Mr. Christopher De Bono

Far Cotton Dental Practice

Inspection report

12 St Leonards Road
Far Cotton
Northampton
NN4 8DP
Tel: 01604761344

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Overall summary

We carried out this announced inspection on 21 October 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 always ask the following questions:

• 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 not 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

Far Cotton Dental Practice is in Northampton 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. The reception and waiting areas are up a steep flight of stairs. The practice is located on a busy high road so is unable to provide car parking spaces. The practice did not have access to a hearing loop for people experiencing hearing difficulties.

The dental team includes one dentist, a practice manager and two dental nurses, one of whom also works as the 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 one dentist, two dental nurses, 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 6pm

Tuesday, Wednesday, Thursday 9am to 5.30pm

Friday 9am to 2pm

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The providers systems were not effective in helping to identify and mitigate against manage risk to patients and staff. Sharps and safety of patients airways were not managed safely. The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. The safeguarding lead was unable to evidence that they had completed safeguarding training on the day of our inspection.
- The provider had staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines. Records did not always contain sufficient detail to support this.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Preventive care and advice was not always recorded in patients dental care records to support better oral health.
- The provider did not always demonstrate 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 information governance arrangements.

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

Summary of findings

- Improve the practice's risk management systems for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.

- Improve the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

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

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

- Take action to ensure dentist is aware of the guidelines issued by the British Endodontic Society for the use of rubber dam or other airway protection for root canal treatment .Improve the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 not providing safe care in accordance with the relevant regulations. We have told the provider to take action. 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)

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. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. We saw evidence that nursing staff had undertaken safeguarding training to a level relevant to their role. We noted that not all staff had updated their training in the suggested timescale. We found that the principal dentist had not completed relevant safeguarding training and evidence was not submitted following our inspection.

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 also had a system to identify adults that were in other vulnerable situations for example, those who were known to have experienced modern-day slavery or female genital mutilation. We noted that this information was not always recorded in patients records.

The provider had an infection prevention and control policy and procedures. They 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. 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 that most 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.

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 and records of water testing and dental unit water line management were maintained.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean. We noted that surfaces in treatment rooms were very cluttered which may make cleaning difficult. We also noted that the head rest was split, and the stool used by the dentist was completely covered in sticky tape which would make it very difficult to clean. We raised this with the provider.

The provider did not demonstrate how they calculated fallow time and air exchange between patients undergoing AGP treatments, to help reduce the risk and spread of COVID 19 infection.

Are services safe?

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We found that clinical waste was not labelled in a way that would enable identification of where it was generated. The provider was unaware of this requirement and informed us they would take action to address this.

The infection control lead carried out infection prevention and control audits. The latest audit of July 2021 showed the practice was meeting the required standards. We did not see that the issues we noted were identified in this audit.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist did not use dental dam in line with guidance from the British Endodontic Society or any other methods to protect the airway when providing root canal treatment. The dentist informed us they were aware of this requirement but had not taken action to implement such safeguards as they had never lost a file yet.

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 four 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.

We found that the provider did not always ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. Evidence was supplied for servicing and validation of some equipment including portable electrical appliances and pressure vessels. We did not see and were not provided with, evidence of servicing and validation for the ultrasonic cleaner or x-ray machines. The provider was unable to supply a valid five yearly electrical safety certificate.

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.

We saw the provider had the required radiation protection information available. The provider did not carry out justification on all radiographs. We noted that when justification was carried out, they used their own code system to justify and grade the radiographs they took. We found this was not translated or logged in patient notes which would make independent verification of quality and effectiveness difficult.The provider was not able to explain why certain radiographs had been taken and routinely used Orthopantomogram (OPG), wide view x-ray taken of upper and lower jaws, to diagnose decay. This is not in line with guidance and may expose people to risk of unnecessary exposure to radiation.

We found that the provider had carried out a radiography audit in October 2021. We noted this did not include assessment of Orthopantomogram (OPG) X-rays.

We did not see and were not provided with evidence that clinical staff had completed continuing professional development in respect of dental radiography.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always effective.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly 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. Staff did not always follow the relevant safety regulation when using needles and other sharp dental items. For example, the dentist did not use needle guards or safer sharps. A sharps risk assessment had been undertaken in July 2021 and was updated annually.

Are services safe?

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 had not completed specific sepsis awareness training. We noted sepsis was discussed at team meetings and sepsis prompts for staff and patient information posters were displayed throughout the practice. This helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

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

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

A dental nurse worked with the dentist when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. We noted that the x-ray development fluid was not stored in line with manufacturers guidance which may pose a risk of harm to staff.

Information to deliver safe care and treatment

Staff did not always have 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 them to confirm our findings and observed that individual records were not always written and managed in a way that kept patients safe. Dental care records we saw did not always comply with General Data Protection Regulation requirements. We found records lacked detail of risk assessments for caries and oral cancer. Tooth wear, sever gum disease and pocket charting were not recorded. The provider confirmed to us they were not carrying out these assessments.

