CK Dental Health Clinic Ltd

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Inspection report

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Overall summary

We carried out this announced focused inspection on 13 July 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we asked the following three 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

CK Dental is a small, well-established practice in Bishops Stortford that provides private treatment to about 1500 patients. The dental team includes just one dentist and a nurse/practice manager, the practice has two treatment rooms.

As access to the practice is down a steep set of stairs, it is not accessible to wheelchair users.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC 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. The registered manager at CK Dental is the dentist.

The practice is open Monday to Friday from 8.30am to 5pm, and appointments are available on a Saturday if required.

During the inspection we spoke with the dentist and the nurse/practice manager. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The provider had infection control procedures which reflected published guidance.
- The provider had systems to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider asked patients for feedback about the services provided.
- The provider dealt with complaints positively and efficiently.
- The provider had staff recruitment procedures which reflected current legislation.
- There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice.
- There were no systems to ensure the effective medicines management and storage.
- There was no system to ensure that regular audits of radiography, antibiotic prescribing and infection control were undertaken at recommended intervals to improve the quality of the service.

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

Full details of the regulation the provider was not meeting are at the end of this report.

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

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.

Summary of findings

- Take action to ensure the clinicians take into account the guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when promoting the maintenance of good oral health

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

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)

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 provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The practice had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

Staff were aware of the recommended way to document when a child was not brought to a scheduled appointment to help identify any safeguarding concerns.

Both the dentist and nurse had disclosure and barring checks in place to ensure they were suitable to work. The practice had a whistleblowing policy in place which staff were aware of.

The provider 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, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. We noted that effective operating standards and measures had been implemented to reduce the spread of Covid 19.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. The practice did not have a washer disinfector so dirty instruments were cleaned by manual scrubbing. We explained to staff that this was the least effective cleaning method and risked increased injury to staff.

The practice undertook regular audits of its infection control procedures; however, these were conduct yearly as opposed to six-monthly as recommended in national 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 legionella assessment of the premises had been completed in 2014 and its recommendations had been actioned.

We saw effective cleaning schedules to ensure the practice was kept clean. We checked treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However, we noted some loose and uncovered dental materials and instruments in treatment room drawers that risked aerosol contamination, and some missing floor grouting that needed replaced. Clinical areas did not have clear signage indicating clean and dirty zones within them.

The provider had policies and procedures in place to ensure clinical waste was segregated, although external clinical waste bins would benefit from being attached to a fixed point to prevent their unauthorised removal. There was not a dedicated container for the safe disposal of crowns and bridges.

Staff told us that rubber dam were used for all root canal treatments. However dental care records we viewed, did not always evidence this. There was not always a clear record for the reason for not using a rubber dam, or a record of the alternative used to protect patients' airway.

Are services safe?

Although the provider had never had to recruit staff in the time, they had owned the practice, there was a recruitment policy and procedure to help employ suitable staff which reflected the relevant legislation.

The dentist was qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection and firefighting equipment was regularly tested. Fire exits were free from obstruction and clearly signposted. Recommendations from the practice's fire risk assessment to increase fire alarm checks from monthly to weekly had been implemented.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. Rectangular collimation was used to reduce patient exposure. We viewed evidence the dentist justified, graded and reported on the radiographs they took, although audits had not been completed following current guidance and legislation.

The dentist had completed continuing professional development in respect of dental radiography.

CCTV has been installed in the car park to provide additional security for patients and staff. Appropriate signage was in place, warning of its use.

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 in the practice and detailed the control measures that had been put in place to reduce the risks to patients and staff. Additional assessments had been completed for risks associated with the Covid-19 pandemic.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. The dentist used the safest types of needle as recommended in national guidance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Due to Covid-19 restrictions this training had been undertaken on-line in 2020. Staff were due to attend a hands-on practical course on 30 July 2021.In addition to this, staff discussed responding to different types of medical emergencies during their regular meetings, evidence of which we viewed.

Emergency equipment and medicines were available as described in recognised guidance. We noted there was no pocket mask with oxygen port, and not a full range of sizes for both adult and children's clear face masks. These were ordered following our inspection. Staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. However, the frequency of these checks needed to increase from fortnightly to weekly, to meet nationally recommended guidance.

The provider had risk assessments to minimise the risk that could be caused from substances that were hazardous to health.

Safe and appropriate use of medicines

The dentist was aware of current guidance with regards to prescribing medicines.

Medicines were stored securely in the practice, although there was no formal system of stock control in place. The fridge's temperature, where some medicines were held, was not monitored to ensure it operated within the correct temperature range.

The practice's name and address were not recorded on the container label of dispensed medicines.

Are services safe?

Anti-microbial audits were not completed to monitor that the dentist was prescribing antibiotics in line with national guidance.

