Manor House Dental

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 30 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 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.
- The practice did not have infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Most appropriate medicines and life-saving equipment were available.
- The practice had systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- The practice did not have staff recruitment procedures which reflected current legislation.
- 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 appointment system worked efficiently to respond to patients' needs.
- 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 effective leadership and a culture of continuous improvement.
- Staff felt involved, supported and worked as a team.
- Complaints were dealt with positively and efficiently although recording of complaints required strengthening.
- The practice had information governance arrangements.

Background

Manor House Dental is in South Yardley, Birmingham and provides NHS and private dental care and treatment for adults and children.

The services are provided by 2 CQC registered providers at this location. This report only relates to the provision of general dental care provided by Manor House Dental, (Provider - Manor House Dental). An additional report is available in respect of the general dental care services which are registered under Manor House Dental, (Provider - Scandi Smile Centre Limited).

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 3 dentists, 4 dental nurses, 1 dental therapist, 1 practice manager and 3 receptionists. The practice has 3 treatment rooms.

During the inspection we spoke with 2 dentists, 3 dental nurses 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 from 8.30am to 5.30pm.

Tuesday from 8.30am to 5pm.

Wednesday from 8.30am to 12.30pm.

Thursday from 10.15am to 7.45pm.

Friday from 8.30am to 5.30pm.

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

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

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

Full details of the regulation/s the provider was/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 the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council. Implement an effective system of checks of medical emergency equipment and medicines taking into account the guidelines issued by the Resuscitation Council (UK).

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.

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?	**No action** ✓
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**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 and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice had infection control procedures however at the time of the inspection they did not reflect published guidance. We found instruments stored in the surgery that had been through the decontamination process but were not stored in pouches or marked in a way to identify the date of decontamination. The provider was therefore unable to verify the sterilisation expiry date.

The practice systems to manage the risk associated with the development and spread of water borne bacteria were not effective. Specifically, the provider had not undertaken training required to be competent in carrying out a legionella risk assessment of the building and was therefore unaware of whether there were any actions required to safely maintain water systems in the premises. Testing and recording of hot and cold water temperatures were not carried out. Following our inspection an external company was booked to carry out a risk assessment.

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 and there was an effective schedule in place to ensure it was kept clean however no checklists were in place. Following our inspection, the provider submitted evidence of a checklist to be completed moving forward.

The practice had a recruitment policy and procedure to help them employ suitable staff. The policy reflected the relevant legislation. However, we found the practice were not following their own policy. Appropriate Disclosure and Barring Service (DBS) checks were not always carried out at the point of recruitment. We identified scope for improvement in ensuring that records of all required pre-employment checks were kept and available for all staff.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

The management of fire safety was not effective. We were told the routine recommended checks of the emergency lighting and fire extinguishers were carried out but not recorded. Following our inspection an external company was booked to carry out a risk assessment.

The practice had some arrangements to ensure the safety of the X-ray equipment. We noted the radiation protection information that was available required updating. For example, the displayed local rules were not in date and were missing some information. We found 2 of the treatment rooms did not have the recommended rectangular collimators. Following the inspection, the collimators were ordered by the provider.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety. A lone working policy was in place; however we noted a risk assessment for those staff working alone had not been carried out.

Are services safe?

Most emergency equipment and medicines were available. We found the 1ml syringes for adrenaline administration and the eyewash kit was missing. The self-inflating bag with reservoir for a child was missing and the adult size was not displaying an expiry date.

We found that some medicines were stored in a fridge. Records of the temperature of the fridge were carried out weekly rather than the recommended daily so the provider could not be assured that medicines were stored in line with guidance. We identified scope for improvement in ensuring that checks of the availability and effectiveness of equipment were carried out at required intervals. Following the inspection, the provider submitted evidence that recording processes were updated.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Child size pads for the automated external defibrillator (AED) were not available and staff were not aware of how to use the adult size pads on a child.

The practice did not carry out risk assessments to minimise the risk that could be caused from substances that are hazardous to health although safety data sheets were available. Following the inspection samples of risk assessments were submitted.

Information to deliver safe care and treatment

We found not all patient care records were complete and legible. We found recording of treatment options, consent and recall intervals were not clearly documented.

The practice had systems for referring patients with suspected oral cancer under the national 2-week wait arrangements.

Safe and appropriate use of medicines

We found shortfalls with the practice systems for appropriate and safe handling of medicines. There was no effective system in place for the security of NHS prescriptions pads or to identify any lost or missing prescriptions. Following our inspection, a log was put in place for dispensing of antibiotics. Antimicrobial prescribing audits were not carried out.

