they had placed for an order for new waste disposal bins a few days before the inspection.

The practice was visibly clean, with the exception of visibly soiled chairs in the waiting area. However, there was limited and inconsistent evidence of cleaning schedules for the cleaner who we were informed attended either daily or every

Are services safe?

other day. The most recent schedule which included a daily log had been completed the day before the inspection. Previous logs were evidenced for week beginning 08 September 2022 but there was no daily log on the schedule to indicate the days on which the cleaner attended – the provider said the schedule had been signed off for the whole week. Another cleaning schedule was evidenced for the month of July 2022, but again there was no indication on this log of which days the cleaner attended to complete cleaning tasks.

Staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting and using instruments, and they had suitable numbers of dental instruments available for the clinical staff.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Recommendations in the assessment had been actioned and records of water testing and dental unit water line management were maintained.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The provider had a whistleblowing policy. Staff we spoke with felt confident they could raise concerns without fear of recrimination.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. We checked recruitment records for six staff and found the provider's recruitment procedure reflected the relevant legislation for all but one member of staff whose evidence of suitable employment history and professional qualification could not be located.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

The provider had arrangements to ensure that some equipment was safe and maintained according to the manufacturers' instructions and current guidance, but this had lapsed in some areas as follows:

- At the time of this inspection there was no evidence of an Electrical Installation Condition Report (EICR) since 2013; this inspection should normally be completed every five years. The registered manager sent us evidence shortly after the inspection to demonstrate that this check was completed a few days before the inspection.
- There was no evidence of servicing of air conditioning unit; the registered manager did not demonstrate clear understanding as to whether or not it required servicing.
- There was no evidence of servicing of emergency lighting installed in 2013, and staff did not complete in-house tests.
- There was no evidence of fire evacuation drills. A member of staff told the inspector they had had two fire drills in the last one and a half years, but the registered manager was adamant they had not carried out any fire drills since they had owned the practice.

At the time of this inspection there was no functioning fire detection system. The registered manager informed us that the practice's other director had assessed that the fire alarm and smoke alarms were not required, despite their 2017 risk assessment (completed by a competent external person) advising regular monitoring and testing of this system. During this inspection, the registered manager purchased two battery-operated smoke alarms. The registered manager sent me evidence via a video shortly after this inspection to demonstrate that the fire detection system had been reconnected after the inspection.

Some staff we spoke with said they did not feel confident on the use of fire extinguishers– the same staff had not received fire safety training.

Are services safe?

Some fire actions had not been implemented from the practice's 2017 fire risk assessment such as implementation of a Personal Emergency Evacuation Procedure (PEEP) and regular monitoring of the fire alarm and weekly testing of the smoke alarm. The provider had completed an in-house fire risk assessment in August 2022, but it had not identified the above-mentioned risks.

The registered manager could not demonstrate how to test the fire detection system. Shortly after this inspection they sent us a video of the fire alarm being tested.

- Risk associated with use of the mercury-based thermometer in the decontamination sink had not been identified by provider.

There were fire extinguishers throughout the building and fire exits were kept clear.

The practice had arrangements to ensure the safety of the radiography equipment. The required radiation protection information was available.

We saw evidence that the orthodontists justified, graded and reported on the radiographs they took. The provider showed us evidence of their last radiography audit which had been completed in 2019. There was evidence of a quality assurance assessment completed in February 2022, but there was no evidence of annual radiograph audits completed since 2019; this was not in line with current guidance which recommends completion of these audits annually.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had not implemented suitable systems to assess, monitor and manage risks to patient safety in relation to fire risks. They had health and safety policies, procedures and risk assessments which were reviewed regularly, but they had not identified the risks we highlighted during this inspection.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

There was no evidence of sepsis training for any staff. However, all of the clinical staff we spoke with had knowledge of the recognition, diagnosis and early management of sepsis.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support, with arrangements to update this training every year.

Emergency equipment and medicines were available as described in recognised guidance.

Staff kept records of their checks of the emergency equipment and medicines to make sure they were available, within their expiry date, and in working order, but these were carried out monthly which was not in line with current guidance recommending a minimum of weekly checks.

A medicine used to treat low blood sugar, oral glucose, had passed its expiry date of March 2022. The registered manager showed us an invoice to demonstrate that they had placed an order for a new batch of this medicine a few days before this inspection.

An orthodontic nurse worked with the orthodontists and the trainee orthodontic therapist when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Are services safe?

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with an orthodontist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records completed by clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site, but it had not identified a medicine that had passed its expiry date. The provider's audit on emergency procedures had not picked up on this issue.

The practice informed us that they did not prescribe or dispense medicines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong.

The registered manager informed us that there had been no safety incidents in the previous 12 months but they evidenced arrangements to ensure that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again..

The practice had a system for receiving and acting on safety alerts to enable staff to learn from external safety events as well as patient and medicine safety alerts. Recent alerts were shared with staff and acted upon where required.

