NDC Plus Limited

ADF Clinic

Inspection Report

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Overall summary

We undertook a follow up focused inspection of ADF Clinic on 19 February 2019. 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 and a follow up inspection on 25 September 2018 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 and was in breach of regulations 12 (Safe Care and Treatment) and 17 (Good Governance) 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.

As part of this inspection we asked:

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

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 area where improvement was required.

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breaches we found at our inspections on 20 November 2017 and 25 September 2018.

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 inspections on 20 November 2017 and on 25 September 2018.

Background

ADF Clinic is in Clacton and provides private treatment for adult patients.

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

The dental team includes one dentist, one dental nurse, one visiting dental hygienist, one receptionist and the clinical manager. The practice has one treatment room.

Summary of findings

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.

During the inspection we spoke with the dentist and the clinical manager. 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:

- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- Systems were in place to ensure X-ray and decontamination equipment was maintained in line with manufacturers recommendations'.
- Legionella risk assessment had been undertaken. There was limited evidence that any recommended actions had been completed.
- Staff recruitment procedures were in place. There were no records to confirm staff Hepatitis B immunity.

We identified regulations the provider was not meeting. 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:

- Review the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- 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?

No action ✓

We found that this practice was providing safe care and was complying with the relevant regulations.

Emergency equipment and medicines were now available as described in recognised guidance. The practice had replaced missing items including airways and facemasks. An automated external defibrillator was available. We were told staff undertook regular checks of this equipment to ensure it was available and in working order. These checks were not logged.

The medical oxygen cylinder had been replaced and staff kept weekly logs of checks to make sure this was available, within the expiry date, and in working order. We highlighted the storage of the medical oxygen cylinder near open flame candles could pose a potential risk

Are services well-led?

Requirements notice ✗

We found that this practice was not providing well-led care and was not complying 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 were not assured that the provider had any oversight or understanding of systems to monitor the servicing of equipment at the practice,

- what further action was required with regard to the actions identified from the full survey of radiation equipment.
- what further action was required with regard to the 15 recommendations identified in the January 2018 legionella risk assessment.

We found the checks in place were not effective to monitor all emergency drugs and equipment and we were not assured a system was in place to mitigate risks we had previously identified.

There were no records to confirm Hepatitis B immunity in clinical staff records or visiting clinical staff records and no supporting risk assessment to mitigate the risks.

The practice did not have evidence of a sharps risk assessment which considered the preferred method or who was responsible for handling and dismantling conventional equipment.

Are services safe?

Our findings

At our previous inspections on 20 November 2017 and on 25 September 2018, we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 19 February 2019 we found the practice had made the following improvements to comply with the regulations:

Emergency equipment and medicines were now available as described in recognised guidance. The practice had replaced missing items including airways and facemasks. We noted that eyewash and first aid kits were in date and accessible to staff. Staff knew how to respond to a medical emergency and had all completed training in emergency resuscitation and basic life support on 9 October 2018.

The practice had purchased an automated external defibrillator (AED). We were told staff undertook regular checks of this equipment to ensure it was available and in working order. These checks were not logged. We noted the AED battery was not connected to the AED and was still in its plastic wrapping the rear pouch of the AED bag. We discussed this with the clinical manager who immediately attached the battery.

The medical oxygen cylinder had been replaced and staff kept weekly logs of checks to make sure this was available, within the expiry date, and in working order. We highlighted the storage of the medical oxygen cylinder near open flame candles could pose a potential risk

Are services well-led?

Our findings

At our previous inspections on 20 November 2017 and on 25 September 2018 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 19 February 2019 we found the practice had made the following improvements to comply with the regulations:

The servicing of X-ray equipment had been undertaken. We noted the practice autoclave service was overdue and this had not been identified by staff. This was due on 15 February 2019. We discussed this with the clinical manager who immediately contacted the external provider to arrange an autoclave service. We were not assured that the provider or clinical manager had any oversight of systems to monitor the servicing of equipment at the practice.

