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Park Road Dental Surgery

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 14 June 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 adviser.

To get to the heart of patients' experiences of care and treatment, we always ask 5 key questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- 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.
- Staff knew how to deal with medical emergencies although not all essential medicines and life-saving equipment were available.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked well as a team.
- Patients were asked for feedback about the services provided.

Summary of findings

- Infection control procedures did not reflect published guidance.
- The practice did not have systems to manage risks for patients, staff, equipment and the premises.
- Recommended audits were not completed to help drive improvement in the practice.
- Overall governance systems in the practice needed to strengthen to ensure a safe service was provided.

Background

Park Road Dental Surgery is based in Wellingborough and provides both NHS funded and private dental care and treatment for adults and children.

The dental team includes a dentist, a trainee dental nurse, and 2 part-time receptionists. There is 1 treatment room. The premises are not accessible to wheelchair users.

During the inspection we spoke with the dentist, the trainee dental nurse and 1 receptionist.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open on Mondays from 9.30am to 5pm, on Tuesdays to Thursdays from 9am to 5pm, and on Fridays from 9am to 12.30pm.

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.
- Ensure care and treatment is provided in a safe way for service users.

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 staff follow guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- Take action to ensure all clinicians are adequately supported by a trained member of the dental team when treating patients in a dental setting taking into account the guidance issued by the General Dental Council.

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?	No action	✓
Are services well-led?	Requirements notice	✗

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 Notice 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)

The practice had some safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. However, none of the staff had undertaken accredited training in safeguarding people and we found staff had a limited knowledge of where to report safeguarding concerns outside of the practice.

The practice had infection control procedures which did not always reflect published guidance. The manual scrubbing of dirty instruments was not conducted correctly. The water temperature for cleaning dirty instruments was not monitored, the nurse scrubbed instruments under the running tap, an inappropriate hand disinfectant was used to clean the instruments and there was no system in place to ensure long handled brushes and rubber gloves were replaced every week. There were no daily or weekly checks lists to demonstrate the decontamination procedure had been completed correctly.

Daily Helix tests to measure steam penetration for the autoclave and weekly protein residue tests for the ultrasonic bath were not undertaken to ensure the equipment was operating effectively. An infection control audit had been undertaken in March 2023, but there was no action plan arising from it, and it had failed to identify the shortfalls we found.

The practice had recently undertaken a Legionella risk assessment but had not implemented its recommendations such as the need to monitor hot and cold-water temperatures.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, although we noted the clinical waste bin was not attached to a fixed post and could be accessed by members of the public.

The practice appeared clean and there were cleaning schedules in place to ensure it was kept clean.

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

The practice ensured some equipment was safe to use, maintained and serviced according to manufacturers' instructions. However, we were not provided with evidence to show that the air conditioning unit and ultrasonic bath had been serviced regularly, or that gas safety had been checked.

A fire risk assessment had been completed for the premises in 2020, and we noted some of its recommendations had not been implemented. For example, the need for a log of weekly fire alarm and emergency lighting checks had not been actioned; there was no record of staff fire training, and missing screws in fire doors had not been replaced.

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

Risks to patients

The practice had not undertaken a full health and safety risk assessment of the premises. Without this, it was difficult for potential risks to be identified by staff and actions implemented to mitigate against them.

The practice had assessments to minimise the risk that could be caused from hazardous products, although safety data sheets we requested in relation to some products used by staff could not be found on the day of our inspection.

Are services safe?

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. However, we noted several essential items of equipment and medicines were missing from the practice's kit such as buccal Midazolam, dispersible aspirin, a spacer device, clear face masks and a child's self-inflating bag. There were no bodily fluids or mercury spillage kits available and no eye wash.

Information to deliver safe care and treatment.

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements.

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

Safe and appropriate use of medicines

Glucagon was kept in the practice's fridge, but its temperature was not monitored daily to ensure it was operating effectively. Prescription pads were stored securely but there was no system to identify any lost or missing scripts. We found pre-stamped prescriptions in the receptionist's drawer. The practice's name and address were not included on dispensed medicines' containers to patients.

Antimicrobial audits were not undertaken to ensure the dentist was prescribing in line with national guidance.

Track record on safety, and lessons learned and improvements.

The practice recorded some accidents and incidents such as staff injuries, in the accident book. However, there was no evidence of any learning from these to prevent their recurrence. Staff told us of one incident involving an aggressive patient: we found no written record of this.

The practice had a system for receiving and acting on national patient 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 kept records of the care given to patients including information about treatment and advice given. We found the dentist staff provided patients' care and treatment in line with current guidelines. We noted however, that the dentist did not always use a rubber dam to protect patients' airways during root canal treatment.

Helping patients to live healthier lives.

The practice provided preventive care and supported patients to ensure better oral health. A range of dental products was available to buy such as interdental brushes, disclosing tablets and mouthwash to help support patients with their dental health.

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.

