Oradent Operations Limited

Oradent - High Street, Rochester

Inspection report

360 High Street
Rochester
ME1 1DJ
Tel: 01634404590

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Overall summary

We carried out this announced focused inspection on 19 December 2023 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 practice 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 and operations manager. They were supported by a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, the following 2 questions were asked:

- Is it safe?
- Is it well-led?

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

Our findings were:

- Not all areas of the dental clinic were clean or well-maintained.
- The practice generally had infection control procedures which reflected published guidance. However, improvements were needed.
- Staff knew how to deal with medical emergencies. The majority of appropriate medicines and life-saving equipment were available.
- The practice had ineffective systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place. However, some staff did not know their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- The practice had staff recruitment procedures which reflected current legislation. However, improvements were needed.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- There was generally leadership and a culture of continuous improvement.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Background

Oradent, High Street Rochester is part of Oradent, a dental group provider.

Oradent, Hight Street Rochester is in Rochester and provides NHS and private dental care and treatment for adults and children.

There is step free 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. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 3 dentists, 1 qualified dental nurse, 1 trainee dental nurse, 1 dental hygienist, 1 practice manager and 1 receptionist. The practice has 2 treatment rooms.

During the inspection we spoke with 1 dental nurse, 1 receptionist and 2 practice managers. One of the practice managers was from another practice that was also part of Oradent. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Tuesday from 8:30am to 5pm

Wednesday to Friday from 9am to 5pm

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider is not meeting are at the end of this report.

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

- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.
- Improve the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

Summary of findings

- Implement an effective system for recording, investigating and reviewing accidents, incidents and significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

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 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)

The practice had safeguarding processes. However, the practice did not have a process in place for children that 'Was Not Brought.' Recording or noting 'Was Not Brought' enables a practitioner to consider the reasons why a child was not brought to an appointment, the implications for them not having been brought, and assess the potential risks or safeguarding concerns for them, especially if there is a repeat pattern of non-attendance. Following the inspection, the practice had updated their safeguarding children's policy and we saw evidence of this.

Some staff did not know their responsibilities for safeguarding vulnerable adults and children. Following the inspection, the practice held a meeting with staff to discuss the importance of safeguarding and we saw evidence of the meeting notes.

The practice had infection control procedures which reflected published guidance. However, the infection control policy did not mention staff training requirements and frequency of training updates, who the infection control lead was and their responsibilities. Some staff were unsure how often training needed to be refreshed. Following the inspection, the practice held a meeting with staff to discuss the importance of infection control, updated their policy and we saw evidence of this.

We saw heavy duty gloves were used when cleaning and handling instruments. However, the gloves were not changed weekly, as detailed in recommended guidance. Following the inspection, we saw evidence this had been discussed in a practice meeting and a new protocol was in place.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment. However, this was not always followed. We saw Legionella water temperature checks had been carried out on the shower from 18/09/2023 to 23/11/2023; staff were unable to tell us why checks had been stopped and one staff member told us the shower had been removed prior to 18/09/2023.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. However, this was not always followed. We saw a clinical waste bag was stored in the decontamination room and the clinical waste bin outside was not secure. Following the inspection, we saw evidence that a padlock had been ordered and the clinical waste bag was removed from the decontamination room.

Not all areas of the dental clinic were clean or well-maintained. There was an ineffective cleaning schedule in place to ensure it was kept clean. We saw limescale was present on the majority of the taps, the cleaning cupboard was visibly dirty, there were holes in the wall of the decontamination room and the basement storage room. The downstairs bathroom had a leak and was visibly dirty too.

Following the inspection, we saw evidence the practice had carried out a deep clean of the premises and had contractors attend the site to address the leak. The drains have been unblocked, the faulty part had been replaced and the practice was assured this will permanently resolve the issue. Due to the drainage on the streets, the practice aims to remove the downstairs toilet and shower from the lower ground floor in its entirety, as there is ongoing issues when there is extensive rain.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These reflected the relevant legislation. However, improvement was needed to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

Are services safe?

We could not be assured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice did not ensure the facilities were maintained in accordance with regulations.

Portable appliance testing was overdue; the practice manager told us this had been scheduled for 09/01/2024 but was unable to show evidence of the booking. Following the inspection, we saw evidence of this.

A health and safety risk assessment had not been carried out. We were assured this would be carried out.

A fire safety risk assessment was carried out in line with the legal requirements. However, this was overdue. The management of fire safety was ineffective. We saw stacks of empty cardboard boxes in the basement and clutter around the compressor which posed a fire risk.

Fire alarm switches had been turned off; there was no evidence that these had been tested or serviced on a regular basis. There were no fire marshalls. Fire extinguishers had not been serviced. The servicing for the compressor was overdue. Emergency lighting tests had not been carried out; the practice manager did not know what this was.

Following the inspection, we saw evidence:

- the fire policy had been updated.
- the smoke detectors and the emergency lighting have been confirmed to be working and been tested; we saw logs of this.
- all flammable materials which were potential fire hazards had been removed.
- servicing for fire extinguishers and fire alarms had been scheduled.
- a new external fire risk assessment had been scheduled.
- 2 members of staff have been appointed as fire marshalls and had completed the relevant training.

