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Hitchin Dental Centre

Inspection report

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Overall summary

We carried out this announced inspection on 4 May 2021under 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.

As part of this inspection we asked the following questions

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was providing effective 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.

Summary of findings

Background

Hitchin Dental Centre is a well-established practice that offers both private and NHS treatment to patients. It is based in Hitchin has four treatment rooms. The dental team includes four dentists, five dental nurses, a hygienist and reception staff. The practice is a referral centre for endodontics, prosthodontics and periodontics, and one dentist has a special interest in removeable dentures.

The practice is open Monday to Friday from 9am to 5.30pm.

The practice is owned by an individual who is the principal dentist. 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.

On the day of inspection, we spoke with two dentists and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had systems to help them manage risk to patients and staff.
- Staff felt respected, supported and valued.
- Systems for obtaining patient feedback about the service were good
- The practice appeared to be visibly clean and well-maintained.
- Comprehensive procedures had been implemented to reduce the spread of Covid-19.
- Recruitment procedures did not ensure that appropriate checks had been completed prior to new staff starting work
- Clinicians did not follow the guidance provided by the Faculty of General Dental Practice when completing patient dental care records.
- Medicines and prescription management did not follow nationally recommended guidance.

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

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 effective?	**No action** 
Are services well-led?	**Requirements notice** 

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training and knew about the signs and symptoms of abuse and neglect, and how to report concerns. One of the nurses was the lead for safeguarding concerns and planned to undertake a level three safeguarding course in August 2021. Information about key protection agencies was on display in the staff area, making it easily accessible.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. Latex free rubber dams were also available.

We confirmed that all clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. The practice had a recruitment policy and procedure to help them employ suitable staff, which reflected the relevant legislation. We looked at recruitment information for the most recently recruited employee. This showed the practice had not followed their procedure, as a recent disclosure and barring check had not been obtained for them at the point of their recruitment, and only one reference had been obtained.

The practice ensured that facilities were safe, and that equipment was serviced according to manufacturers' instructions, including electrical and gas items. A maintenance service for the practice's air conditioning unit was commissioned immediately following our inspection. Records showed that fire detection and firefighting equipment was regularly tested, and staff undertook fire drills. One of the dentists had undertaken specific fire marshal training.

The practice had a business continuity plan describing how staff would deal with events that could disrupt its normal running.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and the practice had the required information in their radiation protection file. Rectangular collimators were in use to reduce patient exposure.

The dentists justified, graded and reported on the radiographs they took. However, we noted that radiographic bitewings had not been taken in accordance of FGDP guidelines. The practice carried out radiography audits, but these audits were limited in scope as they did not include the actual grade of the X-ray to demonstrate if national guidelines were being met.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards and detailed the control measures that had been put in place to reduce the risks to patients and staff. This included specific Covid-19 risk assessments for each member of staff. However, the practice had not implemented a local safety procedure to prevent wrong site dental extractions. Following our inspection, the provider wrote to us to confirm this had been implemented and sent us a photo of a laminated copy of the procedure that had been displayed in each treatment room.

Are services safe?

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. A safer sharps system was available in the practice but not all the dentists used it. A risk assessment had not been completed to justify this. Sharps' bins were sited safely and labelled correctly.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Emergency equipment and medicines were available as described in recognised guidance, apart from clear face masks sizes 0 to 4. However, these were ordered immediately following our inspection.

There was a comprehensive Control of Substances Hazardous to Health (COSHH) Regulations 2002 folder in place containing chemical safety data sheets for the materials used within the practice. We noted this had been reviewed regularly to ensure its contents were up to date.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff carried out infection prevention audits and the latest audit showed the practice was meeting the required standards. Additional measures had been implemented to the patient journey to reduce the spread of Covid-19.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05, although we noted that dirty instruments were not always kept moist whilst waiting to be sterilised and staff were not measuring the volume of water needed for the detergent to achieve the correct concentration specified by the detergent manufacturer. Following our inspection, the provider emailed to inform us that the correct dilution information for manually cleaning instruments had been put on display above the sink.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

We saw staff had procedures to reduce the possibility of legionella or other bacteria developing in the water systems, in line with a risk assessment. A risk assessment had been completed in 2017 and records of water temperature and dip slide testing were maintained.

We noted that all areas of the practice were visibly clean, including the waiting area, corridor toilets and staff areas. We checked treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. Staff told us they were issued with enough uniforms to wear a clean one each day.

The practice used an appropriate contractor to remove dental waste from the practice.

The provider had installed closed-circuit television to improve security for patients and staff and appropriate signage was in place warning of its use.

Safe and appropriate use of medicines

There was a stock control system for medicines which were held on site. However, there was no way of identifying if a medicines bottle had gone missing until the end of a batch. When we checked, the number of bottles of antibiotics recorded as being in stock, did not reflect the actual amount held. This had not been identified by staff. Legally required dispensing information, such as the practice's details, was not displayed on the bottle labels.

Patients' notes we viewed showed that the dentists had been not been prescribing the nationally recommended dosage of antibiotics and they were unaware of current guidance.

A hygienist worked at the practice, but a patient group directive had not been completed to allow them to administer local anaesthetics, without the need for a written, patient-specific prescription from an approved prescriber. This issue was rectified following our inspection.

Are services safe?

Logs were kept demonstrating that the fridge temperature where glucagon was stored, was monitored to ensure it operated effectively.

