Simply Smile Shire Court Limited

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Inspection report

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Date of inspection visit: 15 March 2022
Date of publication: 05/05/2022

Overall summary

We carried out this announced focused inspection on 14 March 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 usually ask five key questions, however due to the ongoing COVID-19 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:

- The dental clinic appeared to be visibly clean and well-maintained.
- The practice had infection control procedures which reflected published guidance. We found these were not always followed or applied effectively.
- Staff knew how to deal with medical emergencies. Some items of life-saving equipment were missing from the medical emergency kit, in particular, airway sizes 0-4, clear face masks sizes 0-4 and the self-inflating bag for adult and child with reservoir had exceeded the manufacturer's use by date.

Summary of findings

- Systems to help manage risk to patients and staff were not always implemented effectively and guidance was not always followed.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice staff recruitment procedures did not reflect current legislation.
- Clinical staff did not always evidence they 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.
- The appointment system took account of patients' needs.
- The service was not well led. Leadership was not always effective and evidence of a culture of continuous improvement was not observed.
- Staff felt involved and supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The dental clinic had information governance arrangements.

Background

The provider has six practices and this report is about Simply Smile Shire Court Limited, also known as Shire Court Dental Practice.

Shire Court Dental Practice is in Towcester in Northamptonshire and provides 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, including dedicated parking for people with disabilities, are available near the practice. The practice has made adjustments to support patients with additional needs, including access to translation services and the offer of longer appointment times.

The dental team includes four dentists, five dental nurses, of whom two are trainees, two dental hygienists, a practice manager and three receptionists. The practice has four treatment rooms.

During the inspection we spoke with two dentists, two dental nurses, one 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 9am to 5.30pm

Tuesday 9am to 5.30pm

Wednesday 10am to 6.30pm

Thursday 9am to 5.30pm

Friday 8.30am to 12.30pm

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** 
Are services effective?	**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 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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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 had infection control policies which reflected published guidance. We found these were not always implemented effectively. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

The decontamination of instruments was not carried always carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance.

We found multiple single use dental healing caps, used in dental implant treatments, prepared and ready for use after being put through the decontamination process. Following our inspection, the provider informed us they had disposed of these items.

We noted that the illuminated inspection magnifier was not used to check instruments, evidence that brushes and heavy-duty cleaning gloves were changed at approved intervals was not recorded and that logs to confirm testing and maintenance of the washer disinfector and autoclave were not available. Following our inspection, the provider submitted evidence of completed logs for the washer disinfector and autoclave.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems.

A legionella risk assessment had been undertaken in 2011. We noted that some recommendations made in the Legionella risk assessment had been actioned, including carrying out a bacteriological water test in 2017. However, we found that records to demonstrate that water testing, including temperature checks, had only begun in January 2019. The records of these tests indicated that the water had never reached the recommended temperature of 50 degrees at any time or for any outlet. Checks that cold water did not exceed 20 degrees had never been 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 clinical waste bags were not marked in a way to identify the practice and allow their tracking if required. Following our inspection, the provider informed us waste bags would be marked with the practice's postcode.

We saw the practice was visibly clean and there was a cleaning schedule to ensure the practice was kept clean. We found that recording of the cleaning schedule was not effective. The practice manager informed us certain areas and items were cleaned but we did not see this on the schedule. The document used for recording cleaning was a laminated wipe clean sheet, with no facility to record any action required or taken to address issues.

Are services safe?

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. We reviewed five staff files and found that evidence of required pre employment recruitment checks was missing or not recorded in all five. We noted that two files did not contain evidence of disclosure and barring service checks (DBS), three files did not include references or employment history and two files lacked proof of identification. Following our inspection, the provider informed us they had addressed these issues.

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

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

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

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working.

Emergency equipment and medicines were not available and checked in accordance with national guidance. In particular, airway sizes 0-4, clear face masks sizes 0-4 and the self-inflating bag for adult and child with reservoir had exceeded the manufacturer's use by date.

