

Mr. Si Nen Mooi

Selsdon Dental Surgery

Inspection report

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Overall summary

We carried out this announced inspection on 3 June 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 usually ask five key questions, however due to the ongoing pandemic and to reduce time spent on site, only the following three questions were asked:

- 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

Selsdon Dental Surgery is in the London Borough of Croydon and provides NHS and private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available at the front of the practice and on roads surrounding the practice.

The dental team includes a principal dentist, a dental nurse and a receptionist. The practice has two treatment rooms.

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.

During the inspection we spoke with all the team. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Fridays from 8.30am to 5.00pm

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- 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.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had infection control procedures which reflected published guidance although some improvements could be made in relation to the dirty to clean flow in the decontamination room.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available. Glucagon was not stored in a fridge where temperatures were being monitored.
- The clinical staff provided patients' care and treatment in line with current guidelines. However, staff were not up to date with continuing professional development in the provision of dental care using conscious sedation. As a result of this the provider has formally notified us that they have stopped carrying out treatment under sedation until staff had completed the appropriate training.
- The provider had systems to help them manage risk to patients and staff. Improvements were required with regards to the sharps risk assessment and Control of Substances Hazardous to Health (COSHH).
- The provider did not have appropriate information governance arrangements.

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

Summary of findings

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

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 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 had clear systems to keep patients safe.

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 staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC and the local safeguarding authority.

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

The provider had introduced procedures in relation to COVID-19 and these were being followed. Additional standard operating procedures had been implemented to protect patients and staff from Coronavirus. Appropriate PPE was in use and staff had been fit tested.

The provider had an infection prevention and control policy and procedures. They broadly 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. Improvements were required with the layout of the decontamination room to ensure the dirty to clean flow was in line with guidance. The provider contacted us shortly after the inspection to confirm that the flow from dirty to clean was now in line with guidance.

Staff completed infection prevention and control training and received updates as required.

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 was validated, maintained and used in line with the manufacturers' guidance. *The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.*

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.

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. All recommendations in the assessment had been actioned. Records of dental unit water line management were maintained, however records of water temperature testing were not. The practice did not have a thermometer to test water temperatures. There was therefore no way to verify that hot and cold-water temperatures were within the required range.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean.

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

The provider carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

The practice's whistleblowing policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.

Are services safe?

The dentists 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 documented in the dental care record and a risk assessment completed.

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 both staff recruitment records. These showed the provider followed their recruitment procedure.

We observed that clinical staff were 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.

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 dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were reviewed at timely intervals to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually. Improvements were required to the risk assessment to ensure that it considered all sharps in the dental practice.

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, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. However staff could not evidence that they had completed Immediate Life Support training with airway management for staff providing treatment under conscious sedation. We discussed this with the provider, and they formally notified us that they have stopped carrying out treatment until all requirements were met.

Emergency equipment and medicines were available as described in recognised guidance. Glucagon was stored in the fridge and there was no thermometer to measure fridge temperatures. The provider contacted us shortly after the inspection and confirmed that a thermometer had been purchased and fridge temperatures were now being monitored.

We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. However, some items in the practice were not listed. We discussed this with the provider, and they assured us that they would update the Control of Substances Hazardous to Health Regulations 2002 (COSHH) file as soon as possible.

Are services safe?

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings. Dental care records we saw were legible, were kept securely and complied with General Data Protection Regulation requirements. However dental care records were not always complete. We reviewed eight dental care records and information that the dentist told us they discussed with patients was not always documented in records. The provider assured us that they would review this and ensure they kept complete dental care records.

The provider had 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.

Safe and appropriate use of medicines

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

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been no safety incidents. Staff 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 provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

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 clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered conscious sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The staff assessed patients for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the guidance.

The records showed that staff recorded important checks at regular intervals. These included pulse, blood pressure, breathing rates and the oxygen content of the blood.

The practice did not have systems in place to undertake the provision of dental care procedures using conscious sedation safely. They were not providing sedation in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015 in regards to training requirements. Staff had not completed the required continuing professional development (CPD) in sedation and had not completed Immediate Life Support training. We discussed this with the provider, and they confirmed on the day of the inspection that they would stop sedation procedures with immediate effect. Shortly after the inspection the provider emailed us to confirm their decision. They also provided details of the training they had booked to ensure staff were suitably trained.

Staff had access to an intra-oral camera to enhance the delivery of care.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

Where applicable, the dentist discussed smoking, alcohol consumption and diet with patients during appointments. This was however, not always documented in dental care records.

Consent to care and treatment

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

The practice team 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 are looked after. The dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions.

Are services effective?

(for example, treatment is effective)

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. Staff were aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. Improvements were required to make dental care records more complete and more reflective of consultations. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. Training for sedation and Immediate Life Support was outstanding.

The team had worked together for many years and there had not been any new starters for several years. However, there were processes in place for staff new to the practice to have a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

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

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

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 principal dentist was knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them.

The staff team was small, but they told us that the principal dentist was visible and approachable. The staff team told us they worked closely with them to make sure they prioritised compassionate and inclusive leadership.

Culture

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

Staff discussed their training needs at appraisals and one-to-one meetings. They also discussed learning needs, general wellbeing and aims for future professional development.

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

Improvements were required to governance arrangements. For example, not all policies and procedures were kept at the practice; records of water temperature checks were not maintained; the COSHH file was not reviewed regularly or kept up to date and the sharps risk assessment was not reviewed and updated. The provider contacted us shortly after the inspection and sent evidence that policies and procedures were not kept at the location.

The principal dentist had overall responsibility for the management and clinical leadership of the practice and was also responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

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

Appropriate and accurate information

Improvements were required to ensure information was accurate and appropriate. We reviewed eight dental care records and we found the information was not always complete.

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

Staff involved patients and staff to support the service.

The provider usually obtained feedback from patients via patient surveys and comment cards. Due to COVID-19 they were only obtaining verbal comments from patients.

Are services well-led?

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used.

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 systems and processes for learning, continuous improvement and innovation.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. For example, non-clinical staff had access to all training and learning development that clinical staff had, and this was paid for by the practice.

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 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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</p> <p>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 improve the quality and safety of the services being provided.</p> <p>In particular:</p> <ul style="list-style-type: none">• Staff were not up to date with continuing professional development requirements relating to provision of dental care procedures under conscious sedation. This included sedation and ILS training;• The COSHH file was not reviewed regularly and was not up to date;• Temperature checks of the hot and cold-water outlets were not being recorded;• The sharps risk assessment had not fully assessed all sharps being used within the dental practice and was not reviewed appropriately;• Not all policies and procedures were readily available at the practice for staff or other relevant bodies to access if required. <p>Regulation 17 (1)</p>