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Church Street Dental Care

Inspection Report

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Overall summary

We undertook a focused inspection of Church Street Dental Care on 16 September 2019. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Church Street Dental Care on 5 March 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe, effective or well led care and was in breach of regulation 9,12,17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Church Street Dental Care on our website www.cqc.org.uk.

As part of this inspection we asked:

- Is it safe?
- Is it effective?
- Is it well-led?

When one or more of the five questions are not met we require the service to make improvements and send us an action plan (requirement notice only). We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 5 March 2019.

Are services effective?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 5 March 2019.

Are services well-led?

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

Summary of findings

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 5 March 2019.

Background

Church Street Dental Care is in Littleborough, Lancashire and provides private treatment for adults and children.

There is single step access into the practice. Car parking is available near the practice on local side streets.

The dental team includes the principal dentist, four dental nurses and one dental hygienist. 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 the principal dentist and a dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday by appointment only.

Tuesday 10am to 7:30pm, Wednesday 10am to 2:30pm, Thursday 9am to 5pm and Friday 8am to 4pm.

Our key findings were:

- Infection control processes were now in line with relevant guidance.
- Improvements had been made to staff recruitment procedures. Further improvement was required to ensure that the process was fully in line with relevant legislation.
- The management of medicines was now effective and met current regulations.
- Further improvements could be made to ensure the provider is up to date with national guidance and is meeting quality standards.
- Further improvements could be made to ensure clarity when reporting on X-rays taken.
- The level of detail recorded in the patient dental care records had improved but needed further attention.
- The medical emergency kit now reflected recognised guidance and the system to monitor the kit was effective.
- The provider was not using dental dams to protect the patient's airway during root canal treatment.
- Improvements could be made to ensure action taken in response to a patient safety alerts were recorded for future reference.
- Safe sharps systems had been improved but were not fully in line with current regulations.
- Recommendations identified in the disability access audit and the fire risk assessment were now complete.
- Further action could be taken to improve control measures when using the Orthopantomogram (OPG) in line with current regulations.
- Systems to assess, monitor and improve the quality and safety of the service were now more effectively managed.
- Leadership and oversight of governance systems and processes could be improved.

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

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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?	**Requirements notice** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At our previous inspection on 5 March 2019 we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 16 September 2019 we found the practice had made the following improvements to comply with the regulations:

The provider described how they had tried to implement the use of dental dams during root canal procedures but felt further training was needed to be fully confident in its use. Currently when not using rubber dam, the provider protected the patients' airway using other methods. A training course was currently being sourced.

The provider had made improvements to the staff recruitment evidence gathering process to ensure the required information was retained in staff files. For example:

- We saw that all staff had adequate indemnity cover.
- We saw that references and employment history was obtained for the newest staff member.

Further improvements could be made to ensure the recruitment process was fully in line with relevant legislation. For example, be aware of when to carry out an appropriate DBS risk assessment and to ensure the recruitment policy reflects this. The provider told us they were aware when there was a need to risk assess the DBS process, but had not done so for one staff member whose existing DBS check was more than three months old at point of application.

Infection prevention and control processes were now carried out in line with recommended guidance. In particular:

- The provider now wore a clinical top when treating patients.
- A suitable bowl was in place to clean instruments.
- Water temperature was now monitored during the instrument cleaning process.

The medical emergency kit reflected recognised guidance and all required medicines and equipment were in place. An effective system was in place to check expiry dates and the proper function of the equipment.

Safer sharps systems had been improved to identify responsibilities when handling needles, but the process did not fully align with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. A policy was displayed in the treatment room and a risk assessment was in place. The risk assessment did not cover all other sharps in use at the practice. The provider assured us this would be reviewed.

The provider had acted in line with the disability access audit and the fire risk assessment recommendations. In particular:

- A hearing loop was available and visible signage was in place.
- An access ramp was available, and the front step was painted to provide a contrast for patients entering the practice as recommended in the audit.
- Fire assembly point signage was now in place.
- Evacuation signage and practice plan was complete and displayed in the waiting area.
- All staff had completed fire training and fire training was included in the staff induction pack.