We found the practice did not have effective medicines used to manage low blood sugar as these had exceeded the manufacturer's use by date.

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

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

The dental care records we saw were not always complete or legible. In particular, we noted the care records of some clinicians lacked detail and evidence of patient consent, treatment options discussed, or examinations carried out.

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 systems for appropriate and safe handling of medicines.

Antimicrobial prescribing audits were carried out. We noted that action plans were not always developed from these if issues were identified.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating when things went wrong. We found this was not effective or robust. Reporting practices did not include details of near misses. Records of accidents or incidents did not include detail of mitigation of risk, lessons learned, mechanism of injury, follow up care and treatment or further reporting. The practice had a system for receiving and acting on 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 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

Dental care records we looked at showed there was a lack of consistency in staff obtaining patients' consent to care and treatment.

Records were not available to demonstrate staff undertook training in patient consent and mental capacity. Reference to Gillick competencies were not included in policy and procedure documents we viewed.

Not all staff were able to describe how they involved patients' relatives, or carers when appropriate, and did not ensure they had enough time to explain treatment options clearly. In particular we found evidence that consent given for treatment to be carried out was not recorded consistently in patient records.

Monitoring care and treatment

There were inconsistencies in the information recorded within the dental care records we looked at. For example, not all clinicians were recording medical history of patients, risk assessments for dental caries, oral cancer or tooth wear, social history, treatment options or costs of treatments.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

Evidence was not available to demonstrate that all dentists justified, graded and reported on the radiographs they took.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

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 dentists 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

There was a lack of effective leadership and oversight at the practice. Systems and processes were not embedded among staff and the inspection highlighted some issues and omissions. For example, the vast majority of oversight, governance and day to day running of the practice was the responsibility of the practice manager. We noted that they carried out all audits, checks, reviews and assessments related to governance and work was not delegated equitably amongst the practice team.

The information and evidence presented during the inspection process was not always organised and well documented. For example, the use of wipe clean documents for daily checks meant some information recorded was not always legible. A system to digitally record these had been introduced recently but we found information was not always available.

Culture

The practice aimed to provide a culture of high-quality sustainable care and staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs during annual appraisals, one to one meetings and during clinical supervision. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had arrangements to ensure staff training was up-to-date and reviewed at the required intervals.

Governance and management

The practice did not have effective governance and management arrangements.

Whilst the provider had a system of clinical governance along with processes for managing risks, issues and performance, we found this was not always applied or implemented effectively. For example; the previously noted issues of, legionella risk management, decontamination processes and lack of required pre employment recruitment checks. Additionally, auditing and oversight of clinical notes and recording of consent, timely completion of audits and reviews and learning from accidents, incidents or near misses was not effective or robust.

Appropriate and accurate information

Staff acted on 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

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings, surveys, 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

Are services well-led?

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement. Audits were not always carried out at recommended intervals and action plans were not always developed to support and monitor improvements.

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 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: • Assessment and mitigation of risk of legionella and other water borne bacteria was not effective or robust. Cold water temperature checks were never carried out. Hot water checks identified failings that were not addressed and could expose people to unnecessary risk. • The provider did not analyse or share learning from accidents or incidents. • Care records were not detailed or accurate. Evidence of options discussed, treatment given, and consent obtained were not recorded. • Radiography, Disabled Access Audit (DDA) and Infection prevention and control audits were not completed in recommended timescales. Actions from information gathering for audits and surveys were not identified or implemented. • Checks of availability and suitability of equipment and medicines to deal with medical emergencies were not effective. • Legionella risk assessment was completed over ten years ago, water temperatures recorded were not within the recommended parameters and no remedial action to rectify had been carried out. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

This section is primarily information for the provider

Requirement notices

- Appropriate pre employment checks were not carried out for all staff. Evidence to confirm staff identification, conduct in previous employment, employment history or obtain references, Disclosure and Barring Service (DBS) checks was not provided.