Effective staffing

Clinical staff were qualified and registered with the General Dental Council. The staff team was very small, consisting of a dentist, a trainee nurse and 2 part-time receptionists. As a result, staff told us that, occasionally, the dentist worked without chairside support.

Co-ordinating care and treatment

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services caring?

Our findings

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

Kindness, respect, and compassion

We viewed the results from 24 completed surveys and patients consistently commented positively about the friendliness and caring attitude of the staff, and the clear explanation of their treatment. One patient stated that staff were particularly comforting in moments of stress.

Staff described to us some of the practical ways they supported very nervous patients to undertake their treatment. They also told us of the additional care and support they had provided to a patient that had sustained dental injury after a bad fall.

Privacy and dignity

Archived patient notes were held securely in lockable, fireproof cabinets. Staff password protected patients' electronic care records and backed these up to secure storage.

Although the waiting area was not very private, the receptionist spoke knowledgeably about some of the practical ways they maintained patient confidentiality.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care. Staff described to us the methods they used to help patients understand treatment options discussed.

We noted helpful patient information about the range of treatments on offer on the practice's website.

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

Due to a small number of steps to the entrance of the practice, the premises were not accessible to wheelchair users. There was no accessible toilet for people with limited mobility or portable induction loop for people who wore hearing aids. There was no information available in large print or reading glasses kept behind the reception desk to assist patients.

Timely access to services

At the time of our inspection the practice was not able to take on new NHS patients, although was accepting new privately paying patients. Waiting times for a routine appointment were about 3 to 4 weeks, and for more complex treatment about a month.

Patients with the most urgent needs had their care and treatment prioritised and emergency appointments were available each day. This had recently increased to 2 slots in the morning and 2 slots in the afternoon to improve access to urgent dental care. Details of a local out of hours emergency dental service were available on the practice's answer phone.

Patients could sign up to a text or email appointment reminder service.

Listening and learning from concerns and complaints

There was no information on the practice's website or in the waiting room to inform patients how they could raise their concerns or complaints. We were not able to assess how well the practice managed patients' complaints as complete information about a recent complaint was not available to view and the provider did not keep any sort of record or tracker of complaints to ensure they were managed in a timely way.

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 Notice 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 dentist had overall responsibility for patient clinical care and the management of the service. He was a busy, committed, single-handed NHS dentist who had prioritised patient care over governance systems. He had struggled to recruit staff and only had a trainee nurse and two part-time reception staff to support him. We found him welcoming of our findings and he appeared committed to addressing the shortfalls we had identified.

We identified several issues in relation to the practice's infection control procedures, risk assessing, medicines management, fire safety, equipment servicing and auditing which indicated that governance and oversight of the practice needed to be strengthened. During our inspection, staff sometimes struggled to locate information to fully demonstrate and assure us that the practice was compliant with the relevant legislation and guidance.

Culture

Staff stated they felt respected and valued and told us they enjoyed their work. They reported that the dentist was supportive and responsive to their needs. Their ideas were listened to and their suggestion to increase the number of emergency appointments had been implemented.

Staff were aware of the Duty of Candour and the responsibilities it entailed.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

There were no formal recorded communication systems in place to ensure key information was shared, and practice policies and protocols discussed with staff.

Appropriate and accurate information

The practice 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 practice gathered feedback via patient surveys which could be completed on paper or online on the practice's website. They asked for patients' views on the ease of making an appointment, the friendliness of staff, the facilities and the quality of their treatment. We viewed the results of 24 completed surveys and noted high patient satisfaction rates with the service provided. One patient's suggestion to change the practice's answer phone system had been implemented.

Continuous improvement and innovation

The dentist did not have clear oversight of staff training and was not able to provide clear and robust evidence during our inspection that all staff had undertaken all recommended training in accordance with guidelines.

We were not provided with evidence that staff had received an annual appraisal of the performance.

Are services well-led?

Not all recommended clinical audits such as dental care records and radiology were completed to assess adherence to nationally recommended guidance and to drive improvement effectively.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>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:</p> <ul style="list-style-type: none">• Staff had not received accredited training in safeguarding people and had a limited knowledge of reporting processes and protection agencies outside of the practice.• The practice's infection control procedures and protocols did not follow the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices.• Recommendations made in the practice's Legionella risk assessment had not been implemented.• Recommendations identified in the practice's fire risk assessment had not been implemented.• The provision of medical emergency equipment and medicines did not take into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.• The management of medicines and NHS prescription pads did not meet national guidance.• Some equipment had not been serviced or maintained and gas safety checks had not been undertaken.• There was no effective system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

Requirement notices

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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:

- There was no risk assessment system in place to identify potential hazards in the practice.
- There was no system in place to ensure that staff received formal appraisal and feedback about their working practices.
- There was no system in place to ensure essential staff training was up-to-date and reviewed at the required intervals.
- There was no effective system for identifying, receiving, recording, and responding to complaints raised by patients.
- Audits of radiography and dental care records were not undertaken at recommended intervals and there were no documented learning points or action plans in place so that improvements could be demonstrated.