The provider had attached radiation signage to the door in the waiting rooms to advise patients they were entering an area where X-rays were taken. An Orthopantomogram (OPT) X-ray machine was located at the top of the open stairway and public rooms were at either side of this machine. There was no policy, risk assessment or written scheme of work for staff to follow to lower the risk of a patient inadvertently using the stairs, exiting the bathroom or waiting area whilst the machine was in use. We discussed the option of seeking advice from the provider's Radiation Protection Advisor in respect to this concern.

The provider had registered to receive patient safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). We reviewed the folder containing retrospective alerts from the previous 12 months and we noted that records were not kept confirming actions taken in response to the alerts. We highlighted this to the provider who assured us this would be implemented in future.

Are services safe?

Medicines management was now effectively controlled. Prescribed dosing for antibiotics were now in line with guidance, a log book was in place to monitor and track prescribed medicines and all prescribed medicines were appropriately labelled. The provider had also utilised the on-line application for the British National Formulary.

The provider had put systems and processes in place for the following areas previously found to be ineffective:

- Identification, reporting and recording of significant incidents. Staff were aware of the process and could describe potential incidents which would be considered significant.
- The X-ray cable in the treatment room had been replaced and was now safe to use.
- We saw up-to-date staff records of the effectiveness of the Hepatitis B vaccination for all staff.
- The provider had put in place a system to induct temporary agency staff.
- The system in place to risk assess materials that can be hazardous to health was now effective.

The provider had also made further improvements:

- The storage of mops was in line with the guideline's issues by the Department of Health – Health Technical Memorandum 01-05 Decontamination in primary care dental practices.
- The provider had registered the use of X-ray equipment as required, with the Health and Safety Executive.

These improvements showed the provider had taken action to comply with the regulations when we inspected on 16 September 2019.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this practice was not providing effective care and was not complying 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).

The provider had improved their awareness of the guidance provided by the National Institute for Clinical Excellence guidance, in particular, antibiotic stewardship, antimicrobial prescribing and sepsis awareness. For example:

- Antibiotic stewardship was now being more closely monitored. The provider had introduced a log book to record when prescribing antibiotics to assist with the audit process. We discussed with the provider that an antibiotic audit would be beneficial.
- Staff had completed Sepsis awareness training and a policy had been implemented, visual aids were seen throughout the practice and a Sepsis awareness worksheet was available to familiarise staff to help identify symptoms.

The provider told us, and we saw they had made improvements to more closely follow guidance from The Faculty of General Dental Practice UK (FGDP (UK) in respect of patient dental care records. We noted for example:

- Risk assessments were now being completed in patient dental care records.
- An extra oral examination of the patient was now consistently recorded.
- The patients' social history was now recorded.
- Recall according to risk factors was now recorded, although we identified some inconsistency in respect to this.
- Recording of consent in patient dental care records was now consistent.
- Recording of treatment options was more consistent.

During review of the patient dental care records and discussion with the provider we found there was still room for improvement, for example:

- The risk factor annotation was generic (not patient specific) and did not always accurately reflect the dental care records we reviewed. For example: we found patient dental care records were risk categorised as moderate, the provider agreed these should have been categorised as high risk and some should have been categorised as low risk.
- Basic Periodontal Examinations were not always accurately recorded when reviewed against current radiographs. The provider agreed with these findings.
- There was no evidence in the patient care record that patients were informed of their current gum health. The provider agreed with our findings.

The provider discussed how they had improved the process to consistently justify, grade and report on the radiographs taken. We found the justification and grading was in line with guidance.

Further improvements could be made to ensure the provider accurately reported on the radiographs in the patient care record. For example:

- Of the patient dental care records we reviewed with the provider, all were reported on as NAD 'nothing abnormal detected'. Upon closer review of these records we identified that some radiographs appeared to show bone loss and caries, this had not been identified and acted upon. The provider agreed with our findings.
- The provider continued to be unclear on the guidance relating to the frequency to take radiographs and the justification for doing so.

