Dentalcare Limited

Dentalcare Langley 2

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 9 November 2022 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 ask five 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 practice was visibly clean.
- The practice's infection control procedures were not effective.
- Staff knew how to deal with medical emergencies.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- 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

- Staff training was not monitored effectively.
- The provider did not have effective leadership and a culture of continuous improvement.
- Information governance arrangements required improvement.

Background

Dentalcare Langley 2 is in Slough and provides NHS and private orthodontics and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs.

Car parking spaces are available at the rear of the practice.

The dental team includes 1 dentist, 3 dental nurses, 1 dental hygienist, 1 orthodontist, 3 orthodontic therapists, a receptionist and a practice manager.

The practice has 5 treatment room of which 4 are in use. The 5th room is used as a staff and storage room.

During the inspection we spoke with 1 dentist, 3 dental nurses, 1 dental hygienist, 1 receptionist and the practice manager.

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

The practice is open:

- Monday 8.00am to 5.00pm
- Tuesday 8.00am to 7.00pm
- Wednesday 8.00am to 5.30pm
- Thursday 8.00am to 7.00pm
- Friday 8.00am to 5.00pm
- Saturday 9.00am to 2.00pm (once a month)

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 recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and specific information is available regarding each person employed.

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

There were areas where the provider could make improvements.

Summary of findings

- Implement a system 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.
- Implement protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

The practice manager and practice owner accepted the shortfalls that we raised.

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

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 Notices 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.

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 provider had a system to highlight vulnerable patients and patients who required other support such as with communication, within dental care records.

The practice did not have effective infection prevention and control procedures which reflected current published guidance. We found:

- Patient chairs were covered in a fabric material which made cleaning a barrier.
- Visors were not used by staff performing decontamination duties.
- Local anaesthetic ampules were stored outside of blister packs in treatment room drawers.
- Treatment room 1 had a clinical waste bin which was not foot operated.
- Out of date dental materials were seen in the fridge used to store glucagon.
- An infection prevention and control audit presented to us did not document analysis, reflection and learning points which meant any improvements could not be evidenced. A previous audit was unavailable.
- The radiator in the wheelchair accessible toilet was rusted.

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

A legionella risk assessment was carried out two days prior to our inspection. We were told a previous assessment could not be found. We have since received a copy of the assessment.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, but improvements were needed. In particular:

- A clinical waste bin at the rear of the practice could not be locked.
- The bin was not tethered to a fixed point to prevent it being removed from the practice property.

During our visit this shortfall was addressed. A replacement bin was delivered and secured appropriately.

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

- Cleaning schedules were not completed.
- Cleaning checks were informal and not recorded.
- The storage arrangements for the cleaning equipment did not follow national guidance.

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

Recruitment procedures were not operated effectively to ensure only fit and proper persons were employed and specified information was available regarding each person employed. We looked at 3 staff recruitment records. Evidence presented to us confirmed that:

- None of the 3 staff had evidence of employment references.

Are services safe?

- One out of the 3 staff had evidence of a full employment history.
- Two of the 3 staff had evidence of photographic identification.
- Two of the 3 staff had evidence of eligibility to work in the UK.

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

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

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. In particular:

A fire safety risk assessment was carried out two days prior to our inspection. We were told a previous assessment could not be found. We have since received a copy of the assessment.

- The fire alarm was not tested.
- Emergency lights were not tested.
- The fire alarm had not been serviced since September 2021. We have since received evidence to confirm this shortfall has been addressed.
- There was no emergency lighting present on the stairwell between the ground and first floor.
- Emergency lighting was not serviced.
- Fire escape direction signage was insufficient around the practice building.
- Fire extinguishers were last serviced in December 2018.
- A five yearly electrical installation test certificate was not available.
- A carbon monoxide detector was not available.
- An oxygen warning sign was not displayed near the location of the oxygen cylinder.
- General rubbish bins at the rear of the practice were positioned under the staircase of the flat above. Bins were not protected from unauthorised interference and potential arson.
- Fire drills were not carried out.

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

The practice management could not demonstrate competence in fire safety management. We have been advised that training has been booked to take place in January 2023.

The practice did not have arrangements to ensure the safe use of the X-ray equipment.
In particular:

- The practice did not have a radiation protection supervisor.
- Local rules were not specific to the practice.
- The x-ray in treatment room 1 was missing a rectangular collimator.
- Appropriate tests for the CBCT machine were not carried out.

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

Risks to patients

The practice had not effectively implemented systems to assess, monitor and manage risks to patient and staff safety. Specifically:

A health and safety risk assessment was carried out two days prior to our inspection. We were told a previous assessment could not be found. We have since received a copy of the assessment.

