The Smile Centre (UK) Limited

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Inspection Report

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Overall summary

We carried out a follow-up inspection at The Smile Centre (UK) Limited on 27 March 2018.

We had undertaken an announced comprehensive inspection of this service on 16 January 2018 as part of our regulatory functions where breaches of legal requirements were found.

After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breaches. This report only covers our findings in relation to those requirements. We checked whether they had followed their action plan to confirm that they now met the legal requirements.

We reviewed the practice against two of the five questions we ask about services: are the services safe and well led? You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Smile Centre (UK) Limited on our website at www.cqc.org.uk.

We revisited The Smile Centre (UK) Limited as part of this review and checked whether they now met the legal requirements. We carried out this announced inspection on 27 March 2018 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 CQC inspector who was supported by a specialist dental adviser.

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

This question forms the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services well-led?

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

Background

Summary of findings

The Smile Centre (UK) Limited is in the Whitefield area of Manchester and provides private dental treatment to adults.

There is level access for people who use wheelchairs and pushchairs. A ground floor surgery is available. This is only suitable for patients requiring denture work. Car parking spaces are available near the practice.

The dental team includes two dentists, two dental nurses, (one of whom is a trainee), a treatment coordinator and a receptionist. The practice has enrolled the help of a compliance consultant. 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 Care Quality Commission 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. At the time of the inspection the practice did not have a registered manager in post.

The organisation had recently undergone a period of change and was now under new ownership.

On the day of inspection, we spoke with one patient. This information gave us a mixed view of the practice.

During the inspection we spoke with one dentist, the dental nurses, the receptionist, the treatment co-ordinator, the compliance consultant and the practice owner. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Thursday from 9:00am to 7:00pm

Friday from 9:00am to 12:30pm

Our key findings were:

- The practice was clean and well maintained.
- Significant events were not consistently reported or recorded.
- Staff had completed training in how to deal with medical emergencies. Appropriate life-saving equipment was available. Not all medical emergency medicines were available.
- The practice had completed a fire and Legionella risk assessment. Recommendations from these risk assessments had not been completed.
- The practice's recruitment procedures had improved. Further improvements were required to the process for obtaining evidence of immunity to Hepatitis B for clinical staff.
- A patient satisfaction survey had recently been started.
- Complaints were not always dealt with in line with the practice's policy. Verbal complaints were not always documented.
- Quality assurance processes were not fully embedded within the culture of the practice.
- The practice lacked effective leadership. A new compliance system had been introduced to the practice. Not all staff were familiar with how to access the policies and procedures.

We identified regulations that were not being met and the provider must**:**

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

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?

Enforcement action 

We found that this practice was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We have told the provider to take action (see full details of this action in the Enforcement Action 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.

Since the inspection on 16 January 2018 some improvements had been made. We were not assured that systems and processes had been implemented to ensure compliance with the regulation.

We were told that significant events would be reported and documented. We were told of an event which could be deemed as a significant event. This had not been reported to the practice owner or recorded.

A sharps risk assessment had not been carried out. There were no details in the sharps injury protocol of where to contact in the event of a sharps injury.

Staff had completed medical emergency training. The medical emergency equipment reflected current guidance. There was no glucagon in the medical emergency kit. This had not been identified by the practice's checking system.

Improvements had been made to the recruitment process. Further improvements could be made to ensure evidence of immunity to Hepatitis B is sought at the point of employment.

Fire and Legionella risk assessments had been carried out. The recommendations from these risk assessments had not been actioned.

Staff were unable to demonstrate if recommendations from the critical examination of the OPT machine had been actioned. This had been identified at the inspection on 16 January 2018.

Are services well-led?

Enforcement action 

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 Enforcement Action section at the end of this report).

A change of ownership since the last inspection had disrupted the service delivery and the new owner was in the process of assessing the requirements. Not all staff were aware of how to access policies and procedures. Individual leads had been identified for roles. The practice had recently employed a lead dental nurse who was going to be responsible for governance at the practice.

Summary of findings

Systems and processes to reduce the risks associated with the carrying out of the regulated activities had not been implemented. These included fire, Legionella, sharps and referrals of suspected malignancies.

Quality assurance processes had not been fully implemented at the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff described to us how accidents, incidents and significant events would be reported. We were told no significant events had been reported since the last inspection. We asked to see the accident book. There was one accident which had been documented. Other staff were unaware this had been documented. During the inspection a patient described to us an incident which occurred at the practice whilst they were waiting for their appointment. This had not been reported to the management or recorded as a significant event.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of adults who were vulnerable due to their circumstances. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. We saw evidence that staff received safeguarding training and were due to complete further training in the near future. Contact details for the local safeguarding team were available if required.

Staff were familiar with the concept of whistleblowing. Staff told us they felt confident they could raise concerns without fear of recrimination. We asked the dentist where they could find the whistleblowing policy. They were unaware of where this would be.

We looked at the practice's arrangements for safe dental care and treatment. A safer sharps system was in use at the practice and the dentist was responsible for handling sharps. There was no documented risk assessment to support this. The sharps injury protocol displayed in the surgery did not have contact details of where a staff member could go in the event of a sharps injury.

Medical emergencies

Staff had all completed medical emergency training. Emergency equipment was available as described in recognised guidance. We noted there was no glucagon (a drug used for the treatment of severe hypoglycaemia). We were shown evidence that it had been ordered but the company had sent the incorrect item. This had not been identified during the regular checking of the medical emergency medicines which had been implemented.