Lessons learned and improvements

The practice had procedures in place to investigate, respond to, and learn from significant events and complaints, and staff were aware of formal reporting procedures. We viewed a report that had been completed for one incident concerning a patient complaint.

A system was in place to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and implement any action if required. All alerts were downloaded to a file and relevant dental ones were disseminated to staff, who signed and dated them.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The principal dentist told us that he was a member of The British Society for Restorative Dentistry to help him ensure that clinical care was in line with nationally agreed standards across the practice.

The principal dentist offered dental implants to patients and we noted he had undergone appropriate post graduate training for this. We found that the provision of dental implants was in accordance with national guidance.

We checked a sample of dental care records and saw that patients' medical histories had been regularly updated and that intra-oral examinations and soft tissue checks had been completed. However, patients' risk of caries, periodontal disease and oral cancer had not always been recorded consistently to inform recall intervals. Some patients had not received a basic periodontal examination and clinicians were unaware of the recommended age patients should receive these.

The practiced offered sedation to very nervous patients, which was provided by a visiting specialist. However, the practice did not fully assure itself of the visiting sedationist's competency or qualifications for the role. Following our inspection, we were sent evidence that this had been obtained.

Helping patients to live healthier lives

The dentists discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health. A dental hygienist was employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease.

Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the Act when treating adults who might not be able to make informed decisions. However, staff were less sure about their responsibilities in relation Gillick competence guidance when treating patients under the age of 16 years old. Following our inspection, the practice sent us a copy of their newly implemented Gillick Competence and Fraser guidelines. Not all dental care records we viewed clearly evidenced the patient consent process.

Effective staffing

Staffing levels had not been unduly affected by the Covid-19 pandemic, and there were enough suitably qualified staff to treat patients safely and effectively. The hygienist worked with chair side support.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role.

The provider had current employer's liability insurance in place.

Co-ordinating care and treatment

The practice was a referral clinic for periodontics and endodontics, and staff checked of all incoming referrals daily. Outgoing patient referrals were monitored effectively to make sure they were dealt with promptly.

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 section at the end of this report).

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice and was also supported by his staff. Management responsibilities had been shared across the whole staff team with specific leads for areas such as health and safety, reception, governance, infection control and radiography.

The principal dentist told us he was a member of a WhatsApp group of about 40 clinicians where best practice and changes of regulations were shared.

Culture

The practice was small and friendly and had built up a loyal and established patient base and staff group over the years. Staff told us they felt respected and valued, and clearly enjoyed their job. One staff member told us that senior staff been very supportive and understanding of their caring responsibilities, something which they greatly appreciated.

The practice had a duty of candour policy in place, and staff were aware of its requirements for openness and honesty with patients if things went wrong.

Governance and management

The practice had comprehensive policies, procedures and risk assessments to support the management of the service and to protect patients and staff. At the time of our visit staff were in the process of switching to a new on-line governance tool to assist them in the running of the practice.

Staff told us that communication systems in the practice were effective, with a monthly team meeting which now took place on-line to reduce the risk of Covid-19 spread.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. All patient records were kept in locked cabinets behind the reception area.

The practice had a policy which detailed its complaints procedure, the timescales for managing them and other organisations where patients could raise their concerns. One of the dentists was the lead for patients' complaints and details of how to complain were available in the corridor for patients. These were moved to a more visible area following our inspection. We viewed the most recent complaint received by the practice and noted it was not possible to ascertain if it had been managed in line with the practice's own policy.

We identified a number of shortfalls during our inspection including the recruitment of staff, the quality of dental care records, medicines management, antibiotic prescribing, auditing, and the handling of complaints. Although the provider rectified some of these issues following our inspection, it was clear that the practice's governance procedures had not been effective in identifying them in the first place and needed to be strengthened as a result.

Engagement with patients, the public, staff and external partners

Are services well-led?

The practice used surveys to gain patient feedback about its service. Patients were asked to comment on ease of making appointments waiting times, value for money and the quality of their treatment. We viewed about a dozen completed surveys which indicated high levels of patient satisfaction in all areas. The practice also used the NHS Friends and Family Test and 20 patient responses we checked were positive. A staff member told us that one patient's suggestion to remove old carpeting in the reception area had been actioned, demonstrating that the practice listened to its patients.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and told us these were listened to and acted upon.

The GDC's standards for the dental team were also on display setting out the industries standards of conduct, performance and ethics so that patients would know what to expect from their treatment.

Continuous improvement and innovation

All staff received an annual appraisal of their performance by one of the senior dentists, evidence of which we viewed. Staff told us they found their appraisal useful as they received feedback about what they did well and areas for improvement. Staff also had personal development plans in place.

However, we found that some audits needed to be improved. For example, the radiography audit did not include grading and the dental care records audit had failed to identify some of the shortfalls we noted.

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 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 ineffective systems or processes in place as 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: • Recruitment procedures did not ensure that appropriate checks had been completed prior to new staff starting work • Sharps management procedures to did not comply with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice. • Medicines and prescription management did not follow NICE guidance. • Anti-biotic prescribing did not follow FGDP(UK) Antimicrobial Prescribing for General Dental Practitioners guidance.

This section is primarily information for the provider

Requirement notices

- Audits of dental care records and radiography were not effective in identifying shortfalls and areas for improvement.
- Clinicians did not follow nationally recommended guidance in the identification of patients' periodontal disease.
- There was no effective system for recording, handling and responding to patients' complaints.