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Specialist Dental Partners

Inspection report

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Overall summary

We carried out this announced focused inspection on 2 November 2021under 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 asked 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 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?

Summary of findings

We found this practice was not providing well-led care in accordance with the relevant regulations.

Background

Specialist Dental Partners is based on Melbourne Science Park and provides private treatment to about 1700 patients. The dental team includes three dentists, one visiting orthodontist, two dental hygienists, two reception staff and five dental nurses. The practice has three treatment rooms.

The premises are accessible to wheelchair users and there is parking available directly outside the building.

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.

The practice is open Monday from 9.30am to 5.30pm, on Tuesdays, Wednesday and Thursdays from 9am to 5.30pm, and on Fridays from 9am to 4pm.

During the inspection we spoke with the principal dentist, two dental nurses and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had systems to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff felt respected and supported.
- The provider did not have robust staff recruitment procedures in place to ensure only suitable staff were employed.
- There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice.

We identified regulations the provider was not meeting. They must:

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

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

- Implement processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

- Review the need for a door in one surgery to ensure patient confidentiality is maintained and reduce the risk of aerosol spread following and aerosol generating procedures.

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 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. The principal dentist was the lead for safeguarding concerns and information about protection agencies was available in the reception area. We noted information about local domestic violence services in the patient toilet, making it easily accessible.

The practice had a whistleblowing policy in place which staff were aware of. They told us they felt confident to raise concerns if they had them.

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. Additional measures had been implemented to reduce the spread of Covid-19. However, we noted that staff had not undergone fit testing for the specialist masks they used for respiratory protection until April 2021. This possibly put them at unnecessary risk as they had been using these masks prior to this date. Staff were unable to demonstrate how fallow times following an aerosol generating procedure had been calculated to ensure treatment areas were safe to use.

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 were validated, maintained and used in line with the manufacturers' guidance. The decontamination area was small, and we noted it did not have a separate dedicated hand wash sink, or clear air flow from clean to dirty. The practice undertook audits of its infection control procedures but not every six months as recommended in national guidance. The last one had been completed in September 2020 and had identified and number of shortfalls. No plan or timescales for action had been implemented to address these.

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 which had been undertaken in June 2021. The principal dentist and one of the nurses were the lead for legionella and had undergone training for this. Staff demonstrated a good awareness of dental line water management.

We saw effective cleaning schedules to ensure the practice was kept clean. We checked treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However, we noted some loose and uncovered dental materials and instruments in treatment room drawers that risked aerosol contamination. We found some out of date resin cement in one drawer. One dental chair had two small rips in it. One treatment room did not have a door. Not only did this compromise patient confidentiality but meant the room could not be properly closed off following an aerosol generating procedure.

The provider had policies and procedures in place to ensure clinical waste was segregated, although external clinical waste bins were not attached to a fixed point to prevent their unauthorised removal.

Staff told us that rubber dam was used for all root canal treatments so that patients' airways were protected. They were also used in all aerosol generating procedures.

Are services safe?

The provider had a recruitment policy and procedure to help them employ suitable staff. However, this policy was not being followed. There was no evidence of any disclosure and barring service (DBS) checks for two staff members. Although DBS checks were available for another two recently employed staff, these had not been obtained at the point of employment and were two to three years old. No references had been obtained for these members of staff.

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.

Records showed that fire detection and firefighting equipment was regularly tested. Fire exits were free from obstruction and clearly signposted. Two staff had received specific training in fire marshalling in 2019.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. We viewed evidence the clinicians justified, graded and reported on the radiographs they took. Audits of radiography were undertaken regularly, which showed clinicians were meeting target levels of acceptable radiographs. Clinicians had completed continuing professional development in respect of dental radiography. We noted that the acceptance test for the X-ray unit in surgery two identified that additional shielding was needed for the partition walls. Evidence that this had been done was not available, although the provider told us he would contact his radiation protection advisor to test the walls. We noted that one of the three X-ray units did not have a rectangular collimator attached to help reduce patient exposure.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards in the practice and detailed the control measures that had been put in place to reduce the risks to patients and staff.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. Although a comprehensive sharps risk assessment had not been completed, staff used the safest types of needles and matrix bands as recommended in national guidance.

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, although we noted there were no paediatric pads for the defibrillator. Staff kept records of their checks of equipment and medicines to make sure they were available and within their expiry date. However, these checks had failed to identify an out of date Salbutamol inhaler and an out of date Glucagon injection. The checks were not undertaken as frequently as recommended in national guidance. We had raised this issue during a monitoring call with the practice in July 2020, but it had not been addressed.

