Enhance Dental Centre Partnership

Enhance Dental Centre

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 8 March 2023 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 visibly clean.
- The dental practice was visibly clean.
- The practice's infection control procedures were not effective.
- Staff knew how to deal with medical emergencies.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures were not operated effectively.
- The clinicians provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.

Summary of findings

- 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.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Background

Enhance Dental Centre is in High Wycombe and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice via a portable ramp, for people who use wheelchairs and those with pushchairs.

Car parking, including dedicated parking for disabled people, are available near the practice.

The practice has made reasonable adjustments to support patients with access requirements. These include:

- A hearing loop.
- Accessible toilet.
- Vision aids (a magnifying glass).
- Step free access (via a ramp).

The dental team includes 6 dentists, 1 dental nurse, 4 student dental nurses, 2 dental hygiene therapists and 2 receptionists.

The practice has 5 treatment rooms.

During the inspection we spoke with 3 dentists, 3 dental nurses and 2 receptionists.

We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

- Monday 9.00am – 5.00pm
- Tuesday 9.00am – 5.00pm
- Wednesday 9.00am – 5.00pm
- Thursday 9.00am – 5.00pm
- Friday 9.00am – 5.00pm

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

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

There were areas where the provider could make improvements. They should:

Summary of findings

- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.

Improve the practice protocols to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

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 did not have effective management of infection control procedures. Specifically:

The infection control audit was not completed correctly. Findings did not reflect current practice. We have since received evidence to confirm this shortfall has been addressed.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems but improvements were needed. Specifically:

Two of the 4 sentinel taps were water temperature tested. A legionella risk assessment highlighted that all 4 taps were required to be tested. We have since received evidence to confirm this shortfall has been addressed.

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

There was not an effective cleaning process in place to ensure the practice was kept clean. Specifically:

- Cleaning checks were informal and not recorded.
- Cleaning equipment storage did not follow national guidance.

We have since received evidence to confirm these shortfalls have been addressed.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation.

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

A fire safety risk assessment was carried out in line with the legal requirements.

The management of fire safety was not effective. In particular:

- Emergency lighting was not tested correctly.
- Fire alarm tests did not include every alarm call point in the practice.
- We could not assure ourselves that the 2 gas boilers had been serviced in the previous 12 months.

We have since received evidence to confirm these shortfalls have been addressed.

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 provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus.

The effectiveness of the vaccination was checked for 7 of the 14 clinical staff. We have since received evidence to confirm this shortfall has been addressed.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available.

Are services safe?

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working but improvements were needed. Specifically:

- Three of the five sharps' bins in the practice were either not labelled appropriately or remained in use beyond the 3-month date they should be replaced.
- Sharps injury information was not available in any of the clinical areas of the practice.
- Lone working risk assessments were not available for both the hygienist and cleaner.
- Window blinds were present at practice windows. The operating cords were not secured to the window frame in line with British Safety standards.

We have since received evidence to confirm these shortfalls have been addressed.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Emergency medicines and equipment was stored near the first-floor patient wating area. This area was not monitored by staff. We have since received evidence to confirm this shortfall has been addressed.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health (COSHH).

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. Improvement was needed is areas. These included:

- COSHH applicable products were not stored securely.
- COSHH storage areas were not signed appropriately.
- A radiation warning sign was missing from the OPG room.

We have since received evidence to confirm these shortfalls have been addressed.

Information to deliver safe care and treatment

Patient care records were complete, legible.

- A computer in an X-ray area did not follow information governance codes of practice and locked when not in use.
- A General Data Protection Regulation (GDPR) compliant accident book could not be found.

We have since received evidence to confirm these shortfalls have been addressed.

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

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

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.

Dental implants

We saw the provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

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

involvement in local schemes

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

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.

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 dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance.

Effective staffing

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

Clinical staff completed continuing professional development (CPD) 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.

Referrals were not centrally monitored to ensure they were received in a timely manner. We have since received evidence to confirm this shortfall has been addressed.

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.

The practice had installed closed-circuit television (CCTV) to improve security for patients and staff. A privacy impact assessment was available.

Relevant protocols were not effective. In particular:

- CCTV was present in treatment rooms.
- Information for patients was not available to explain the purpose of recording images.
- The name and contact details of those operating the surveillance scheme were not displayed.

We have since received evidence to confirm these shortfalls have been addressed.

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

Historical paper records were stored in the attic of the practice which was not accessible to patients.

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.

The dentists explained the methods they used to help patients understand their treatment options. These included study models, X-ray images and an intra-oral camera.

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 has made reasonable adjustments to support patients with access requirements. These included:

- A hearing loop.
- Accessible toilet.
- Vision aids.
- Step free access (via a ramp).

Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

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

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 when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. 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. Staff discussed outcomes 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 (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.

Leadership capacity and capability

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective.

We saw the practice had processes to support and develop staff with additional roles and responsibilities, but improvement was needed to ensure the staff carried out their roles effectively.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

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 provider had overall responsibility for the clinical leadership of the practice.

The provider had a system of clinical governance in place which included policies, protocols and procedures. These were accessible to all members of staff, but systems were not routinely followed.

Specifically, the management of fire safety, COSHH, infection control, sharps and legionella required improvement.

We saw there were clear and effective protocols for managing risks, issues and performance but these were not followed which resulted in poor risk management at the practice.

We have since received evidence to confirm these shortfalls have been addressed.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice's information governance arrangements required improvement. We have since received evidence to confirm these shortfalls have been addressed.

Engagement with patients, the public and staff

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, surveys, 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, quality assurance, continuous improvement.

Are services well-led?

These included audits of patient care records, disability access, radiographs, antimicrobial prescribing, and infection prevention and control.

Staff kept records of the results of these audits and the resulting action plans and 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 17 HSCA (RA) Regulations 2014 Good governance 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: **Fire Safety** • Emergency lighting was not tested correctly. • Fire alarm tests did not include every alarm call point in the practice. • We could not assure ourselves that the 2 gas boilers had been serviced effectively in the previous 12 months. **Infection Control** • Cleaning checks were informal and not recorded. • Cleaning equipment storage did not follow national guidance. • The infection control audit was not completed correctly. **Sharps** • Three of the five sharps bins in the practice were either not labelled appropriately or remained in use beyond the 3-month date they should be replaced. • Sharps injury information was not available in any of the clinical areas of the practice. • Lone working risk assessments were not available for both the hygienist and cleaner. **Patient Safety** • Window blinds were present at practice windows. The operating cords were not secured to the window frame in line with British Safety standards.

This section is primarily information for the provider

Requirement notices

COSHH

- COSHH applicable products were not stored securely.
- COSHH storage areas were not signed appropriately.
- A radiation warning sign was missing from the OPG room.

Data Protection

- A computer in an X-ray area did not follow information governance codes of practice and locked when not in use.

Staff Training

- There was no evidence available to confirm that a visiting clinician completed IR(ME)R, fire safety and basic life support training.

CCTV

- CCTV was present in treatment rooms.
- Information for patients was not available to explain the purpose of recording images.
- The name and contact details of those operating the surveillance scheme were not displayed.

Legionella

- Two of the four sentinel taps were water temperature tested.

A legionella risk assessment highlighted that all 4 taps were required to be tested.