NDC Plus Limited

ADF Clinic

Inspection Report

91 Woodlands Close,
Clacton-on-Sea.
CO15 4RY
Tel: 01255476700

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Overall summary

We undertook a focused inspection of ADF Clinic on 25 September 2018. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of ADF Clinic on 20 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe or well led care in accordance with the relevant regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for ADF Clinic on our website www.cqc.org.uk.

When one or more of the five questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

- Is it safe
- Is it well-led?

Our findings were:

Are services safe?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 20 November 2017.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 20 November 2017.

Background

ADF Clinic is in Clacton On Sea and provides private treatment to adult patients. There is level access for people who use wheelchairs and pushchairs. Car parking spaces are available near the practice.

The dental team includes one dentist, one dental nurse, a clinical manager, and two receptionists. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

No patients were available to talk with during our inspection.

Summary of findings

During the inspection we spoke with the principal dentist and the two dental receptionists. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Thursday from 11am to 6pm and Friday from 9am to 2pm.

Our key findings were:

- The practice was not giving due regard to the tests and quality checks for the cone beam computed tomography (CBCT) machine. Following the inspection in September 2018 the provider confirmed no further scans would be taken until the CBCT had been serviced. We were then sent evidence to confirm a named radiation protection adviser had been appointed and maintenance and servicing of the CBCT had been scheduled for 9 November 2018.
- The practice had still not purchased an automated external defibrillator as highlighted at the inspection in November 2017. There was no risk assessment in place to ensure the practice had reviewed the risks of access to an AED. Following this inspection, the practice provided evidence that an AED had been purchased.
- We noted the practice had recorded daily checks to the oxygen at the practice. These checks had not highlighted that the oxygen cylinder was out of date and was due for replacement in June 2018.
- Emergency equipment and medicines were mostly available as described in recognised guidance. There was not a size 0 airway or a paediatric ambubag. We noted the packaging for the other airways was damaged and no longer airtight, therefore the other airways required replacing. In addition, we noted there was not an eyewash station or a first aid kit available at the practice. Following the inspection, the principal dentist sent us evidence that these had been replaced.
- Annual CPR training had been undertaken at the practice on 11 October 2017. However, the practice had recruited two new members of staff since then who had not undergone CPR training.
- A Legionella risk assessment had been undertaken at the practice on 29 January 2018. There was no action plan in place to monitor the areas that required addressing, when they had been addressed and when they were completed. Dip slide testing had not been undertaken.
- We found no records of DBS checks for any staff working at the practice, no evidence of recent GDC registration for clinical members of staff and no records of Hep B immunity in staff records.
- The practice had not moved to a system of safer sharps since the previous inspection in November 2017. Not all the staff we spoke with were aware of safe processes for the disposal of sharps.
- Sharps bins were signed and dated. Clinical waste was stored in a suitable locked bin in a secure area outside the practice.
- There was a system in place for receiving and acting on safety alerts to ensure the practice learned from external safety events as well as patient and medicine safety alerts.
- The practice had made some reasonable adjustments for patients with disabilities. These included step free access. There was no hearing loop available at the practice to assist patients who wore a hearing aid and no Equality Act risk assessment in place to assess where action would be required.

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way for patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

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

- Review the practice's systems for environmental cleaning taking into account current national specifications for cleanliness in the NHS.
- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?

Requirements notice 

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

At our previous inspection on 20 November 2017 we judged it was not providing Safe care and told the provider to take action as described in our requirement notice. At the inspection on 25 September 2018 we found the practice had not made sufficient improvements to comply with the regulations:

Shortfalls identified at our previous inspection had not been addressed such as availability of emergency equipment, the practice still did not have access to an automated external defibrillator (AED) and the medical oxygen cylinder had expired. There was no eyewash station and no first aid kit available.