Track record on safety, and lessons learned and improvements

The practice had an incident reporting policy in place and specific forms were available to complete in relation to these. We reviewed a recent incident and saw it had been completed in depth, with the action taken and learning from it documented.

The practice did not have its own formal place to receive medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and relied on notification from the local dental committee.

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. We saw the dentist mostly assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Patients' dental care records had been audited to check that the dentist recorded the necessary information. However, they had not been effective in identifying some of the shortfalls we found. For example, information and patients' risk level of caries, gum disease, oral cancer and non-carious tooth surface loss had not always been recorded. Patients' medical history updates had not been recorded at every course of treatment.

Helping patients to live healthier lives

There was a selection of dental products for sale to patients including interdental brushes, mouthwash, toothbrushes and floss. The practice also provided patients with a range of leaflets about oral health and dental treatments, although these had been temporarily removed due to Covid-19 restrictions. We noted a poster on the treatment room wall, with helpful information and diagrams in relation to surface caries, plaque discolouration and gingivitis that the dentist regularly used to help explain treatment to patients.

The dentist provided all hygiene services and was aware of the principals of the Delivering Better Oral Health toolkit. However, dental care records we viewed did not always demonstrate it had been implemented. For example, greater detail was needed as to the actual amounts of alcohol drunk and the number of cigarettes smoked by patients, and it was not always clear if advice had been provided around these.

Consent to care and treatment

Staff understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who were looked after. The dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. However, the practice did not have specific polices in relation to the Mental Capacity Act and Gillick competence.

Effective staffing

We confirmed the dentist 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.

Staffing levels at the practice had been hugely affected as a result of the Covid-19 pandemic, with two dental nurses having left as a result. The staff team was now very small, consisting of just the dentist and the nurse/practice manager. The nurse assured us that if they were not available to provide chair side support to the dentist, all patient appointments would be cancelled.

Co-ordinating care and treatment

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

Staff confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. This was done on-line so that referrals could be monitored. If not, the dentist always followed up with a phone call to ensure the referral had been received and acted upon.

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

The practice has faced significant staffing and financial challenges in the previous year. Two staff had left due to the Covid-19 pandemic, leaving the practice without any qualified nurses. The practice's previously dedicated practice manager had changed role and was in the process of undertaking dental nurse training. It was a credit to the determination and tenacity of the remaining staff that they had pulled through to maintain a service to their patients. Staff had clearly been focussed on the needs of their patients as a priority in challenging times and, as a result, routine governance had been adversely affected. For example, there was no effective system to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice, or that regular audits of radiography, antibiotic prescribing and infection control were undertaken at recommended intervals to improve the quality of the service. The management of medicines needed to improve to ensure their safe use as did the management of national patient safety alerts.

Staff were aware of the shortfalls and had begun their own action plan to remedy a number of shortfalls. They were looking forward to a period of calm and financial stability to allow them to implement improvements.

Culture

Staff demonstrated a transparent and open culture in relation to people's safety. Staff were responsive to our findings, and it was clear they were keen to remedy the shortfalls we had identified.

The provider did not have a specific Duty of Candour policy in place, although openness and honesty were demonstrated when responding to the incidents and complaints we reviewed.

Governance and management

There were some processes for managing risks, issues and performance. The practice had comprehensive policies, procedures and risk assessments to support the management of the service and to protect patients and staff. There were monthly practice meetings that were used to discuss policies and monitor aspects of the service, evidence of which we viewed.

The practice had a policy which detailed its complaints' procedure, and details of how to complain were available in the waiting area. The practice kept a specific register to record all complaints received from patients. We viewed the last complaint received and noted it had been investigated and responded to in a timely, empathetic and professional way.

Engagement with patients, the public, staff and external partners

The practice used its own survey to gather feedback from patients which covered areas such as the friendliness of staff, cleanliness and the explanation of treatment options. We viewed around 20 responses and noted high satisfaction rates reported by patients. Patients' suggestions to change the lighting in the toilet and provide an umbrella in reception had been implemented by the practice. The suggestion from a member of staff to install a handrail alongside a set of internal stairs had also been actioned.

Continuous improvement and innovation

Are services well-led?

The provider had some quality assurance processes to encourage continuous improvement. Audits were undertaken however we found they were not always completed as recommended, and audits for radiography and anti-biotic prescribing had never been conducted.

The principal dentist was a member of several national dental bodies as well as the local dental committee to help keep the practice up to date with the latest guidance.

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
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures	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 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: • There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice. • There was no system to ensure that regular audits of radiography, antibiotic prescribing and infection control were undertaken at recommended intervals to improve the quality of the service. • There was no system for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England. • There were no systems to ensure the effective medicines management and storage.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1)