We found the checks in place were not effective to monitor all emergency drugs and equipment and we were not assured a system was in place to mitigate risks we had previously identified.

A full survey, servicing and maintenance of the Cone Beam Computed Tomography scanner (CBCT) had been undertaken in October 2018 and local rules for this equipment were now in place. The dentist had completed a two-day training course on CBCT in October 2018. We noted that the practice registration with the Health and Safety Executive (HSE) with regard to working with ionising radiation had been updated to reflect the latest Ionising Radiations Regulations 2017 (IRR17).The radiation file provided following the full survey listed 13 recommended actions, these included the population of the file with evidence of actions taken, a weekly audit of films undertaken, a training register for all operators and Continual Professional Development contents for all operators. Whilst we found evidence of some of these having been actioned, these were not clearly evidenced in the file, there was little understanding or oversight by the provider of what further action was required.

We noted the clinical manager had undertaken legionella training in 2018. However, the staff did not have an awareness of legionella to help them better understand their responsibilities in line with legionella management. We found the provider was still unable to confirm if any of the 15 actions identified in the legionella risk assessment from January 2018 had been actioned or completed. We noted that some actions such as sentinel water temperature testing were being undertaken and now logged monthly. Immediately following the inspection, the provider emailed CQC to confirm that a plumber had been requested to attend the practice on 21 February 2018 to review other actions.

The previous audit for infection control had not identified where the practice was not in line with national guidance. The practice had taken some actions to address the areas identified at the inspection on 25 September 2018. These included replacing the illuminated magnifier, and the provision of bowls in the decontamination room. We noted there was scope for further improvement such as:

- the brushes used for manual cleaning were worn and required replacing.
- the area in and around the decontamination room appeared dirty on the day of inspection and the three-bowls provided were too small to effectively manual scrub instruments in line with guidance.

Some shortfalls identified at our previous inspections had been addressed. We saw that staff appraisals had been completed and disclosure barring service checks were in place. There had been no newly recruited members of staff since the inspection in 25 September 2018 and therefore no evidence of any new staff induction.

Recruitment information, in line with Schedule 3 was now in place at the practice for the one visiting member of staff. There were no records to confirm Hepatitis B immunity.

We looked at three staff records. Records of recent General Dental Council registration for clinical members of staff were now retained in staff records. There were records of clinical staff vaccinations, but there were still no records to confirm Hepatitis B immunity in clinical staff records and no supporting risk assessment to mitigate the risks.

There were limited assessments of potential risk from sharps undertaken. The dentist detailed how they continued to use conventional syringes and matrix bands. They described how they had not been able to source safer sharps or equipment such as a needle block. The practice did not provide evidence to CQC of a sharps risk assessment which gave consideration to the preferred method or who was responsible for handling and dismantling conventional equipment.

Are services well-led?

The practice had made some reasonable adjustments for patients with disabilities. This 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.

The practice had also made further improvements:
Systems for environmental cleaning had been reviewed at the practice taking into account current national specifications for cleanliness in the NHS. Cleaning equipment was appropriate and stored separately. Staff described oversight and checks of the cleaning service. There were no logs of these checks.

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 Regulation 17 Good governanceSystems 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: · There was no system in place to ensure good governance and effective leadership in the practice. · The provider had limited oversight of systems to monitor the servicing of equipment at the practice. · There was little understanding or oversight by the provider of what further action was required with regard to the actions identified from the full survey of radiation equipment. · The provider had limited understanding or oversight of what further action were required with regard to the 15 recommendations identified in the January 2018 legionella risk assessment. · Checks in place were not effective to monitor all emergency drugs and equipment and we were not assured a system was in place to mitigate risks we had previously identified. · There were no records to confirm Hepatitis B immunity in clinical staff records or visiting clinical staff records and no supporting risk assessment to mitigate the risks.

This section is primarily information for the provider

Requirement notices

· The practice had not submitted an action plan following either inspections on 20 November 2017 and on 25 September 2018.

Regulation 17 (1)