There was no evidence of a three-year survey or any annual servicing of the CBCT scanner. The principal dentist was unable to confirm who the named practice radiation protection adviser was and there were no local rules available in either the treatment or the CBCT/decontamination rooms. The principal dentist had no knowledge of the new requirements for registration with the Health, Safety and Environment Standards (HSE) in regard to radiation or the new Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or the new Ionising Radiation Regulations(IRR17).

Recommendations identified in the Legionella risk assessment from January 2018 had not all been actioned.

Not all cleaning equipment was fit or purpose or stored in line with current national specifications for cleanliness in the NHS.

There were no records of appraisals for those staff who had been with the practice for the previous year and no evidence of a scheduled induction for the two newer members of staff. DBS checks had not been undertaken.

Are services well-led?

Requirements notice

We found that 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).

At our previous inspection on 20 November 2017 we judged it was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 25 September 2018 we found the practice had not made sufficient improvements to comply with the regulations:

The practice had put some systems and processes in place to ensure good governance in accordance with the fundamental standards of care. The practice had introduced a system for receiving and acting on safety alerts. We noted there

Summary of findings

were some completed risk assessments in place to ensure staff and patients were protected. However, where recommendations were identified, the practice had not implemented an action plan to ensure these were completed. For example, there were no records to evidence what actions had been completed from the January 2018 Legionella risk assessment.

Shortfalls identified at our previous inspection had not been addressed such as the checks of equipment, maintenance of complete detailed staff records including schedule three information for visiting clinicians. There was no oversight for maintenance checks and servicing for the CBCT scanner. The medical oxygen cylinder had expired in June 2018.

Staff meetings were undertaken, there was no evidence that systems such as safer sharps and the process when not using these had been discussed with staff to ensure safe practice.

Are services safe?

Our findings

At our previous inspection on 20 November 2017 we judged the practice was not providing safe care in accordance with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 25 September 2018 we found the practice had made some improvements to comply with the regulations but found areas that had not improved:

At our previous inspection on 20 November 2017 we noted that the cone beam computed tomography (CBCT) scanners servicing was overdue by five months and there was no named radiation protection advisor recorded in the practice records. At our inspection on 25 September 2018, we found the practice were unable to provide any evidence or documentation to confirm if this servicing had been undertaken. Furthermore, the practice team were unable to provide any documentation regarding installation, critical exam testing and acceptance testing for the CBCT scanner. There was no evidence available at the September 2018 inspection of a three-year survey or any annual servicing of the CBCT scanner. The principal dentist was unable to confirm who the named practice radiation protection adviser was and there were no local rules available in either the treatment or the CBCT/decontamination rooms. In addition, the principal dentist had no knowledge of the new requirements for registration with the Health, Safety and Environment Standards (HSE) in regard to radiation or the new Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or the new Ionising Radiation Regulations(IRR17) which came into effect from 1 January2018.

We discussed this with the principal dentist and following our inspection the principal dentist practice took immediate action and agreed to stop all X-ray services until the practice equipment had been surveyed and the correct documentation was available and provided on site.

The principal dentist told us after this inspection that the CBCT scanner was scheduled for survey, servicing and maintenance on 9 November 2018.

We noted the practice had lasers on site, however the principal dentist told these were no longer used. During our inspection the principal dentist confirmed these would be removed from the practice.

The practice did not have access to an automated external defibrillator (AED). The principal dentist told us they had discussed this with a local GP surgery which was 0.4miles from the practice and they had an agreed plan. The principal dentist told us the plan would be; should an AED be required a member of staff would telephone the GP surgery and a member of the GP staff would bring the AED, if not in use to the dental practice. However, the principal dentist had not undertaken a risk assessment, they had not assessed the risk of the AED being in use at the GP surgery, they had not allowed for the time frame in getting through to the GP practice on the telephone, for the time it would take for a member of the GP staff to drive the AED to the dentist surgery or for the potential for traffic delays. Following the inspection on 25 September 2018, the clinical manager emailed CQC and provided an invoice to evidence that the practice had purchased an AED.