Staff recruitment

Improvements had been made to the recruitment process. We looked at three staff recruitment files. These showed the practice followed their recruitment procedure.

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

Monitoring health & safety and responding to risks

Since the inspection on 16 January 2018 a fire risk assessment and a health and safety audit had been carried out by an external company. The fire risk assessment recommended that the practice implements regular checks of the fire alarm and emergency lighting, displays a fire evacuation procedure and carries out fire drills. None of these recommendations had been actioned.

We noted there was no evidence of immunity to Hepatitis B for two new members of staff. One of these staff members was involved with the manual scrubbing of used dental instruments.

We were shown the Control of Substance Hazardous to Health (COSHH) folder. This now contained safety data sheets for substances used in the practice. The external cleaner had their own COSHH folder for domestic cleaning products.

Infection control

Improvements had been made to the infection prevention and control procedures. Instruments were now manually scrubbed fully immersed in water with a detergent. Light magnification was used to inspect the instruments after decontamination prior to them being sterilised. Instruments were bagged and we saw they were all within their expiry dates.

An external cleaner had been employed by the practice. We saw evidence of a cleaning schedule and cleaning equipment for different areas of the practice.

Are services safe?

A new Legionella risk assessment had been carried out. This had recommended the removal of a dead leg, monthly water temperature testing and the flushing of the dental unit water lines following lunchtime and at the end of the day. These recommendations had not been actioned.

We asked to see an infection prevention and control audit. We were shown one which had been partially completed.

Equipment and medicines

We evidence of servicing documentation for the autoclave and the compressor. The washer disinfector had been taken out of use by the practice.

Radiography (X-rays)

At the inspection on 16 January 2018 we observed that the orthopantomogram X-ray machine critical examination report contained some recommendations including ensuring the X-ray dose was not too high. There was no evidence these recommendations had been considered or actioned. We asked to see evidence that these had been actioned. Staff were unable to provide evidence that this had been done. We saw a letter from the radiation protection adviser asking for "additional information" with regards to the X-ray machines. Staff were unable to show us evidence that this letter had been replied to.

Local rules were now available. The local rules did not contain the name of one of the new dentists.

An X-ray audit had been completed by a dentist. This reflected current guidance and legislation.

Are services well-led?

Our findings

Governance arrangements

Since the inspection on 16 January 2018 the practice had introduced an electronic clinical governance system. We were shown this system and how policies and procedures would be accessed by staff. These policies had been adapted to reflect the individual nature of the practice. We saw evidence from these policies that individual leads had been appointed. These included a lead for safeguarding and one for infection control. We were told that staff had access to the policies and procedures. When we spoke with staff, not all were familiar of how to access these.

Some improvements had been made to the process for managing risk. For example, fire and Legionella risk assessments had been completed. Both risk assessments contained recommendations. The practice had not acted on these recommendations. A sharps risk assessment had not been completed.

During the inspection we spoke with the dentist about whether there were any referral pathways in order to refer patients to secondary care if they needed treatment the practice did not provide. They were unaware of any such pathways. We asked what they would do in the event of a patient presenting with a suspected malignancy. They were unaware of where to refer such patients.

We asked to see evidence of how the practice dealt with complaints. We saw a complaint which had been received by the practice on 19 March 2018. The patient again contacted the practice on 26 March 2018 to enquire if they had received the complaint. The compliant was acknowledged on 26 March 2018. The practice complaints policy stated that complaints should be acknowledged within three working days. We also discussed how verbal complaints were dealt with. We were told that verbal complaints were not always documented.

Leadership, openness and transparency

The practice lacked an effective leadership structure. A new member of staff had recently been employed to oversee the day to day running of the service. They had only been in the post for one day and had not had sufficient time to implement systems and processes in order to ensure the smooth running of the service.

Staff and the patient told us that in the last few weeks there had been a marked improvement in the atmosphere within the practice. Staff told us that the new owner listened to them and is engaged with them. It was clear the new owner was focussed on making improvements and providing the necessary leadership.

Learning and improvement

We saw a radiography audit had been completed by a previous dentist. This reflected current guidance and legislation. We were told these audits would be completed for the new dentists going forward.

We asked to see an infection prevention and control audit. We were shown an audit which had been partially completed.

Practice seeks and acts on feedback from its patients, the public and staff

We were told and saw evidence that a patient satisfaction survey had been commenced. This focussed on the patient's experience of the practice. As it was in the early stages no results had been identified yet.

This section is primarily information for the provider

Enforcement actions

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 **How the regulation was not being met** The registered person had systems or processes in place that operated 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 infection prevention and control audit had not been fully completed. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Significant events were not consistently reported or recorded. • A sharps risk assessment had not been completed. • There were no details in the sharps injury protocol of who to contact in the event of a sharps injury. • The system for checking the emergency drugs failed to identify the lack of glucagon. • Recommendations resulting from the fire risk assessment had not been actioned.

This section is primarily information for the provider

Enforcement actions

- Recommendations from the Legionella risk assessment had not been actioned.
- Evidence of immunity to Hepatitis B was not available for two members of staff.

There was additional evidence of poor governance. In particular:

- Not all staff were aware of how to access policies and procedures.
- Complaints were not dealt with in line with the practice's policy.
- A referral pathway was not in place for urgent referrals.
- There was no evidence that recommendations from the critical examination of the OPT machine had been actioned.