- Sharps injury information did not include occupational health department contact details.
- Sharps dismantling procedures did not follow the practice sharps policy.
- A sharps bin in treatment room 1 had not been changed after three months. This bin was dated August 2021.

Are services safe?

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, however we found areas that required attention:

- The emergency medicines and equipment kit was sited in the first-floor patient wating area. This area was not monitored by staff.
- Glucagon was stored in a fridge which contained dental materials and staff food. This fridge reached temperatures above the recommended level of 8 degrees Celsius on two occasions during our inspection.

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

Ten of 11 staff had completed training in emergency resuscitation and basic life support in the previous 12 months. We noted that 2 of these had carried out online training.

The practice had risk assessments to control substances that are hazardous to health (COSHH). Improvement were need to their storage. In particular:

- COSHH identified products were not stored securely in the patient toilet and the staff kitchen.
- Storage areas were not labelled appropriately with COSHH warning signs.

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

Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were 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

The practice did not have a system for appropriate and safe handling of prescriptions. Specifically:

- Two clinicians were not aware of current guidance with regards to prescribing medicines.
- A prescription pad was not logged. We have since received evidence to confirm this shortfall is being addressed.
- Antimicrobial prescribing audits were not carried out.

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

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

We observed that the accident book did not comply with General Data Protection Regulations (GDPR). We have been advised that a replacement accident book has been ordered.

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 did not have systems in place to ensure dental professionals were up to date with current evidence-based practice. In particular:

- Reporting of x-ray quality changed to a new two-point grading of 'acceptable or unacceptable' in 2021. This system was not being used by any of the clinicians taking radiographs.

We have since received evidence to confirm this shortfall is being addressed.

Orthodontics

The orthodontist carried out a patient assessment in line with recognised guidance from the British Orthodontic Society.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance.

Staff 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 did not have effective assurance processes to encourage learning and continuous improvement. Specifically:

- Patient dental care record audits were not carried out.
- Radiography audits were not carried out.
- Cone-beam computed tomography (CBCT) radiograph audits were not carried out.

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

Effective staffing

Evidence was not available to demonstrate all staff had the skills, knowledge and experience to carry out their roles. Evidence presented to us confirmed that:

- Records showed that a clinician had carried out only three hours of IRMER (Radiography) training in the previous five years.
- Ten out of 11 staff had carried fire safety training in the previous 12 months.
- Ten out of 11 staff had carried out Basic Life Support training in the previous 12 months.
- Fire safety management training was not carried out by the 'responsible person'.

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

Evidence of Cone-beam computed tomography (CBCT) training was not available for the machine operator. We have since been advised that the CBCT has been decommissioned and will not be used until staff are trained appropriately.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

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

A dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide but these were not monitored to ensure they were received in a timely manner. We were assured that referrals were logged for NHS and private patients. We will review this when we return for our follow up visit.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

On the day of inspection, we spoke with three patients which told us staff were compassionate and understanding.

Privacy and dignity

Closed circuit television (CCTV) was present in four of the five treatment rooms, the reception and hall area and in the car park at the rear of the practice.

The practice did not demonstrate an awareness of the importance of protecting patients' personal information. In particular:

- CCTV signage was not present outside the building or prominently around the inside of the building.
- The positioning of cameras in treatment rooms did not protect the privacy of patients.
- A privacy impact assessment had not been carried out.

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

Patients electronic care records were backed up to secure storage.

Computers in treatment room did not automatically lock when left unattended. We have since received evidence to confirm this shortfall has been addressed.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

Staff 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 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?

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.

A disability access audit was carried out two days prior to our inspection. We were told a previous assessment could not be found. We have since received a copy of the assessment.

We reviewed the wheelchair accessible toilet and found:

- Cleaning equipment was stored in the wheelchair user's transfer area.
- The mirror was out of reach to a wheelchair user.
- The waste paper bin was foot operated.
- A hearing loop was not available.

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

Timely access to services

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.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff 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 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.

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.

The practice manager oversaw three of the providers locations and was allocated 2 days a week to this practice.

The practice was part of a corporate group. We were told that the management team to support the effective running of the business was disbanded during Covid 19 and not reinstated. We have since received evidence which confirms the practice manager had support resources available, but these were not used effectively

Culture

Staff stated they felt respected, supported and valued.
Staff did not have annual appraisals or one to one meetings.

- Staff meetings were held monthly on the same day of the week which meant staff who did not work on that day could not attend.
- Minutes of meetings were not shared with staff.

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

Governance and management

The provider had a system of clinical governance in place which included policies, protocols and procedures but systems were not followed.

The management of radiography, legionella, fire safety, health and safety, recruitment, COSHH, infection control, training and equipment required immediate improvement.

