Poole Orthodontics Ltd

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Inspection report

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Overall summary

We carried out this unannounced comprehensive inspection on 23 January 2024 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 who was supported by a second inspector and a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The dental clinic appeared clean and well-maintained, however, systems to support the cleaning processes required review.
- The practice had infection control procedures which did not always reflect published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available, but these were not always in date or stored appropriately.
- The practice had some systems to manage risks for patients, staff, equipment and the premises. However, some identified risks required urgent review, and others were missing.

Summary of findings

- Staff knew their responsibilities for safeguarding vulnerable adults and children, but safeguarding processes were not up to date.
- The practice did not have recruitment procedures and staff recruitment did not reflect current legislation.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. However, staff did not always take care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- Improvements could be made to the appointment system to ensure that it works efficiently to respond to patients' needs.
- Leadership at the practice required urgent review.
- The practice did not have systems in place to obtain feedback about the services provided.
- Improvements to the systems in place to manage complaints were underway.
- The practice had information governance arrangements but these required review.

Background

Poole Orthodontics Ltd is in Broadstone, Poole and provides NHS and private orthodontic 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 2 orthodontists, an orthodontic therapist, 3 dental nurses, a practice manager and a receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with 2 orthodontists, the orthodontic therapist, 2 dental nurses, the receptionist and the practice manager. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday, Wednesday and Friday 8:30 – 5:30pm

Tuesday and Thursday 08:30 – 7pm

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

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties
- Ensure specified information is available regarding each person employed

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 protocols for the use of closed circuit television cameras taking into account the guidelines published by the Information Commissioner's Office.
- Improve the practice's complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.

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?	**Enforcement action**
Are services effective?	**No action**
Are services caring?	**No action**
Are services responsive to people's needs?	**No action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action. We will be following up on our concerns to ensure they have been put right by the provider.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service.

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

Staff knew their responsibilities for safeguarding vulnerable adults and children. However, processes required improvement as staff did not have up to date contact details of the local authority in case of having to make a safeguarding referral for vulnerable children.

The practice had infection control procedures which did not always reflect published guidance. Audits of infection prevention and control were not always being completed at six-monthly intervals or in a consistent manner in accordance with national guidance. The most recent audit dated 31 October 2023 was not available onsite, but was sent to us following the inspection. This was not complete as 10 questions were not answered, 6 questions were answered in a manner which did not reflect the procedures used in the practice, and there were 22 actions indicated but no evidence that these have been addressed.

Decontamination logs and surgery checklists were not always being completed, completed consistently or dated incorrectly.

Orthodontic appliances were not being disinfected on return from the laboratory before being placed in patients' mouths. Following the inspection, we received evidence that this has been added to their infection control policy; however, we have not received evidence to show that this is being carried out.

We saw a tear in the floor in 1 surgery, preventing effective cleaning.

We saw that systems in place to ensure that wrapped instruments did not exceed their maximum storage time of 12 months was ineffective. We saw wrapped instruments which had been stored beyond their use by date. Date stamping of instruments required review to ensure that this was carried out consistently. We saw that sharps bins were not dated.

We saw that there were no systems in place to ensure that staff had received appropriate vaccinations and no risk assessment in place to mitigate against this. We did not see evidence of Hepatitis B immunity levels for 3 staff members.

Systems and processes in place to reduce the risk of Legionella and other bacteria developing in the water system were ineffective. We saw that a risk assessment had been carried out in September 2019, however, we did not see evidence that any of the actions required had been completed. Staff were not maintaining the Legionella logbook and staff were not carrying out water temperature checks. Additionally, actions recommended from the previous inspection in October 2021 had not been addressed.

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

The practice appeared clean, however there was no cleaning schedule to ensure the effectiveness of cleaning or to evidence the frequency of cleaning of the premises. The required colour coded buckets and mops to reduce cross contamination between the clinical areas, bathroom, staff and waiting area were not available. We noted only 1 yellow

mop in the kitchen cupboard, and 1 yellow mop and bucket and 1 red mop and bucket in an outside store. The cleaning arrangements detailing the standards of cleanliness required, responsibility and frequency of cleaning were not available. Staff were unable to tell us how often the cleaner attends and whether the cleaner works alone; therefore, a lone worker risk assessment would apply but was not in place.

The practice had ineffective systems in place to ensure that recruitment procedures complied with the requirements of the relevant legislation or helped them to employ suitable staff, including for agency or locum staff. A recruitment policy was in place with reference to Schedule 3 of the Health and Social Care Act 2008; however, this was not being followed. On the day of inspection only staff recruitment records for 4 staff members were available for review, there was no documentary evidence for any other staff.

Clinical staff were qualified and registered with the General Dental Council (GDC). We did not see evidence of suitable indemnity insurance for 3 staff members.

The practice did not always ensure that equipment was safe to use, maintained and serviced according to manufacturers' instructions. We did not see evidence of servicing for the electric water heater. An electrical installation condition report (EICR) was not seen. Neither did we see evidence of servicing of the air-conditioning, ultrasonic bath or compressor. We did not see evidence that portable electrical appliances had been checked. Following the inspection, we were sent evidence of the EICR, portable appliance testing and the compressor servicing report.

