57 FG Limited

57 Friar Gate Dental Practice

Inspection report

57 Friar Gate
Derby
DE1 1DF
Tel:

Date of inspection visit: 15 November 2023
Date of publication: 21/12/2023

Overall summary

We carried out this announced comprehensive inspection on 15 November 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 advisor.

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

- The dental clinic appeared clean. There was scope for improvement in ensuring it was well-maintained.
- The practice infection control procedures did not always reflect published guidance.
- Staff knowledge and confidence in how to deal with medical emergencies was not robust or effective. Appropriate medicines and life-saving equipment were not always available as identified in guidance.
- Systems to manage risks for patients, staff, equipment and the premises were not effective or established in practice procedures.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures reflected current legislation.

Summary of findings

- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Leadership was not effective. Systems to promote continuous improvement and monitoring of the service were not effective.
- Systems to monitor and encourage staff training and development were not in place.
- A system to gather and respond to staff and patients feedback about the services provided were not established.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

57 Friar Gate Dental Practice is in Derby and provides private dental care and treatment for adults and children.

The building has a listed status and is accessed via a set of steps. As such it is not accessible people who use wheelchairs and those with pushchairs and provision cannot be made to improve access.

The dental team includes 1 dentist, 4 dental nurses, 1 trainee dental nurse, 1 dental therapist, 1 practice manager and 1 receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with the dentist, 2 dental nurses and the trainee dental nurse, the dental therapist, the receptionist and the practice manager. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday, Tuesday and Thursday from 8.30am to 6pm.

Wednesday and Friday from 8.30am to 1pm.

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

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

- 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.

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

- Take action to ensure audits of antimicrobial prescribing and infection prevention and control are undertaken at regular intervals to improve the quality of the service. Practice should also ensure that, where appropriate, audits have documented learning points, and the resulting improvements can be demonstrated.

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?	**No action** ✓
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 providing safe care in accordance with the relevant regulations.

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 practice infection control procedures did not always reflect published guidance. Staff carrying out decontamination did not demonstrate correct handwashing technique, measurement of detergent solution or monitoring of water temperature. Daily task lists for cleaning and preparing the treatment rooms were not effective. Following our inspection, the provider submitted evidence that further training was delivered for all staff in order to address this issue.

The practice systems to reduce the risk of Legionella, or other bacteria, developing in water systems were not robust, effective or in line with guidance. Accurate records of monitoring to prevent the development of legionella were not kept. A risk assessment was completed in June 2023 which included guidance that seldom used outlets should be flushed regularly, including a list identifying these outlets. Staff we spoke with, who told us they carried out these tests, were not aware of the location of these outlets and failed to identify a redundant shower unit despite having signed on four sperate occasions to state this had been flushed and monitored in line with guidance. Additionally, the risk assessment identified the need for bacteriological checks to be carried out to exclude the presence of legionella in the water system. We did not see evidence that these were carried out.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted that bags were not marked in a way to identify the practice as their source. Following our inspection, the provider submitted evidence that action was taken to address this issue.

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These reflected the relevant legislation.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice process to ensure facilities were maintained in accordance with regulations were not effective. The provider had never obtained a required satisfactory 5 year electrical safety certificate. Following our inspection, a certificate was obtained which rated the system as unsatisfactory and identified 16 faults that required urgent remedial action.

A fire safety risk assessment was carried out in line with the legal requirements. The management of fire safety was not effective or robust. Staff confirmed that fire evacuation drills had not been carried out since 2021. Staff we spoke with were not aware of how to raise the alarm or operate the alarm system. Recording of completion of fire safety monitoring checks was not effective. The practice risk assessment identified that fire detection equipment was required on the top 3 floors of the building in June 2021. Records showed that staff had recorded this omission, but no action was taken to address this. We saw that the recording form was updated to include a printed statement that the detection equipment was missing. We were not provided with evidence following our inspection that action was taken to address this issue.

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

Risks to patients

Are services safe?

The practice systems to assess, monitor and manage risks to patient and staff safety were not effective. We did not see, and were not provided with, evidence of risk assessments for sharps safety, health and safety, sepsis or lone working.

Emergency equipment and medicines were available and checked. We found not all equipment was available in accordance with national guidance. Specifically needles to administer adrenaline were not available and an EpiPen (a pre drawn dose of adrenaline used to treat people in anaphylaxis) had expired.

We saw evidence that staff had completed training in emergency resuscitation and basic life support every year. Staff were not able to demonstrate they knew how to respond to a medical emergency.

We did not see evidence that the practice had risk assessments or safety data sheets to minimise the risk that could be caused from substances that are hazardous to health.

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 2-week wait arrangements.

Safe and appropriate use of medicines

The practice systems for appropriate and safe handling of medicines were not effective. Prescription pads were not stored securely, and their use and issue was not monitored. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

We did not see evidence of the practice systems to review and investigate incidents and accidents. The practice did not have a system for receiving and acting on safety alerts. We did not see and were not provided with evidence that safety alerts were reviewed or shared with staff.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

We saw the provision of dental implants was in accordance with national guidance.