The practice did not have arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available. Local rules were out of date and servicing for X-ray equipment had not been carried out regularly. Local Rules identify key working instructions to ensure that exposure of staff or others to radiation is restricted. Following the inspection, we saw evidence the local rules had been updated and a service for X-ray equipment had been scheduled.

Risks to patients

The practice had some systems to assess, monitor and manage risks to patient and staff safety. We saw traditional syringes were used; there were no needle guards present to prevent a sharps injury. Following the inspection, we saw evidence this had been ordered.

We noted risk assessments had not been carried out for staff who had not met Hepatitis B surface antibody levels as per Department of Health Green Book immunisation guidance. There was no evidence to show they had received one additional dose of vaccine, or taken further action as per recommendations. We discussed the importance of obtaining these immunity levels for staff and following the inspection we saw evidence risk assessments had been completed.

The majority of emergency equipment and medicines were available and checked in accordance with national guidance. For use with adrenaline ampoules, needles for obese patients were not available. Adult size oxygen face mask with reservoir and tubing was not available. Following the inspection, we saw evidence these had been ordered.

The medical emergency equipment was not checked weekly. We explained the importance of regular checks and were assured this would be addressed.

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

Are services safe?

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health (COSHH). However, COSHH risk assessments had not been carried out regularly; the last risk assessment was carried out in April 2020. We were assured this would be addressed.

Information to deliver safe care and treatment

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements. However, clinicians were not recording risk assessments (periodontal/caries/cancer/tooth wear) consistently. Clinicians had recorded the local anaesthetic batch number and expiry date but the dosage was not always recorded. Following the inspection, we saw evidence this was discussed in a practice meeting.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. However, this was not always followed. For example, the leak in the basement had not been raised as an incident. We explained the importance of logging and reviewing incidents and were assured this would be addressed.

The practice did not have a system for receiving and acting on safety alerts. The practice manager was unsure what safety alerts were. Following the inspection, we saw evidence that the process for safety alerts was discussed in practice meeting.

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/ Enforcement Actions 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

The practice staff did not demonstrate a transparent and open culture in relation to people's safety. For example, there were discrepancies around when the leak in the basement occurred; staff were unable to tell us what immediate actions had been taken. However, the owners of the group were able to provide evidence of the work carried out and a detailed response of immediate actions taken.

We saw the practice had ineffective processes to support and develop staff with additional roles and responsibilities. Staff told us support was not available from previous compliance managers but felt the owners of the group were approachable.

There was generally a leadership with emphasis on peoples' safety and continually striving to improve. As a result of the inspection, the provider made the decision to close the practice temporarily to enable them to address any shortfalls. Patients were moved to a local buddy dental practice that is part of the group to minimise any impact to patients and staff.

The information and evidence presented during the inspection process was not clear or well documented. Documents could not be located; following the inspection we were told by the owners that the documents were in place and due to a change of computer software, this could not be easily located. Where evidence showed they had been carried out before the inspection, we have not referred to these in the report.

We saw evidence the practice had worked hard to address all the other issues found on the inspection. The response and reactiveness of the owners to close the practice and address the points has assured us they are accepting of the findings and have taken responsibility to address all the issues.

Systems and processes were not embedded. There were gaps in the governance systems and the inspection highlighted a number of omissions. Staff told us the company was going through a lot of changes due to a change in the organisation structure and new computer software. We were told a new compliance manager has been employed and is due to start in the upcoming weeks.

Culture

Staff could not show how they ensured high-quality sustainable services or demonstrate improvements over time.

Staff told us support was not always available from the previous compliance managers but felt the owners of the group were approachable.

We could not see evidence that staff discussed their training and learning needs, general wellbeing and aims for future professional development.

The practice did not have arrangements to ensure staff training was up-to-date and reviewed at the required intervals. Following the inspection, we were assured that a risk assessment had been carried out to ascertain if an individual is suitable to continue fulfilling their role in a safe manner.

Any shortcomings have been addressed and staff are now up to date with training. As a result of the inspection, all staff have been provided access to a training platform to complete any further required learning and training. We were told a new compliance manager has been employed and is due to start in the upcoming weeks.

Are services well-led?

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

The practice had a governance system which included policies, protocols and procedures that were reviewed on a regular basis. However, these were not easily accessible to all members of staff.

Processes for managing risks, issues and performance were not clear and effective.

Appropriate and accurate information

We could not be assured that staff acted on appropriate and accurate information. For example, some staff were not aware of safety alerts.

The practice had information governance arrangements and staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings and informal discussions.

Continuous improvement and innovation

The practice generally had systems and processes for learning, quality assurance, continuous improvement. These included audits of antimicrobial prescribing and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements. However, the practice must ensure the practice's risk management systems is effective for monitoring and mitigating the various risks arising from the carrying on of the regulated activities. In particular, take action to mitigate risks to fire and health and safety. Improvements were needed to the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **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 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: • Risk management systems were ineffective for monitoring and mitigating the various risks arising from fire, health and safety and maintenance of the equipment and premises. • Systems for environmental cleaning taking into account the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices were ineffective. • Systems for checking, monitoring and ensuring equipment is well maintained taking into account relevant guidance were ineffective. • Systems for fire safety and ongoing fire safety management were ineffective. • Protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment were ineffective.