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The Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 16 January 2020 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 always ask the following five 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:

Are services safe?

We found this practice was not 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 caring?

We found this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found this practice was providing responsive 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.

Background

The Dental Surgery in the London Borough of Southwark and provides NHS and private dental care and treatment for adults and children.

The dental team includes the principal dentist and two trainee dental nurses. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist there. 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 collected ten CQC comment cards filled in by patients and spoke with four other patients.

Summary of findings

During the inspection we spoke with the principal dentist and the two trainee dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open between 8.45am and 5pm on Monday to Fridays:

Our key findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had information governance arrangements.
- The clinical staff provided patients' care and treatment in line with current guidelines. Improvements were needed so that detailed records were maintained in respect of patient assessment and treatments carried out.
- Improvements were needed to ensure that the practice is visibly clean and well-maintained.

- The provider had infection control procedures which reflected published guidance. However these were not adhered to consistently.
- Staff knew how to deal with emergencies. Some life-saving equipment was not available on the day of the inspection. This was made available following our inspection.
- There were ineffective systems to help assess and manage risk to patients and staff.
- The provider had ineffective leadership to support a culture of continuous improvement.
- There were ineffective systems to monitor staff learning needs and to ensure that they understood and followed relevant guidance, policies and procedures.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties

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 always ask the following five questions of services.

Are services safe?	Requirements notice 
Are services effective?	No action 
Are services caring?	No action 
Are services responsive to people's needs? <Findings here>	No action 
Are services well-led?	Enforcement action 

Are services safe?

Our findings

We found this practice was not providing safe 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.

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. We saw evidence that the principal dentist had received safeguarding training. The trainee dental nurses told us that they covered safeguarding as part of their dental nurse training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had an infection prevention and control policy. Improvements were needed to ensure that staff 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. The dental nurses were not wearing suitable personal protective equipment such as suitable tunics and footwear when providing chairside support.

The provider had procedures for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The trainee dental nurses told us they covered infection prevention and control training as part of their dental nurse training course. Improvements were needed to ensure that staff followed these procedures when cleaning dental instruments. We saw that the dental nurses were manually cleaning dental instruments with bur brushes, which is not recommended and not in line with current national guidelines.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

The principal dentist described to us the procedures used to reduce the possibility of Legionella or other bacteria developing in the water systems. They told us that the dental unit waterlines were regularly disinfected and that cold water temperatures were monitored but there were no records maintained in respect of these measures. There was no hot water supply to the practice and the principal dentist told us that there was no mains gas supply to the premises. The principal dentist told us that a Legionella risk assessment had not been undertaken. This meant that they could not be assured that all risks had been assessed and that there were suitable risk control measures in place.

The practice had cleaning schedules and plans. When we inspected we saw that some areas of the practice were not visibly clean. Work surfaces and the interior of cupboards in the decontamination room were visibly dusty and dirty.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Some of these were not routinely followed. The dental sharps bin in the dental surgery was stored in a cupboard and not used. The dental nurses transferred dental sharps from the surgery to the decontamination room for disposal, which is contrary to guidelines.

The principal dentist was the infection control lead and carried out infection prevention and control audits twice a year. The latest audit indicated the practice was meeting the required standards. However the audit did not identify areas where the practice infection control procedures were not being adhered to.

The provider had whistleblowing policies and procedure. Staff felt confident they could raise concerns without fear of recrimination.

The dentist told us they used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was not documented in the dental care record and a risk assessment was not completed.

Are services safe?

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at four staff recruitment records. These showed the provider followed their recruitment procedure. All of the appropriate checks including Disclosure and Barring Service checks, proof of identity, evidence of conduct in previous employment where applicable were carried out.

We observed that the dentist was qualified and registered with the General Dental Council and had professional indemnity cover.

Improvements were needed to ensure that equipment was maintained according to manufacturers' instructions, including electrical installations and appliances. The dentist told us that the required five year fixed electrical test had not been carried out and no checks had been carried out for the portable electrical equipment.

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

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

We saw evidence the dentist, graded the radiographs they took and undertook audits to assess the quality of dental radiograph images. A review of patient dental care records showed that the dentist did not record the justification for taking dental radiographs or report on the findings to support clinical diagnosis and treatments provided.

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

Risks to patients

The provider had some systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. Staff did not follow the relevant safety regulation when using needles and other sharp dental items. There was no sharps risk assessment to identify risks associated with the use and disposal of dental sharps.

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. Improvements were needed to ensure that the effectiveness of the vaccinations was checked. Both trainee dental nurses had received suitable vaccinations. However there were no records to show that the effectiveness of the vaccines had been checked to ensure that staff were suitably protected against the risk of infection.