A fire safety risk assessment was carried out on 20 May 2019 in line with the legal requirements, however, we did not see evidence that recommendations stated within this had been acted upon. An additional fire risk assessment was completed in-house by practice staff on 20 January 2022. This was not completed by a person with the competency, knowledge or experience of assessing the risks associated with fire safety management. We did not see a fire logbook, nor receive assurance that periodic checks of the fire safety equipment, including the fire alarm system and the emergency lighting system, were being carried out. There was no evidence that fire drills were carried out, and staff informed us they hadn't had a fire drill. We saw evidence that only 1 staff member had completed fire marshal training and no staff member had completed training in fire safety. The management of fire safety was ineffective.

The practice had ineffective arrangements to ensure the safety of the X-ray equipment and not all of the required radiation protection information was available. There was no evidence that electro-mechanical testing was carried out annually or in line with the manufacturer`s guidance on the intraoral radiography units.

Risks to patients

The practice had ineffective systems to assess, monitor and manage risks to patient and staff safety. There was a lack of oversight of the assessment and mitigation of risk within the practice. For example, there was no information for staff in relation to sharps safety, sepsis awareness or lone working. Following the inspection, we were sent evidence that systems had been implemented to improve sharps safety, however contacts detailed on the new posters were not all able to assist or offer advice to the practice in the event of a sharps injury. Legionella and fire safety risk assessments both required urgent review.

Emergency equipment and medicines were mostly available, however were not being checked in accordance with national guidance. We did not see evidence that the medical emergency drugs and equipment were being checked weekly. Dextrose powder was included in the emergency medical kit, as a substitute for out-of-date Glucogel. However, this is not a medication recommended by national guidance. Following the inspection, we have seen evidence that Glucogel has been ordered. Glucagon (the emergency medicine used to treat severe low blood sugar) was stored in the food fridge and the expiry date was not visible on external packaging. The temperatures of the fridge were not being checked or recorded and the temperature was seen to be 10 degrees Celsius. This is not in line with the manufacturer's instructions, which states Glucagon should be stored at a temperature of 2 to 8 degrees Celsius. Following the inspection, we were told that Glucagon has been ordered and a new fridge has been purchased; however, we have not received any evidence that temperature checks are being completed on a daily basis. Syringes for adrenaline were not accessible as

they were not kept with the emergency medicines, which could result in a delay in administering the adrenaline when needed. There were no effective systems for ensuring that expired or used items were removed or replaced. Out of date medicines were seen with the emergency medicines and equipment and in an unlocked office. Following the inspection, we were told these items have been removed and will be disposed of. The practice had made a second oxygen cylinder available, but this has not been included on the medical equipment check list and was therefore not being checked. In addition, this was not stored appropriately with the medical emergency equipment. Signage to indicate to emergency services that oxygen was on the premises was not seen. We have been told this is now available.

Staff knew how to respond to a medical emergency, but only 4 of the 8 staff members had evidence of completing training in emergency resuscitation and basic life support.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health, however improvements were needed to ensure risks assessments and product data sheets were available for all items.

Information to deliver safe care and treatment

Patient care records reviewed, were complete, legible, kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Track record on safety, and lessons learned and improvements

The practice did not have effective systems to review and investigate incidents and accidents. The accident book did not comply with GDPR requirements and there was no system to log when things went wrong in the practice. In addition, there were no systems in place to share information with staff on significant events and accidents, and no meetings were being held to share learning. The practice had a system for receiving and acting on safety alerts.

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 dental professionals kept up to date with current evidence-based practice.

The orthodontist carried out a patient assessment in line with recognised guidance from the British Orthodontic Society.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. They understood their responsibilities under the Mental Capacity Act 2005, however staff told us they did not have a specific policy for this.

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 patient care records in line with recognised guidance.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability.

We saw evidence the orthodontists justified, graded and reported on the radiographs they took. However, we did not see evidence of radiography audits being carried out six-monthly in line with current guidance. The last audit completed was dated 5 May 2023 and we were told that the most recent audit had been started in November 2023 but had not been completed.

Effective staffing

Evidence was not available to demonstrate all staff had the skills, knowledge and experience to carry out their roles. The practice did not have systems in place to ensure clinical staff had completed highly recommended Continuing Professional Development as required for their registration with the GDC. We did not see recruitment information for 4 of the 8 staff members and saw limited records of any training.

Newly appointed staff did not have a structured induction. Improvements were required to ensure that clinical staff completed continuing professional development required for their registration with the GDC, and that practice staff implemented systems to ensure the appropriate monitoring of staff training.

Co-ordinating care and treatment

Staff were not always working together to ensure the delivery of effective care and treatment. There was a clear breakdown in effective communication between leaders, which impacted their ability to work together.