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

Appropriate and accurate information

We found improvements were needed to the management and oversight of procedures that supported information governance arrangements. In particular, computers in treatment room did not automatically lock when left unattended.

We have since received evidence to confirm this shortfall has been addressed.

Engagement with patients, the public, staff and external partners

The practice told us they used patient surveys to obtain patients' views about the service.

Continuous improvement and innovation

The provider had quality assurance processes to encourage learning and continuous improvement, but these were not operated effectively.

Are services well-led?

Antimicrobial prescribing, radiography, patient care record audits were not carried out.

Training was not monitored effectively. Evidence was not available to confirm that all relevant staff had completed the 'highly recommended' training as per General Dental Council professional standards.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 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: **Infection Control** • Patient chairs were covered in a fabric material which made cleaning a barrier. • Visors were not used by staff performing decontamination duties. • Local anaesthetic ampules were stored outside of blister packs in treatment room drawers. • Treatment room 1 had a clinical waste bin which was not foot operated. • Out of date dental materials were seen in the fridge used to store glucagon. • The radiator in the wheelchair accessible toilet was rusted. • An infection prevention and control audit, presented to us, did not document analysis, reflection and learning points which meant any improvements could not be evidenced. A previous audit was unavailable. • Hand hygiene audits were not available. • The storage arrangements for the cleaning equipment did not follow national guidance. **Control of Substances Hazardous to Health (COSHH)** • COSHH identified products were not stored securely in the patient toilet and the staff kitchen. • Storage areas were not labelled appropriately with COSHH warning signs. **Health and Safety** • Sharps injury information did not include occupational health department contact details.

This section is primarily information for the provider

Requirement notices

- Sharps dismantling procedures did not follow the practice sharps policy.

A sharps bin in treatment room 1 had not been changed after three months. This bin was dated August 2021.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not ensure that recruitment procedures were operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed. In particular: Recruitment checks were not monitored to ensure they were completed or stored appropriately. We looked at 3 staff recruitment records. Evidence presented to us confirmed that: • 0 out of 3 staff had conduct in previous employment (references). • 1 out of 3 staff had a full employment history. • 2 out of 3 staff had photographic identification. 2 out of 3 staff had eligibility to work in the UK.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	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** • The fire alarm was not tested. • Emergency lights were not tested.

This section is primarily information for the provider

Requirement notices

- The fire alarm had not been serviced since September 2021.
- There was no emergency lighting present on the stairwell between the ground and first floor.
- Emergency lighting was not serviced.
- Fire drills were not carried out.
- Fire escape direction signage was insufficient around the practice building.
- Fire extinguishers were last serviced in December 2018.
- A five yearly electrical installation test certificate was not available.
- A carbon monoxide detector was not available.
- An oxygen warning sign was not displayed near the location of the oxygen cylinder.
- General rubbish bins at the rear of the practice were positioned under the staircase of the flat above. Bins were not protected from unauthorised interference and potential arson.
- The practice management could not demonstrate competence in fire safety management.

Radiography

- The practice did not have a radiation protection supervisor.
- Local rules were not specific to the practice.
- The x-ray in treatment room 1 was missing a rectangular collimator.
- Tests for the CBCT machine were not carried out.
- Reporting of x-ray quality two-point grading of 'acceptable or unacceptable' was not being used by any of the clinicians taking radiographs.

Emergency Medicines and Equipment

- The emergency medicines and equipment kit was sited in the first-floor patient wating area. This area was not monitored by staff.
- Glucagon was stored in a fridge which contained dental materials and staff food.
- The glucagon storage fridge reached temperatures above the recommended level of 8 degrees Celsius on two occasions during our inspection.

Medicines

This section is primarily information for the provider

Requirement notices

- Two clinicians were not aware of current guidance with regards to prescribing medicines.
- A prescription pad was not logged.

Audits

- Radiography audits were not carried out.
- Infection control audits were partially carried out.
- Cone-beam computed tomography (CBCT) radiograph audits were not carried out.
- Records of cleaning standards audits were not available

CCTV

- CCTV signage was not present outside the building or prominently around the inside of the building.
- A privacy impact assessment had not been carried out.
- The positioning of CCTV cameras in treatment rooms did not protect the privacy of patients.

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Training

- Training was not monitored to ensure staff kept up to date with their mandatory training and their continuing professional development.

General Data Protection Regulations (GDPR)

- Computers in treatment room did not automatically lock when left unattended.
- We observed that the accident book did not comply with General Data Protection Regulations.

Equality Act 2010

- A hearing loop was not available.
- Cleaning equipment in the wheelchair accessible toilet was stored in the wheelchair user's transfer area.
- The mirror in the wheelchair accessible toilet was out of reach to a wheelchair user.
- The waste paper bin in the wheelchair accessible toilet was foot operated.