The provider had risk assessments to minimise the risk that could be caused from substances that were hazardous to health held within the practice, including cleaning materials.

Safe and appropriate use of medicines

Clinicians were aware of current guidance with regards to prescribing medicines. Patient group directions were in place for the practice's dental hygienists so they could administer local anaesthetics.

Medicines were stored securely in the practice, although there was no formal system of stock control in place. Anti-microbial audits were not completed to monitor that clinicians were prescribing antibiotics in line with national guidance.

Track record on safety, and lessons learned and improvements

Are services safe?

The practice had an incident reporting policy in place and specific forms were available to complete in relation to these. There had been no unusual or significant events recorded since 2012, but 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 national patient 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 clinicians assessed patients' needs and delivered care and treatment. We found this was not always recorded in line with current legislation, standards and guidance or supported by clear clinical pathways and protocols.

Patients' dental care records had been audited to check clinicians recorded the necessary information. We noted that the audits had identified some of the same shortfalls we did. For example, patient basic periodontal examinations had not always been recorded and there were no diagnoses recorded in line with the British Society of Periodontists guidance. Information about patients' risk level of caries, gum disease, oral cancer and non-carious tooth surface loss had not always been recorded. Not all records clearly demonstrated that treatment options had been fully discussed with patients.

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. Two dental hygienists were employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease.

There was a selection of dental products for sale to patients including interdental brushes, mouthwash, toothbrushes and floss.

Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005. Staff 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 were looked after.

Effective staffing

We confirmed the dentist completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role.

Staffing levels at the practice had not been affected as a result of the Covid-19 pandemic and staff told us they had enough time to do their job. The dental hygienists did not always work with chairside support, but a risk assessment had been completed for this.

Co-ordinating care and treatment

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

Staff 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 identified several shortfalls during our inspection including the quality of dental care records, the recruitment of staff, auditing procedures and the checking of emergency equipment and medicines which demonstrated that governance procedures in the practice needed to be strengthened.

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 took responsibility for the overall leadership in the practice supported by a dental nurse who led on compliance issues. There was also a specific nurse who took the lead for decontamination within the practice.

We conducted a telephone monitoring call with the practice in March 2021. During that call we advised the provider to review the frequency of checks of their medical emergency kit and to calculate fallow times following any aerosol generating procedures undertaken. We noted that neither of these actions had been implemented during this inspection.

Culture

Staff stated they felt valued and enjoyed their work. They stated that the principal dentist was supportive and understanding of their family commitments, something which they greatly appreciated.

The provider had a specific Duty of Candour policy in place, and staff were aware of their responsibilities under it. We noted that openness and honesty were demonstrated when responding to the recent complaint we reviewed.

Governance and management

There were some processes for managing risks, issues and performance. The practice had comprehensive policies, procedures and risk assessments to support the management of the service and to protect patients and staff. The provider used an on-line governance tool to assist in the management of the service.

Communication across the practice was structured around regular meetings. Staff told us these provided a good forum to discuss practice issues and they felt able and willing to raise their concerns in them. The meetings were used to discuss the practice's policies and a different policy was chosen for each meeting.

Information about how patients could raise concerns was available in the waiting area, although it was not easily visible or accessible. We viewed the last complaint received and noted it had been investigated and responded to in a timely, empathetic and professional way.

Engagement with patients, the public, staff and external partners

There was no formal system in place to gather feedback from patients and help improve the service.

Staff told they were listened to and their ideas considered by the principled dentist. One staff member's suggestion to shorten the lunch break had been implemented.

Continuous improvement and innovation

The provider had some quality assurance processes to encourage continuous improvement. Audits were undertaken although we found they were not always completed as frequently as recommended and had not been effective in driving

Are services well-led?

improvement. For example, a dental care records audit had been undertaken in January 2021 and had identified several areas for improvement. We found similar shortfalls in the dental care records we reviewed during our inspection, some ten months later. An antimicrobial prescribing audit had never been conducted and infection control audits were not undertaken as frequently as recommended.

All staff received an appraisal of their performance. However, they told us these were always consistently positive and would value them more if they also identified areas for improvement.

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 Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good Governance 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. How the regulation was not being met: The registered person had ineffective systems or processes in place as they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice. • There was no effective system in place to ensure essential audits were undertaken in line with nationally recommended guidelines. The provider should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated • There was no system to ensure checks of medical emergency equipment and medicines took into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council. • There was no system in place to ensure appropriate recruitment checks were completed prior to new staff commencing employment at the practice.

This section is primarily information for the provider

Requirement notices