There were risk assessments in relation to safety issues, but some recommended actions for improvement had not been completed.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The provider had systems to keep their dental professionals up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols.

The orthodontists carried out a patient assessment in line with recognised guidance from the British Orthodontic Society. An Index of Orthodontic Treatment Need was recorded which would be used to determine whether a patient was eligible for NHS orthodontic treatment. The patient's oral hygiene was also assessed to determine if the patient was suitable for orthodontic treatment.

Helping patients to live healthier lives

Clinicians provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The clinicians, where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and told us they were able to provide written information to help patients with their oral health.

Consent to care and treatment

Clinicians obtained informed consent to care and treatment in line with legislation and guidance, and the practice team understood the importance of this. The clinicians gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions; we saw this documented in patients' records. Patients confirmed the clinicians listened to them and gave them clear information about their treatment.

The practice had policies which included information about the Mental Capacity Act 2005. The team understood their responsibilities under the Act when treating people who might not be able to make informed decisions. Clinicians we spoke with were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

The practice also had policies including guidance on Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The clinicians assessed patients' treatment needs in line with recognised guidance.

The provider had evidence of a quality assurance process, in line with a clinical dental care record audit commenced a week prior to this inspection and a radiograph audit completed in 2019, to encourage learning and continuous improvement. Although the practice recorded grading of radiographs the clinicians took, there was no evidence of completion of annual radiograph audits since 2019. Staff kept records of the results of these audits, but there were no action plans identifying any improvements.

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

The registered manager informed us that all staff new to the practice underwent a one-day induction programme. We checked staff records and found that induction records were evidenced for two out of five staff, an induction form for the fourth member of staff was not dated to indicate when it had been completed, and the induction form for the fifth member of staff was not fully complete. The registered manager was not able to explain why it was not complete.

We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The clinicians confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

The practice received referrals from other dental providers for orthodontic treatments; staff monitored these and ensured the clinicians were aware of all incoming referrals. Staff monitored outgoing online referrals through an electronic referral and tracking system to ensure they were responded to promptly. There was no system in place to monitor outgoing postal referrals.

Are services well-led?

Our findings

We found this practice 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 Notices section at the end of this report).

We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found that there was insufficient capacity and skills to ensure effective leadership in relation to the monitoring and management of risks.

The registered manager demonstrated an understanding of the challenges faced by the practice and they explained how they were addressing some of these. For example, they described ongoing plans to train an existing member of staff to undertake a practice management and compliance oversight role.

Staff told us the practice leaders were visible and approachable. Staff told us the practice leaders worked closely with them to make sure they prioritised compassionate and inclusive leadership.

Culture

The registered manager told us they had a vision to provide of patient-centred high-quality care, the provision of services in line with the needs of their patients, and continuous improvement through the views and experiences of their patients.

Staff told us they felt respected, supported and valued, and they appeared proud to work for the practice.

The registered manager told us they discussed the training needs, learning needs, general wellbeing and aims for future professional development of their staff during annual appraisals. They provided us with evidence of completed appraisals for all but one staff member who started working for the practice approximately two years prior to this inspection. Three of the appraisals were overdue.

The provider demonstrated openness, honesty and transparency were when responding to incidents and complaints. The provider had systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

The practice directors had overall responsibility for the management and clinical leadership of the practice, and they were both responsible for the day to day running of the service.

The provider had not established systems to support effective governance and management.

There appeared to be a lack of organisation in some areas, a lack of cohesive understanding of arrangements, and a lack of awareness and understanding of current guidance and legislation, as we observed that these were not followed appropriately in all areas. For example:

- The registered manager was unable to provide answers to various questions we asked during the inspection such as, for example, why the fire detection systems were not operational, how to test the fire detection system, whether some equipment required servicing, why some induction forms had not been completed, why there was no water to the handwashing sink in the decontamination room, and the location of various documents we requested.
- The registered manager told us staff washed their hands in the treatment rooms after disinfecting instruments in the decontamination room, but we observed staff washing their hands in the sink used to disinfect contaminated instruments in the decontamination room.
- The registered manager did not know how or where images from CCTV recording on the premises were stored, as this was managed by the practice's other director who was not present during this inspection.

Are services well-led?

- It appeared that the compliance system could only be accessed by the practice directors which raised concerns about how this information would be accessed in their absence.
- The registered manager was not aware of current guidance to monitor emergency medicines and equipment at least weekly.

We acknowledged that the provider was transitioning from their previous online-based compliance system to a new online-based compliance system and the provider told us this had resulted in some confusion over where documents had been stored. The registered manager also described challenges in relation to staffing and having to manage several practices over different locations.

Staff knew the management arrangements and their roles and responsibilities; however, some roles had not been carried out effectively in relation to decontamination processes and practice management.