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. We found that not all staff were able to demonstrate they understood their responsibilities under the Mental Capacity Act (MCA) 2005. An MCA policy was not in place we found that 5 of the 9 staff had not received training in its use and application.

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 kept detailed patient care records in line with recognised guidance.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits 6-monthly following current guidance.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. We found that staff did not receive regular appraisals or feedback on their performance. Options to discuss their training needs or concerns were not established within the service.

Newly appointed staff had a structured induction and clinical staff completed 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 caring?

Our findings

We found this practice was providing caring services 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 2 patients and reviewed a range of feedback and reviews relating to the service. The majority of feedback we reviewed was positive and expressed satisfaction with the care and treatment they received.

Patients said staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality, separate rooms were available for people to hold private conversations when required.

The practice had installed closed-circuit television (CCTV) to improve security for patients and staff. Not all relevant policies and protocols were in place. For example, a data security and protection toolkit was not in place. We identified scope for improvement in ensuring signage alerting people to the presence of CCTV was clear.

Staff password protected patients' electronic care records and backed these up to secure storage. We found that information was not always stored securely as paper records were not locked away and information regarding upcoming appointments for patients were displayed prominently on screens in treatment rooms.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and 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 explained the methods they used to help patients understand their treatment options. These included photographs, study models, videos, X-ray images and an intra-oral camera.

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 and preferences.

Staff demonstrated knowledge of the importance of providing emotional support to patients when delivering care.

The practice had made limited adjustments for patients with access requirements. Staff had carried out a disability access audit.

Timely access to services

The practice displayed its opening hours and provided information on their website.

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. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately.

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 provider did not demonstrate a transparent and open culture in relation to people's safety. Processes to ensure safety of staff and patients in event of a fire or requests for assistance if required were not effective, robust or established amongst the practice team. Safety alerts were not reviewed or shared with the staff team and monitoring and response to incidents and accidents was not effective.

The practice lacked strong leadership, lines of accountability were not embedded or clearly communicated. Processes to ensure people's safety and establish a culture of continuous improvement were not in place.

Systems and processes were not embedded amongst the staff team. Our inspection highlighted numerous significant issues and omissions that the providers governance and oversight systems had not identified.

The information and evidence presented during the inspection process was not always clear, accessible or well documented.

Processes to support and develop staff with training or additional roles and responsibilities were not established.

We noted that following our inspection, the provider submitted evidence that indicated action was in the process of being taken to address a number of issues. This demonstrated the providers intention and commitment to improve governance and oversight of the service.

Culture

Processes to show how staff ensured high-quality sustainable services and improvements were not available or established. Audits were not completed in line with guidance or recommended timescales. Required maintenance checks were not carried out in line with guidance and monitoring of fire detection and legionella prevention processes and systems were not robust, effective or accurate.

A process for staff to discuss and receive feedback on their performance or future training needs was not available. The provider confirmed that annual appraisals or 1 to 1 meetings were not held. We did not see evidence of regular practice meetings.

Arrangements to ensure staff training was up to date and embedded were not always effective or robust.

Governance and management

Staff had responsibilities and roles assigned. We found scope for improvement in the systems of accountability to ensure these tasks were completed accurately and in line with guidance to support good governance and management.

Policies, protocols and procedures were accessible to all members of staff via an online governance system. We found that not all policies were reviewed on a regular basis.

Processes for managing risks, issues and performance, were not clear and effective. Legionella, fire safety, lone working, health and safety and sharps risks were not assessed or mitigated against.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Are services well-led?

We identified scope for improvement with the practice information governance arrangements. Computer screens with patient details were visible in treatment rooms. Paper records were stored in unlocked cupboards.

Engagement with patients, the public, staff and external partners

Feedback from patients and external partners was last carried out in 2021. We did not see and the provider did not submit evidence of response to feedback.

Continuous improvement and innovation

The practice systems and processes for learning, quality assurance and continuous improvement were not always effective or robust. Audits of patient care records, disability access and radiographs were completed. However, we found that audits of antimicrobial prescribing and infection prevention and control were not completed in line with guidance and did not reflect our findings during the inspection. Evidence of action plans to address issues identified following audits was not available.

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 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: • Monitoring and recording of checks for fire safety, was not effective and had failed to identify that fire detection equipment was not in place on the top 3 floors of the service despite this being identified as requiring attention in June 2021. • Monitoring and recording of checks for legionella management was not effective and had failed to identify that records of completed tasks were not an accurate reflection of events. • A satisfactory 5 year fixed electrical safety certificate had not been obtained. • Monitoring of completion of training had not identified a lack of training and knowledge for staff in Basic Life Support and Mental Capacity Act. • Risk assessments for health and safety, sharps and lone working were not completed despite a risk of harm identified. • Polices were not updated and reviewed.