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

Emergency medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available and within their expiry date. Emergency equipment was available with the exception of an automated external defibrillator (AED). The dentist told us that they had made arrangements with two dental surgeries within close proximity to them to access their AED if needed. The dentist had not assessed or recorded the procedures for accessing an AED if needed or the risks to patients. During our inspection the dentist obtained a written agreement from one of the local dentists confirming that they could access an AED if needed. Following our inspection the dentist sent us a risk assessment which was to be implemented until an AED was purchased on 29 January 2020.

A dental nurse worked with the dentist when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. There was a record of hazardous substances used at the practice. However the risks associated with use or accidental exposure to these items had not been assessed.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We

Are services safe?

looked at dental care records to confirm our findings and observed that individual records needed improvement to be written and managed in a way that kept patients safe. Dental care records we saw were not complete nor legible.

Records were kept securely and in compliance with General Data Protection Regulation requirements.

The dentist did not have suitable systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist. The dentist told us that they would give patients a copy of the referral letter to take to the local hospital. There were no arrangements to check that the referral had been received or that the patient had been called for assessment or treatment.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

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

An Antimicrobial prescribing audit had been carried and this indicated the dentist was following current guidelines.

Track record on safety, and lessons learned and improvements

The provider had systems for reviewing and investigating should things go wrong.

In the previous 12 months there had been no safety incidents. The dentist told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The practice did not have suitable systems for receiving and acting on safety alerts. The dentist did not access, review or act on safety information such as patient safety alerts. The principal dentist was unaware of any safety alerts issued within the previous 12 months.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentist told us that they kept up to date with current evidence-based practice to delivered care and treatment in line with current legislation, standards and guidance. They undertook relevant training and professional development courses.

Helping patients to live healthier lives

The dentist told us they provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. They said they prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist told us that where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. They also described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. Improvements were needed to ensure details of these discussions were recorded within the patient dental care records.

Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005. The dentist understood their responsibilities under the act when treating adults who might not be able to make informed decisions. Patients confirmed the dentist listened to them and gave them clear information about their treatment.

Improvements were needed to ensure that staff documented patients' consent to care and treatment in line with legislation and guidance. The dentist told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw that improvements were needed to ensure suitable documentation was not documented in patients' records and consent forms were not completed.

Monitoring care and treatment

The dentist described how they assessed patients' treatment needs in line with recognised guidance. The dental care records, which we sampled required improvement in the recorded details and information about the patients' current dental needs and past treatment. Medical history records were incomplete and where patients indicated that they had medical conditions, such as cardiac conditions and where they were prescribed medicines, this information required proper documentation as part of an effective system for monitoring patients' care and treatment.

The principal dentist showed us a dental record audit which they had completed, which indicated that records were completed in detail. This however was not reflective of the dental records which we viewed during the inspection.

Effective staffing

Improvements were needed to ensure that staff had the skills, knowledge and experience to carry out their roles. The trainee dental nurses were enrolled on a training programme and had undertaken training in basic life support at the practice. Both nurses told us that they had completed an induction when they first started work at the practice. However there were ineffective systems to assess their training needs and to ensure that they understood and adhered to procedures, for example infection prevention and control practices.

We confirmed the dentist completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

The dentist told us they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There were ineffective arrangements to make and monitor referrals to ensure that patients received timely and appropriate treatment. There were no arrangements to monitor or follow up on referrals made to ensure that patients had been assessed or treated.

Are services caring?

Our findings

We found this practice was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were kind, caring, helpful and friendly. We saw staff treated patients respectfully and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting area was open plan in design. Staff were mindful when dealing with patients in person or on the telephone. If a patient asked for more privacy, the practice would respond appropriately. Staff did not leave patients' personal information where other patients might see it.

Staff stored paper records securely.

Involving people in decisions about care and treatment

The dentist told us they supported patients to be involved in decisions about their care. They were aware of the Accessible Information Standard and the requirements of the Equality Act.

- The principal dentist told us that they had not experienced any difficulties with patients who did not speak or understand English. They said that they would look into the availability of interpreter services if required.
- Staff communicated with patients in a way they could understand, and communication aids and easy-read materials were available.

Patients confirmed that the dentist listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example study models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

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. It took account of patient needs and preferences.

Staff were clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of supporting more vulnerable members of society such as patients with dementia, and adults with a learning difficulty.

Patients described high levels of satisfaction with the responsive service provided by the practice.

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

10 cards were completed, giving a patient response rate of 20%

100% of views expressed by patients were positive.

Common themes within the positive feedback were satisfaction with dental care and treatment, easy access to dental appointments and the friendliness and helpfulness of staff.

