SC Dental Studio Ltd

SC Dental Studio Ltd

Inspection report

5 Kingfisher Court
281 Farnham Road
Slough
SL2 1JF
Tel: 01753550888
www.dentalstudioslough.com

Date of inspection visit: 9 August 2023
Date of publication: 18/09/2023

Overall summary

We carried out this announced comprehensive inspection on 9 August 2023 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's infection control procedures were not operated effectively.
- The appointment system worked efficiently to respond to patients' needs.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- Staff knew how to deal with medical emergencies, but improvement was needed to ensure emergency medicines were fully appropriate.
- Improvements were needed to the provider's staff recruitment procedures.

Summary of findings

- Staff provided preventive care and supported patients to ensure better oral health.
- The provider did not have effective leadership and a culture of continuous improvement.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Background

SC Dental Studio Ltd Slough and provides NHS and private dental care and treatment for adults and children.

There is step free access via a portable ramp, to the practice for people who use wheelchairs and those with pushchairs.

Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 4 dentists, 2 foundation dentists, 1 visiting anaesthetist,

7 dental nurses, of which 1 is also the practice manager and 1 is a receptionist, 1 dental hygiene therapist, and 1 receptionist. The practice has 5 treatment rooms.

During the inspection we spoke with 2 dentists, 2 foundation dentists, 2 dental nurses, 1 receptionist and the practice manager.

We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

- 9am to 6pm Monday to Friday

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

- Ensure care and treatment is provided in a safe way to patients.
- 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.

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

- Implement protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.
- Improve and develop staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

The practice manager accepted the issues raised and started to take action to address these.

Summary of findings

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report, but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**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, premises, and radiography (X-rays)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice did not have infection control procedures which reflected current published guidance. In particular:

- An open pack of paper hand towels were stored on the worktop in the decontamination room. We have since received evidence to confirm this shortfall has been addressed.
- Protocols for the regular changing of scrubbing brushes and gloves used by staff for cleaning instruments prior to being sterilised were not available. We have since received evidence to confirm this shortfall has been addressed.

The most recent infection control audit indicated the practice was meeting the required standards. However, we found that audit findings were inaccurate.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment. Evidence presented to us confirmed that a legionella risk assessment was in progress. We will review the completion of the resulting action plan at our follow up visit.

The practice had policies and procedures in place to ensure clinical waste was segregated appropriately in line with guidance.

The practice was not visibly clean and there was not an effective cleaning schedule to ensure the practice was kept clean. We observed:

Treatment room floors and skirtings were damaged in places which prevented appropriate cleaning. We have since received evidence to confirm this shortfall has been addressed.

- Peeling paint was present on window sills which prevented appropriate cleaning.
- Woodwork (skirtings and window frames) paintwork appeared visibly dirty.
- Drawer handles in the sedation room were visibly dirty.
- Cleaning schedules for weekly and monthly cleaning were not available.
- Cleaning equipment storage did not follow national infection control standards.
- A material covering to the sedation treatment recovery room door glass panel and a privacy screen in the sedation room were visibly dirty.

We have since received evidence to confirm these shortfalls have been addressed.
A new cleaning company has been commissioned to maintain a clean environment going forward.

Recruitment checks had not been conducted, in accordance with relevant legislation to help them employ suitable staff. We looked at 3 staff recruitment records and evidence presented to us found:

- Two did not have evidence of their employment history (CV). We have since received evidence to confirm this shortfall has been addressed.

Are services safe?

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

The practice did not ensure equipment was safe to use and maintained according to manufacturers' instructions.

The practice manager's office contained 2 fridges.

- Fridge 1's temperature was not checked to ensure temperature levels remained between 2 and 8 degrees Celsius.
- Fridge 2's temperature exceeded the recommended level of 8 degrees Celsius on the day of our visit. No action was taken as a result.
- Both fridges were severely iced up.
- Fridge 1 contained a quantity of syringes of antibiotic solution which displayed June 2022 'use by' dates. We were told these were no longer used and disposal was an oversight. The practice manager disposed of them appropriately immediately.
- Fridge 2 contained a quantity of out-of-date dental materials. We were told these were no longer used and disposal was an oversight.

We have since received evidence to confirm these shortfalls have been addressed.

The management of fire safety at the practice was not effective. In particular:

- A fire risk assessment was carried out in 2019. Annual reviews had not been carried out since that date.
- Fire drills were not carried out.
- The automatic fire alarm was inspected annually. British standards state inspections should take place every 6 months.
- Fire exits and fire escape routes were not signed appropriately.
- A fire risk assessment was carried out by an individual who could not demonstrate fire safety management competence. The provider assured us they would source a professional fire risk assessment as soon as practicably possible.

We have since received evidence to confirm these shortfalls have been addressed.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available, but improvements were needed. Specifically:

The practice had 5 x-ray machines. One machine was fitted with a rectangular collimator. A rectangular collimator reduces the amount of radiation a patient is exposed to during dental intraoral x-ray procedures by reducing scatter radiation. Two further rectangular collimators were found in drawers during our visit. The practice was unable to locate the remaining 2.