We noted staff had been recording daily checks to the oxygen at the practice. We noted the oxygen cylinder was out of date and was due for replacement in June 2018.

Emergency equipment and medicines were mostly available as described in recognised guidance. There was not a size 0 airway and there was not a paediatric ambubag. We noted the packaging for the other airways was damaged and no longer airtight, therefore the other airways would need replacing. In addition, we noted there was not an eyewash station and not a first aid kit available at the practice. We discussed these issues with the principal dentist. Following the inspection, the clinical manager sent CQC evidence that that these had been replaced.

Annual CPR training had been undertaken at the practice on 11 October 2017. However, the practice had since the last training, recruited two new members of staff who had not undergone CPR training. This was therefore overdue for these new members of staff.

We noted systems to ensure an effective cold chain at the practice were now in place with fridge temperatures logged daily.

The practice was now giving some regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices. Staff had undergone infection control training and an audit had been completed in April 2018, we were told a follow up audit was scheduled six monthly with the next audit in October 2018. However, we noted the practice only had one bowl in the decontamination area

Are services safe?

and the magnifying glass was handheld and not illuminated, these areas had not been identified in the infection control audit. Instruments were stored in pouches and were dated. The practice had some arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. Staff completed infection prevention and control training.

We saw cleaning schedules in place for the household and clinical cleaning of the practice. There was scope to ensure cleaning equipment was stored correctly, we saw that the mops were not colour coded and therefore the practice could not confirm which mop was used for treatment rooms and which mop was used for general cleaning. The mops were stored in a room at the rear of the clinic and were standing head down in buckets and therefore could not air dry. The practice had not completed an annual infection control statement.

A Legionella risk assessment had been undertaken at the practice on 29 January 2018 by an external provider and the practice had an overall risk rate of medium. Where areas of concern had been identified in the risk assessment such as: the need for a logbook, a process to identify vulnerable persons, lime scale within the practice, hot water outlets being too hot and the need for regular sampling of water outlets, we found that not all of these had been actioned. We noted there were 15 actions recommended by the risk assessment. There was no action plan in place to monitor the areas that required addressing and there were no records to evidence what had been completed and when. The clinical manager told us the sentinel water testing had been undertaken and we noted temperatures were in the correct range. The clinical manager had undergone some Legionella training, units were disinfected daily and flushing of units was undertaken each morning and between each patient.

We were told the principal dentist was the only member of staff who handled syringes and needles, however one new member of staff described how they had disposed of a syringe and were not aware they should not have been handling these. There was no completed induction sheet for this member of staff and therefore no evidence to show this had been addressed with them when they joined the practice. The principal dentist told us they had not moved to a system of safer sharps since the previous inspection in November 2017.

The practice had also made further improvements:

Sharps bins were signed and dated. Clinical waste was now stored in a suitable locked bin in a secure area outside the practice.

There was a system in place for receiving and acting on safety alerts to ensure the practice learned from external safety events as well as patient and medicine safety alerts.

The practice had recently recruited two new members of staff, we were told one would be undertaking their dental nurse training supported by the practice.

The practice had made some reasonable adjustments for patients with disabilities. These included step free access. There was not a hearing loop available at the practice to assist patients who wore a hearing aid and an Equality Act risk assessment was not in place to assess where action would be required.

These improvements showed the provider had taken some, but not all action to comply with the regulations: when we first inspected on 20 November 2017.

Are services well-led?

Our findings

At our previous inspection on 20 November 2017 we judged it was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 25 September 2018 we found the practice had not made sufficient improvements to comply with the regulations:

The practice had put some systems and processes in place to ensure good governance in accordance with the fundamental standards of care. We noted there were some completed risk assessments in place to ensure staff and patients were protected. However, where recommendations were identified, the practice had not implemented an action plan to ensure these were all actioned, completed and documented. For example, the Legionella risk assessment where 15 actions had been recommended, there were no records to evidence what had been completed and when.

