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Brighton White Dental Studio

Inspection report

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Overall summary

We carried out this focused unannounced inspection on 05 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 three 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 not 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

Brighton White Dental Studio is in Brighton and provides NHS and private dental care and treatment for adults and children.

There is no level access to the practice for people who use wheelchairs and those with pushchairs. The practice is accessed by a flight of stairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes two dentists, two trainee dental nurses, a dental hygienist, a receptionist and a practice manager. The practice has four treatment rooms. One of the treatment rooms is currently decommissioned.

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 both trainee dental nurses, and the receptionist. We asked staff to inform the provider and practice manager that we were there to inspect. The provider and practice manager declined to attend the practice. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday to Thursday 9am to 6pm
- Friday 9am to 5pm

Our key findings were:

- The practice did not appear to be visibly clean and well-maintained.
- The provider had infection control procedures which did not reflect published guidance.
- Staff were not confident with how to deal with emergencies. Appropriate medicines and life-saving equipment were available, although this required improvements
- The provider did not have systems to help them manage risk to patients and staff.
- The provider did not have safeguarding processes and staff were unsure of their responsibilities for safeguarding vulnerable adults and children.
- The provider did not have staff recruitment procedures which reflected current legislation.
- The appointment system did not ensure patients' needs could be fully met.
- The practice did not have effective leadership and a culture of continuous improvement.
- Staff did not feel involved and supported
- The provider did not have information governance arrangements.
- There were poor clinical governance processes and no audits to measure compliance with current legislation or to ensure that the practice was taking into account current guidance.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	Enforcement action 
Are services effective?	Enforcement action 
Are services well-led?	Enforcement action 

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff did not have systems to keep patients safe.

Staff were not sure of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. There were no safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We did not see evidence that staff had received safeguarding training. Staff were unsure about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had an infection prevention and control policy and procedures, which contained out of date information. They did not follow 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. We did not see any evidence that training for infection control had been completed.

The provider had arrangements for transporting, cleaning, sterilising and storing instruments which was not in line with HTM 01-05. We saw that some instruments were stored loose in drawers. These were subject to repeated recontamination as the drawers were opened and closed during aerosol generating procedures. These instruments were only processed after use. Staff were unaware of the requirement to re-process unwrapped instruments at the end of the clinical session. The loose instruments had been in the drawer for four days and not reprocessed. Staff told us they had mentioned to the dentists that instruments should be pouched for storage. Staff said they were told not to pouch the instruments to save time. The records showed equipment used by staff for cleaning and sterilising instruments was validated and used in line with the manufacturers' guidance. However, we saw that the last servicing was conducted in September 2019 and not every six months as required. *Whilst the provider had suitable numbers of dental instruments available for the clinical staff, the current measures did not ensure they were decontaminated and sterilised appropriately.*

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

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 some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A risk assessment could not be produced when requested. We saw that dental unit water lines were maintained. We did not see records of water temperature monitoring and staff when questioned were unsure of what this meant.

We saw cleaning schedules, but this did not ensure the practice was kept clean. Staff told us that they were responsible for the environmental cleaning of the practice. We saw that the floors in all the treatment rooms were dirty. Staff told us they were instructed to only clean the floors once a week on a Friday. We saw that the practice was visibly dirty and, in some areas, cluttered.

The provider had a policy to ensure clinical waste was segregated and stored appropriately in line with guidance. This needed updating to include current information.

Are services safe?

The practice had not carried out infection prevention and control audits twice a year.

The provider did not have a whistleblowing or speak up policy. Staff told us they did not feel confident they could raise concerns without fear of recrimination.

Staff told us that the dentists did not use a dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. Although a dam was available.

The provider did not have a recruitment policy or procedure to help them employ suitable staff. There were no checks in place for agency and locum staff. This did not reflect the relevant legislation. There was no recruitment information or Schedule 3 documentation for any of the members of staff.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We saw that portable appliance testing (Pat) had been conducted in 2021 but there was no 5-year electrical safety certificate.

The practice did not have a fire risk assessment carried out in line with the legal requirements. Staff told us that they had not participated in a fire drill or had any discussions regarding fire safety during their inductions. We saw in treatment room one, piles of boxes and paper that posed a fire hazard.

The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was not available.

We saw logs of the radiographs staff took. The provider carried out radiography audits every year following current guidance and legislation. However, we could not be assured clinical staff had completed continuing professional development in respect of dental radiography, as no certification was available.

Risks to patients

The provider did not have systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies did not contain up to date information for staff to refer to, procedures and risk assessments had not been carried out regularly to help manage potential risk. Staff could not find a current employer's liability insurance certificate.