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.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

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

The dentist was aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits were carried out annually. The most recent audit indicated the dentist was following current guidelines.

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.

Are services safe?

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 not providing effective care in accordance with the relevant regulations. We have told the provider to take action. We will be following up on our concerns to ensure they have been put right by the provider.

Effective needs assessment, care and treatment

Systems to keep dental professionals up to date with current evidence-based practice were not effective or robust. Clinical assessments of patients' needs and treatment were not always delivered in line with current legislation, standards and guidance. We note that records of these assessments were not always recorded in detail in patient records. We advised the provider of the need to keep detailed records.

Staff had access to X-rays and an OPG machine 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 dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives.

The provider told us they did not always take plaque and gum bleeding scores or record charts of the patient's gum condition. This would not support healthy oral health for the patient or meet the needs, aims and requirements of the local community. As a result patients with severe gum disease may not always be identified or offered frequent, preventative treatment and advice.

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 dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records.

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. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

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

Dental care records did not always contain detailed information about the patients' current dental needs, past treatment and medical histories. Checks of gum health where not routinely recorded in line with recognised guidance.

Are services effective?

(for example, treatment is effective)

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, we noted that audits were not always carried out at recommended intervals and action plans were not always developed or acted on to address identified issues.

The provider told us they did not take part in any peer review, clinical support or knowledge sharing with other providers or clinicians.

Effective staffing

Staff had the skills and experience to carry out their roles. We noted the provider did not have records confirming staff had completed all training identified as recommended by GDC. For example, we did not see evidence of completion of training in; fire safety, oral cancer, consent, mental capacity act or equality and diversity.

The practice had a very settled staff team and had not carried out any recruitment recently. We saw that procedures were in place to ensure staff new to the practice would receive a structured induction programme. We did not see and were not provided with, evidence that confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. We noted specific omissions for radiography and IR(ME)R. (Ionising Radiation (Medical Exposure) Regulations).

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. We noted that these referrals were made by the practice manager based on notes recorded by the dentist. The provider confirmed they deferred this responsibility to the practice manager and did not have oversight of the final referral. We raised the lack of detail in patient records as a concern for the safety of the process with the provider and advised them to review this as soon as possible.

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. We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found the principal dentist had the values and skills to deliver high-quality, sustainable care, but did not always have the capacity.

The provider aimed to deliver a service in line with health and social priorities across the region, we noted this was not always achieved. Staff planned the services to meet the needs of the practice population.

Culture

The practice had a caring culture to provide general dental services to its patient community

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

Staff assessed and accessed their own training needs via an online system paid for by the provider. Appraisals were completed with the practice manager. We noted these were at infrequent intervals and the practice manager confirmed they were looking to improve the scheduling of these. Staff and the practice manager stated they had open lines of communication and support and were able to raise and discuss issues informally with the provider as they arose as they were such a small team. We were unable to confirm this as records were not kept of these informal conversations.

We did not see evidence that the provider had formal systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We reviewed a complaint raised to the practice. This was dealt with quickly, thoroughly and in line with the practices own polices. Lines of communication were maintained throughout the investigation and the provider demonstrated a detailed awareness of and commitment to 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

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was 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.

We saw there were processes for managing risks, issues and performance. We noted these were not always applied.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Are services well-led?

Engagement with patients, the public, staff and external partners

Staff involved patients, the public, staff and external partners to support the service. For example:

The provider used comment cards, encouraged verbal comments and online surveys to obtain patients' views about the service.

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. Results were not available to review at the time of our inspection.

The provider gathered feedback from staff through informal discussions. Staff were encouraged to offer suggestions for improvements to the service.

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. We noted these were not always completed at recommended intervals and action plans were not always developed or acted on to address issues identified.

The leaders valued the contributions made to the team by individual members of staff. We did not see evidence of a commitment to or investment in their own learning. The practice did not have any peer support arrangements for clinicians or leaders. We advised that the sharing of information and best practice may be beneficial for the governance, oversight and effectiveness of the service.

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: • A systematic comprehensive approach had not been implemented for staff appraisal. • A system to monitor completion of CPD for the principal dentist was not in place. • There were limited systems for monitoring and improving quality. For example, audit activity was not always completed at recommended intervals and did not result in improvement to the service. • Staff had not received training, to an appropriate level, in the safeguarding of children and vulnerable adults. There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • Patients' dental assessments were not recorded in accordance with nationally recognised evidence-based guidance provided by the College of General Dental Practice. • The reason for taking X-rays and a report on the findings and the quality of the image in compliance with Ionising Radiation (Medical Exposure) Regulations 2017 was not always included in patient care records.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1) (2)