We noted that the clinical lead had undergone training in the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) and had an understanding of the formal reporting pathways required following serious untoward incidents.

Staff meetings were undertaken, we saw evidence of some minutes from these meetings, staff showed us diaries that recorded discussions and concerns raised both at these meetings and during discussion with the clinical manager or the dentist/provider. However there was no evidence that systems such as safer sharps and the process when not using these had been discussed with staff to ensure safe practice.

The practice had introduced a system for receiving and acting on safety alerts. These were overseen by the clinical manager and disseminated to the principal dentist and dental nurse as appropriate.

We identified a number of on-going shortfalls in the practice's governance arrangements including the checks of equipment. We noted the oxygen cylinder had been checked daily, but staff had not identified that the expiry date on the cylinder ended in June 2018.

During the November 2017 inspection we noted there was no effective process for the ongoing assessment and supervision and appraisal of all staff employed at the practice. Since that inspection we were told that some staff had left the practice and during our September 2018 inspection we noted there were two new members of staff working at the practice. We found that there were no records of appraisals for those staff who had been with the practice for the previous year and no evidence of a scheduled induction for the two newer members of staff.

At the November 2017 inspection we noted DBS checks had not been obtained for staff employed by the practice. There was no evidence of any references obtained for staff prior to their joining the practice. During the September 2018 inspection we noted there was some evidence of references for the two newer members of staff in their staff records. However, we found no records of any DBS checks for any staff working at the practice, no evidence of recent GDC registration for clinical members of staff and no records of Hep B immunity in staff records. The principal dentist was able to provide evidence on the day following our request of their own registration and indemnity for all the staff, however there was no recruitment information available at the practice for the dental hygienist. We discussed this with the clinical manager and the principal dentist and during our inspection they contacted the dental hygienist who emailed their recruitment information to the practice. This included photographic identification, records of vaccinations and a certificate of registration. The clinical manager told us during the September 2018 inspection that DBS checks had been applied for prior to the inspection and following the inspection the practice sent confirmation of an email sent to the practice on 1 October 2018 which confirmed these had been requested for three members of staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. How the regulation was not being met; Some emergency equipment was not available in the practice. The practice did not have access to an automated external defibrillator (AED). The medical oxygen cylinder had expired. There was no evidence available of a three-year survey or any annual servicing of the CBCT scanner. The provider was unable to confirm who the named practice radiation protection adviser was. There were no local rules available in either the treatment or the CBCT/ decontamination rooms. The provider had no knowledge of the new requirements for registration with the Health, Safety and Environment Standards (HSE) in regard to radiation or the new Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or the new Ionising Radiation Regulations (IRR17) which came into effect from 1 January 2018. Recommendations identified in the Legionella risk assessment from January 2018 had not all been actioned and there was no action plan in place to identify what action had been taken and what actions were still required. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 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 How the regulation was not being met;

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

Emergency medicines and medical emergency equipment were not all available or in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. The oxygen cylinder had been checked but the practice had failed to identify that the expiry date was three months overdue.

The registered provider did not have oversight on the requirement for tests, quality checks or operator training for the cone beam computed tomography (CBCT) machine. Records or radiation protection files were not available at the practice.

There were no records to confirm that the 15 recommended actions identified in the Legionella risk assessment had been actioned and completed. Not all the recommended prevention methods were in place.

Assessments of potential risk from sharps had not been undertaken. The audit for infection control had not identified where the practice was not in line with national guidance. The practice had failed to take action identified from the previous inspection and had not included the concerns identified in its risk assessment. Shortfalls identified at our previous inspection had not been addressed such as staff appraisals, staff inductions and DBS checks.

There was no schedule three information at the practice for the dental hygienist.

There were no records of recent GDC registration for clinical members of staff and no records of Hep B immunity in staff records.

Regulation 17 (1)