We shared this with the provider in our feedback.

We were able to talk with four patients on the day of inspection. Feedback they provided aligned with the views expressed in completed comment cards.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The layout of the practice which was located on the ground floor of the building provided step free access to the dental surgery. The size and layout of the premises did not afford provision for accessible toilet facilities. Staff had considered the needs of people who have a disability and were developing an action plan to assess and improve access for patients.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. We saw that patients who requested urgent appointments on the day were seen promptly.

Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Patients who required emergency dental treatments when the practice was closed had access to the NHS 111 out of hour's service.

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 confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

Staff told us the principal dentist took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

There was a policy providing guidance to staff about how to handle a complaint. The practice information leaflet explained how to make a complaint.

The dentist was responsible for dealing with these. Staff told us they would tell the dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The practice aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice had dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the previous 12 months. One complaint had been made about the practice within the previous 12 months and this was being investigated at the time of our inspection.

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 Enforcement Actions 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

The dentist was knowledgeable about issues and priorities relating to the quality and future of the service. The dentist had told us that they struggled at times to complete records in relation to the management of the service due to lack of time and peer support.

This was evidenced in the lack of some risk management and governance systems.

Culture

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

Staff discussed their training needs at annual appraisals. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals and personal development plans in the staff folders.

We saw the provider had systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. Policies and procedures were available and these were reviewed regularly.

Improvements were needed to support good governance and management. The dentist acknowledged that they struggled to maintain all of the systems required for the effective management of the practice due to lack of time available.

This impacted on the systems of clinical governance and oversight for the practice. Improvements were needed to ensure that there were clear and effective processes for managing risks and issues. Some risk assessments were not carried out and others were incomplete or did not accurately reflect the procedures carried out within the practice.

Appropriate and accurate information

Improvements were needed so that staff had access to and acted on appropriate and accurate information. Some audits were not carried out fully or consistently to give an accurate view of performance and adherence to guidance in relation to areas such as infection control procedures and effective record keeping.

Relevant safety information such as information in patient safety alerts was not available or used as part of an effective risk management system.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The provider used patient surveys to obtain staff and patients' views about the service. We saw examples of surveys which indicated that patients were very satisfied with the services they received.

The provider gathered feedback from staff 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.

Continuous improvement and innovation

The provider had some systems and processes for learning, continuous improvement and innovation. There were regular staff meetings where information and the outcome of audits carried out were reviewed and discussed.

Are services well-led?

Improvements were needed so that all of the required audits and reviews were carried out robustly as part of a continuous improvement plan for the practice.

The dentist completed the 'highly recommended' training as per General Dental Council professional standards

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 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: There were ineffective arrangements for assessing risks associated with the use and disposal of dental sharps. There were ineffective systems to assess and mitigate the risks associated with the use or accidental exposure to hazardous substances. There were insufficient quantities of equipment to ensure the safety of service users and to meet their needs. In particular: There was no automated external defibrillator available for use in the event of a medical emergency. There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: There were ineffective arrangements to manage risks of Legionella. There was no hot water at the practice and no Legionella risk assessment had been carried out.

Requirement notices

There were ineffective systems in place to ensure that staff were suitably protected against the risk of vaccine preventable infections. The effectiveness of vaccines had not been assessed for the dental nurses.

There were ineffective systems to ensure that staff followed infection control procedures in relation to cleaning dental instruments and wearing suitable personal protective clothing.

Where responsibility for the care and treatment of service users was shared with, or transferred, to other persons, the registered person did not ensure that timely care planning took place to ensure the health, safety and welfare of those service users. In particular:

There were ineffective systems to ensure that referrals were made safely and that they were monitored and followed up to ensure that patients were seen promptly.

There was additional evidence that safe care and treatment was not being provided. In particular:

There were ineffective systems to ensure that relevant safety information was accessed and used to minimise avoidable risks to patients.

Regulation 12(1)

Regulated activity

Diagnostic and screening procedures
Surgical procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform.

In particular:

There were ineffective systems to ensure that staff understood and adhered to relevant policies and procedures in relation to infection control practices.

There were ineffective arrangements to assess and support staff for their learning and development needs.

Regulation 18 (2)

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. 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: They did not have suitable or effective systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained. No records were available to show that the smoke detectors or the emergency lighting had been tested or checked. The provider was unable to tell us if or when these tests had been carried out. The provider could not provide us with a five-year electrical fixed wiring safety check certificate. You told us this safety check had not been carried out.

This section is primarily information for the provider

Enforcement actions

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user.

In particular:

The provider was failing to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulation 17 (1)