At the time of inspection there was no Patient Group Directive (PGD) in place for the Dental Therapist who was providing direct access to patients.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. 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 practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

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

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

At the time of our inspection there was no Mental Capacity Act policy in place and there was a lack of understanding amongst staff regarding their role in its application. Staff had not carried out training in this area. A policy was introduced following our inspection.

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 dentists justified, graded and reported on the radiographs they took however, this was not carried out consistently. The practice carried out radiography audits. These were not carried out within 6-monthly intervals as stated in current guidance. We found that action plans were not always developed from these.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. At the time of our inspection there was no log in place to monitor these referrals. Evidence was presented following our inspection of a log to be used in the future.

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. Staff described to us some of the ways they enabled nervous patients to access their treatments and the additional measures they implemented to support them, for example, arranging appointments during quieter times of the day.

Staff were observed to be friendly, caring and helpful to patients when speaking with them in person and over the telephone.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. Computer screens were not visible to the public at reception and there was an available area away from reception where patients could have a private discussion if requested.

The practice had installed closed-circuit television to improve security for patients and staff. At the time of our inspection, we were informed that it was out of order. No policies or risk assessments were viewed at the time of our inspection.

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

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. We found treatment options were not always recorded in clinical care records.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentists explained the methods they used to help patients understand their treatment options. These included 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.

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

The practice had made reasonable adjustments, including step free access, ground floor treatment rooms and accessible toilet facilities for patients with access requirements. Staff had carried out a disability access audit.

Timely access to services

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

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

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. When the practice was unable to offer an urgent appointment, they worked with local 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 responded to concerns and complaints appropriately. The recording of complaints required strengthening as the log was only filled out once the complaint was resolved rather than throughout the process.

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

Leadership capacity and capability

We identified some shortfalls in relation to the leadership provided, relating to governance systems, recruitment, peoples' safety and continually striving to improve.

Following our inspection, the provider submitted information addressing many of the shortfalls we identified, demonstrating the providers commitment to improving the service for both staff and patients. However, these processes and systems were not embedded within the practice.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs during annual appraisals and during clinical supervision. They also discussed learning needs, general wellbeing and aims for future professional development.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff. Not all policies, protocols and procedures accurately reflected the systems and processes undertaken at the practice.

Appropriate and accurate information

Staff did not always have access to appropriate and accurate information, specifically in relation to fire safety and Legionella monitoring.

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. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

The practice had systems and processes for learning and quality assurance. These included audits of patient care records, disability access, radiographs and infection prevention and control. Antimicrobial prescribing audits were not carried out and we found the infection control audit did not reflect the current working processes undertaken at the practice. Staff kept records of the results of these audits however, they did not show any resulting action plans where appropriate for continuous improvements.

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 12 CQC (Registration) Regulations 2009 Statement of purpose **Regulation 12, Safe care and treatment.** **How the regulation was not being met** Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out and the registered person had not done all that was reasonably practicable to mitigate these risks. In particular: • The security of NHS prescription pads and the system to track and monitor their use was not effective. • Infection prevention and control processes were not in line with HTM 01-05 guidance. In particular, the process of manual cleaning of instruments. • A Legionella risk assessment carried out by a competent person was required and regular monitoring of water temperatures taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.' • A fire safety risk assessment had not been carried out by a competent person. Monitoring of fire detection and suppression equipment had not been recorded. • At the time of inspection there was no Patient Group Directive (PGD) in place for the Dental Therapist who was providing direct access.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 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:

- The systems in place to ensure recruitment procedures complied with the requirements of the regulation were not effective. The provider was unable to demonstrate that all documents required under Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were available for all staff.
- There was a lack of understanding amongst staff regarding their role in the application of the mental capacity Act 2005 and staff had not carried out training in this area.
- There were no systems in place to ensure private patient referrals to other dental or health care professionals were centrally monitored to ensure requested treatment is completed.
- Systems to ensure patient consent to care and treatment was obtained and recorded were not consistently applied to ensure the practice was in compliance with legislation.
- Audits for radiography were not completed at the recommended time scales and the infection prevention and control audit did not reflect working processes. Antimicrobial prescribing audits were not carried out. Audits did not show resulting action plans and improvement where appropriate.

This section is primarily information for the provider

Requirement notices

- The practice's 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 required improvement taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.