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

The practice was a referral clinic for orthodontics, and we saw staff monitored incoming referrals. However, improvements were needed to the systems and processes of patient allocation as staff told us these were not always being managed effectively or in line with protocol.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. However, this was not always observed in the practice and the confidentiality of patient information was at times compromised. We saw computer screens were left unlocked and unattended and also saw that the reception computer screen was visible to patients returning to the waiting area from the treatment area.

The practice had installed closed-circuit television to improve security for patients and staff, but had not carried out a Data Protection Impact Assessment prior to the deployment of the surveillance system at the practice, which is a legal requirement to comply with the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018. In addition, the practice CCTV policy did not identify all areas of the practice that are covered by the cameras and contained no justification for CCTV being in areas other than those detailed in their policy. Staff told us recordings are not kept, only live images are recorded, but this is contrary to the information in the practice policy which states that images are kept.

Staff password protected patients' electronic care records and backed these up to secure storage.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice's website provided patients with information about the range of treatments available at the practice. A patient leaflet was not available.

The orthodontists explained the methods they used to help patients understand their treatment options. These included photographs, study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences, however staff told us of some delays due to referrals being returned when sufficient information hadn't been provided by the clinician.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments to support patients with access requirements, including a fully wheelchair accessible practice with accessible toilet, hearing loop for patients with impaired hearing, and magnifying glass for visually impaired patients. Staff were aware of how to book interpreters and also how and where to refer patients who require specialist dental chairs. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients. Some actions, such as installing a call bell at the front door and adding chairs with arms required attention.

Timely access to services

The practice displayed its opening hours and provided information on their website.

The practice has waiting times of approximately 18 months for initial assessment from referral. Patients were informed of the wait. The practice had an appointment system to respond to patients' needs. The frequency of appointments was agreed between the orthodontist and the patient. Patients had enough time during their appointment and did not feel rushed. However, staff told us appointments often overran.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. Staff told us that patients needing emergency care would be seen as walk in patients and sit and wait to be seen. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice did not always respond to concerns and complaints appropriately and these were not always recorded and tracked. Information on how to complain was not available to the patients in the practice, although the practice complaints policy is available on their website and staff told us they direct patients to this if asked. Staff told us they did not discuss outcomes of concerns and complaints to share learning and improve the service.

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

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

Leadership at the practice required urgent review. There was a lack of clinical and managerial oversight at the practice, and staff employed in positions of oversight did not attend the practice. Staff told us that there was limited communication with the practice manager and not all of the leaders were approachable.

The practice systems and processes were not embedded to effectively support staff in the absence of an onsite manager, and this had not been identified or appropriately managed by the providers.

The information and evidence presented during the inspection process was often missing or not readily available.

We saw the practice had ineffective processes to support and develop staff with additional roles and responsibilities.

Culture

We did not see evidence of annual appraisals, 1 to 1 meetings or clinical supervision for staff to discuss their training needs at, or to support their general wellbeing and future professional development.

The practice did not have arrangements to ensure staff training was up-to-date and reviewed at the required intervals. We found there were no systems in place to monitor training. At the time of inspection, evidence of training was not available for all staff in subjects recommended by the General Dental Council (GDC), their registration body, or by national guidance, including infection control, safeguarding vulnerable adults and children, fire safety, learning disability and autism, Legionella, sepsis awareness and the Mental Capacity Act. We saw evidence of induction for only one staff member.

Governance and management

Staff had responsibilities, roles and systems of accountability to support good governance and management. However, roles and responsibilities had not been reallocated for when staff members responsible were absent. It was not always clear where responsibilities lay and the person who holds overall responsibility did not have the physical capacity to effectively support good governance within the practice.

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff, but were not reviewed on a regular basis. We were unable to confirm that all staff had studied these policies, or that they were discussed with staff. In the absence of regular practice meetings there were also no other forms of formal or informal discussion, so communication across the practice was not as strong as it could be.

The practice did not have clear and effective processes for managing risks, issues and performance. For example, no actions were being carried out to mitigate the risks of fire or the risks associated with Legionella. We did not see evidence that complaints or incidents were managed appropriately or learned from. Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including agency and locum staff.

Appropriate and accurate information

The practice had ineffective information governance arrangements and patient information was not always protected and secure.

Are services well-led?

Engagement with patients, the public, staff and external partners

There was no evidence that the practice encouraged or acted on feedback from patients, the public or external partners. We did not see evidence that feedback was collated and reviewed for the purposes of continually evaluating and improving services. Staff told us they knew that feedback should be collected, but that they weren't doing this at the time of this inspection and didn't have a process in place.

Feedback from staff was not obtained. Staf told us that meetings and surveys were not done. Following the inspection, we were told that a practice meeting had taken place, however not all staff members were present. Staff told us they felt that if they were to offer suggestions for improvements to the service that these would be listened to and acted on where appropriate.

Continuous improvement and innovation

The practice had inadequate systems and processes for learning, quality assurance and continuous improvement. Audits were incomplete, missing or were not reviewed at the recommended intervals. This included audits of radiographs, and infection prevention and control.