We looked at the practice's arrangements for safe dental care and treatment. We could not be assured that staff followed the relevant safety regulation when using needles and other sharp dental items. There was no sharps risk assessment available.

We could not be assured the practice 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. This information was not available for any member of staff when requested. One member of staff told us they had received the full course of three vaccinations but had not had their antibody levels checked. Another staff member told us they had received two doses of the vaccination and the third dose was booked to be received.

None of the clinical staff had knowledge of the recognition, diagnosis and early management of sepsis.

We were not assured all staff knew how to respond to a medical emergency. One member of staff had certification to show completed training in emergency resuscitation and basic life support. Two members of staff had not completed any training for medical emergencies. There was no evidence that other members of staff had completed this training.

Are services safe?

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, we found two items of equipment that were not within their expiry date, these had been checked as fit for use.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment was not available for when the dental hygienist worked without chairside support.

The practice could not produce any risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice occasionally used locum staff. We observed that these staff did not always receive an induction to ensure they were familiar with the practice's procedures.

Information to deliver safe care and treatment

We were unable to assess this during this inspection.

Safe and appropriate use of medicines

The provider did not have systems for appropriate and safe handling of medicines.

We saw that the stock control system of medicines which were held on site was ineffective and had not ensured that medicines did not pass their expiry date. For example, we found five boxes of antibiotics that had expired. The expired medicines were kept with the in-date medicines posing a risk of the expired medicines being dispensed to a patient.

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

We could not determine if the dentist was aware of current guidance with regards to prescribing medicines as no dentist was in attendance during our inspection.

Antimicrobial prescribing audits were not carried out

Track record on safety, and lessons learned and improvements

We did not see a system for reviewing and investigating when things went wrong. There were no risk assessments available in relation to safety issues. We were not assured that staff monitored and reviewed incidents. This indicated that risks could be missed as well as safety improvements implemented.

In the previous 12 months where there had been a safety incident, we saw this was, documented. There was no further information on how this had been addressed or how the risk of it happening again is mitigated. Staff we spoke with were not aware of the incident.

We were not shown a system for receiving and acting on safety alerts when requested.

Are services effective?

(for example, treatment is effective)

Our findings

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Effective needs assessment, care and treatment

We could not be assured the practice had systems to keep dental professionals up to date with current evidence-based practice. No information was available when requested.

Helping patients to live healthier lives

We were unable to assess this area during our inspection. As no clinician staff were available for us to talk to.

Consent to care and treatment

The practice did not have a consent policy. Information about the Mental Capacity Act 2005 was available to staff. The team were not sure of their responsibilities under the act when treating adults who might not be able to make informed decisions.

Monitoring care and treatment

The provider did not have quality assurance processes to encourage learning and continuous improvement.

Effective staffing

We were not assured that all staff had the skills, knowledge and experience to carry out their roles. We found there was insufficient support, training and mentoring for the trainee nurses to undertake their role safely and effectively.

Staff new to the practice including locum staff did not have a structured induction programme. Staff told us they did receive an induction, but it was quick, and they had not discussed fire safety or carried out a fire drill. We could not confirm clinical staff completed the continuing professional development required for their registration with the General Dental Council (GDC) as no information was available for staff that were GDC registrants.

Are services well-led?

Our findings

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

Staff told us that there was little day to day leadership. The practice did not see any patients two days per week as there were not enough dentists to provide services Monday to Friday. Staff told us that most communication was completed via text messages and email.

Culture

Staff stated they did not always feel respected, supported and valued. They said that they could not always get hold of management when they needed to.

Staff had not discussed their training needs at an annual appraisal or one to one meeting. Staff told us they had received an email with a list of the training they needed to complete.

We saw the provider did not have systems in place to deal with poor staff performance.

The practice could not demonstrate they had systems to ensure compliance with the requirements of the Duty of Candour.

Staff had raised concerns. These were not always addressed. Staff had mentioned that storage of instruments was not in line with current guidance, but this had been overridden.

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.

The provider did not have an effective system of clinical governance in place which would include policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

We saw there were no clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

Staff could not act on appropriate and accurate information as some of the reference material available to them was out of date and had not been reviewed in some cases since 2017.

We did not see information governance arrangements. As this could not be produced when requested.

Continuous improvement and innovation

The provider did not have enough systems and processes for learning, continuous improvement and innovation.

The practice did not have quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control.

We could not be assured staff had completed 'highly recommended' training as per General Dental Council professional standards as no records were available.