Appropriate and accurate information

The provider had a system of clinical governance and quality and operational information in place which included policies, audits, protocols, risk assessments and procedures that were accessible to all members of staff and were reviewed periodically. This system had failed to identify the risks and issues that we highlighted during this inspection in relation to fire safety, infection prevention and control, staff induction and appraisal, medicines and equipment monitoring and maintenance. Risks associated with lone working of the practice' cleaning staff on the premises had not been assessed.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information in relation to the provision of clinical treatment. However, the provider failed to follow current guidance and legislation regarding the use of closed-circuit television (CCTV) in private areas of the premises. We observed CCTV cameras in the treatment areas; the registered manager told us the cameras captured visual and audio recording in the treatment areas which is against current guidance. There was a lack of clarity over how and where the images were stored.

We observed CCTV signage near the entrance to the practice, but it lacked information required under current legislation about the person/s operating the system and the purpose of the recording as per current legislation. We did not observe any CCTV signage at all in the treatment room areas.

Engagement with patients, the public, staff and external partners

The provider told us they acted on feedback from patients through verbal and written feedback. They informed us of improvements to provide information on their website regarding how to make a complaint, following feedback from a patient.

Staff told us they were encouraged to raise concerns and offer suggestions for improvements to the service, and they felt confident their views and feedback would be listened to and acted on. Staff told us the provider had used their feedback to make improvements to the organisation of an area of the staff room.

Feedback from patients we spoke with during this inspection was positive regarding feeling welcomed by reception staff on arrival for appointments, the waiting area being comfortable, the cleanliness of the premises and being treated with care and concern. They expressed a desire for increased availability of appointments after school hours, and to be kept informed of late running of appointments.

Continuous improvement and innovation

We saw there were ineffective processes for identifying and managing risks and issues.

The staff were not involved in quality improvement initiatives such as peer review as part of their approach in providing high quality care.

Are services well-led?

The provider had limited evidence of quality assurance processes such as audits of dental care records, radiographs and infection prevention and control. Staff kept records of the results of these audits but there were no resulting action plans to encourage learning and improvement.

The registered manager showed a commitment to learning and improvement in relation to several of the issues we identified during this inspection.

The registered manager told us they valued the contributions made to the team by all members of the practice staff.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** **The registered person had not ensured that infection prevention and control procedures were carried out in line with current guidance:** • There was no evidence of suitable validation of the autoclave vacuum cycles used to sterilise used instruments. • Suitable facilities for handwashing in the decontamination area were not available. • Staff did not demonstrate suitable decontamination processes. • Single-use items were re-used. • Waste disposal bins were not fully functional. • Visibly soiled chairs in the waiting area were made of fabric that could not be suitably disinfected. • Infection prevention and control audits were not completed at the recommended frequency of six-monthly, they were not practice-specific, and they failed to identify several risks. **The registered person had not ensured that suitable recruitment checks had been completed for all members of staff:** • There was no employment history or evidence of qualification for a member of clinical staff.

This section is primarily information for the provider

Requirement notices

The registered person had not ensured that all equipment was maintained suitably:

- There was no evidence of safety inspection of the electrical installation since 2013; this inspection should normally be completed every five years.
- There was no evidence of servicing of the air conditioning unit, and the registered manager was not clear on whether it required servicing.
- There was no evidence of servicing of emergency lighting installed in 2013, and staff did not complete in-house tests.
- Risk associated with use of the mercury-based thermometer in the decontamination sink had not been identified by provider.

The registered person had not ensured that suitable fire safety processes were implemented:

- There was no evidence of fire evacuation drills.
- At the time of this inspection there was no functioning fire detection system.
- Some staff did not feel confident on the use of fire extinguishers, and they had not received fire safety training.
- The registered manager could not demonstrate how to test the fire detection and alarm system.
- Some identified risks from the practice's 2017 fire risk assessment had not been actioned, and the provider's 2022 in-house fire risk assessment failed to identify the above-mentioned risks.

The registered person had not ensured that medicines used to manage medical emergencies were within their expiry date:

- A medicine used in managing low blood sugar had passed its expiry date four months prior to this inspection.

The registered person had systems or processes in place that were operating ineffectively in that they failed to evaluate and improve their practice in respect of the processing of the information referred to under this Regulation. In particular:

- The registered person had not ensured that suitable induction and appraisal processes were established.

This section is primarily information for the provider

Requirement notices

- There was no evidence of completed inductions for some staff, some inductions were incomplete.
- There was no evidence of an appraisal for a member of staff and some appraisals were overdue, which was against the provider's policy on annual appraisals for all staff.
- The registered person failed to identify, monitor and mitigate several risks, and they failed to act on identified risks in relation to fire safety.
- The registered person failed to follow current guidance in relation to the use of CCTV recording in the practice.
- The registered person did not have an effective system in place to store, and retrieve, documents. This included waste consignment records and cleaning schedules.