The provider had made improvements to the process to ensure a patient's medical history was kept up-to-date in line with current guidance. Medical history was now consistently updated every six months and completed in reception. This information is then updated onto the patients' care record.

Are services well-led?

Our findings

We found that this practice was not providing well led care and was not complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

- Infection prevention and control processes were now carried out in line with recommended guidance.
- Medicines management was now effectively controlled.
- The system in place to monitor the medical emergency kit was now effective.
- The system in place to confirm the effectiveness of the Hepatitis B vaccine was now effective.
- Systems had been reviewed to ensure recommendations from audits and risk assessments were acted upon.
- The system in place to risk assess materials which can be hazardous to health was now effective.
- The provider had improved systems to ensure staff were inducted effectively.
- The provider had improved the evidence gathering process to ensure all staff had the required information in their staff file. Further improvements could be made to the DBS checking and risk assessment process.
- The provider had improved the process to ensure a patient's medical history was kept up-to-date in line with current guidance.
- Systems were not in place to ensure the provider used dental dams in line with in line with guidance from the British Endodontic Society.
- Systems were not in place to ensure all sharps items in use had been risk assessed in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The practice's recruitment processes were not fully in line with relevant legislation. The provider had not ensured an appropriate DBS risk assessment was undertaken to mitigate any risks for one staff member. The recruitment policy was not up-to-date to reflect the correct process.
- Systems were not in place in line with IR(ME)R 2018 and Ionising Radiation Regulations 2017 to ensure adequate control measures and a risk assessment had been considered to protect patients from unintended exposure whilst using the OPG X-ray machine.
- Systems were not fully in place or understood to ensure compliance with guidance from the FGDP and IR(ME)R 2017 Regulations in respect to accurate reporting on X-rays taken and the frequency for taking X-rays.
- The process to record action taken in response to a patient safety alert from the MHRA was not effective.
- Systems were not fully in place or understood to ensure compliance with guidance from the FGDP and GDC Standards in respect to the completion of patient dental care records.
- Systems were not fully in place or understood to ensure compliance with guidance from the British Society of Periodontology in respect to recording BPE.

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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment of service users must be appropriate, meet their needs and reflect their preferences. **How the regulation was not being met:** Assessments of the needs and preferences for service user care and treatment were not being carried out collaboratively with the relevant person. In particular: • The registered person had failed to ensure they remained up-to-date with guidance in respect to the completion of dental care records and the frequency to take X-rays. The registered person had failed to ensure they remained up to date with clinical record keeping guidance. In particular: • Reporting of risk factors. • Reporting on radiographs taken. • Recording of Basic Periodontal Examinations was not in line with guidance from the British Society of Periodontology. Regulation 9(1)

This section is primarily information for the provider

Enforcement actions

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 Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. **How the regulation was not being met:** 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. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular: • The registered person had failed to ensure systems were in place to use dental dams in line with in line with guidance from the British Endodontic Society. • The registered person had failed to ensure that adequate systems were in place to risk assess all sharps items in use in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • The registered person had failed to ensure the recruitment policy reflected relevant legislation. • The registered person had failed to ensure an appropriate DBS risk assessment was in place to mitigate any risks. • The registered person had failed to ensure adequate control measures were in place to align with IR(ME)R 2018 and Ionising Radiation Regulations 2017 in respect to use of the OPT X-ray machine.

This section is primarily information for the provider

Enforcement actions

- The registered person had failed to ensure that systems were in place to ensure compliance with guidance from the FGDP and IR(ME)R 2017 Regulations in respect to accurate reporting on X-rays taken and the frequency to take X-rays.
- The registered person had failed to ensure there was a process to record action taken in response to a patient safety alert from the MHRA.
- The registered person had failed to ensure they had improved their awareness to ensure they complied with guidance from the FGDP and GDC Standards in respect to record keeping.
- The registered person had failed to ensure they had improved their awareness to ensure they complied with guidance from the British Society of Periodontology in respect to recording BPE.

Regulation 17 (1) (2)