We have since received evidence to confirm this shortfall has been addressed.

Risks to patients and staff

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

Sharps risk management was not effective:

- Staff manually scrubbed instruments. This procedure was not included in the sharps risk assessment.
- Sharps injury action posters did not include any contact details for accident and emergency and occupational health services.

We have since received evidence to confirm these shortfalls have been addressed.

The provider did not operate an effective system to ensure clinical staff were vaccinated against the Hepatitis B virus. The effectiveness of the vaccination was not checked for 7 of the 16 clinical staff working at the practice. We have since received evidence to confirm this shortfall is being addressed.

Are services safe?

Improvement was needed to the process for checking the availability of emergency equipment and medicines. Specifically:

Glucagon, a hormone used to treat low blood sugar levels, was present in the practice managers room fridge. It was marked with an expiry date of 2017. The practice was unable to locate any further Glucagon. We have since received evidence to confirm this shortfall has been addressed.

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

Evidence was not available to confirm Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) had been carried out for any of the staff who supported sedation in the previous 12 months. We have since received evidence to confirm that training has been booked to take place on 18 October 2023.

The practice did not have risk assessments to minimise the risk that can be caused from substances that are hazardous to health. In particular:

- Risk assessments were not available for all the COSHH identified products used.
- Two yellow clinical waste bins at the rear of the practice were not tethered to a fixed point to prevent being removed from the building car park.

We have since received evidence to confirm these shortfalls have been addressed.

Window blind adjustment looped cords were not tethered to window frames and may pose a risk of choking to young children in the waiting area. We have since received evidence to confirm this shortfall has been addressed.

Information to deliver safe care and treatment

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements, but referrals were not centrally monitored to ensure they were received in a timely way and not lost.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines, but improvement was needed. In particular:

- Prescription pad stock controls were not in place. We have since received evidence to confirm this shortfall has been addressed.
- Antimicrobial prescribing audits were overdue. The last audit was carried out in 2021.

Track record on safety, and lessons learned and improvements

The practice had a system for receiving and acting on safety alerts.

The practice had systems to review and investigate incidents and accidents, but improvements were needed. We noted that:

- A pre-General Data Protection Regulation (GDPR) accident book was in use.
- Completed accident records were not removed and stored securely.

We have since received evidence to confirm these shortfalls have been addressed.

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.

Sedation

The practice offered conscious sedation for patients. The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management and sedation equipment checks.

Dental implants

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.

involvement in local schemes

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

The clinicians we spoke with could not fully demonstrate understanding of their responsibilities under the Mental Capacity Act 2005 and Gillick competence..

Monitoring care and treatment

We were unable to review patient care records because of a system failure with the internet in the local area which meant the clinicians could not access their online note taking system. The practice was using hand written cards in line with their business continuity plan. We will review patient record keeping at our follow up visit.

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

The practice carried out radiography audits six-monthly. Audits were not fully completed to include detailed analysis, outcomes or plans.

Effective staffing

Newly appointed staff had a structured induction.

Clinical staff completed continuing professional development required for their registration with the General Dental Council.

We noted that the required 5 hours of Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) training was not available for one clinician. We have since received evidence to confirm this shortfall has been addressed.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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 caring?

Our findings

We found this practice was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

On the day of inspection, we spoke with 3 patients who all confirmed that staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

The practice had installed closed-circuit television to improve security for patients and staff. Relevant protocols were not in place. In particular:

- A Data Protection Impact Assessment (DPIA) was not available.
- Information for patients to explain the purpose of recording images was not available
- The name and contact details of those operating the surveillance scheme were not displayed.

We have since received evidence to confirm this shortfall has been addressed.

We were told that treatment room cameras had been disconnected and were no longer in use.

Glass partitioning on treatment room doors did not fully protect patients' privacy and dignity. We have since received evidence to confirm this shortfall has been addressed.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentists explained the methods they used to help patients understand their treatment options. These included photographs, study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments, which included hearing and vision aids for patients with access requirements.

A disability access audit indicated the practice was meeting the required standards. However, we found that audit findings were inaccurate. In particular:

- The wheelchair accessible toilet had a foot operated sanitary bin.
- The front door threshold ramp was not available.
- The mirror in the wheelchair accessible toilet was out of reach of a wheelchair user.

We have since received evidence to confirm these shortfalls have been addressed.

Timely access to services

The practice displayed its opening hours and provided information on their website.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs.

The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately. Staff discussed outcomes to share learning and improve the service.

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

Leadership capacity and capability

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective.

We saw the practice had effective processes to support and develop staff with additional roles and responsibilities.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

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

Governance and management

The provider had overall responsibility for the clinical leadership of the practice. The practice manager was responsible for ensuring the practice met the required standards.

The provider had a system of clinical governance in place which included policies, protocols and procedures. These were accessible to all members of staff, but systems were not routinely followed.

We saw there were clear processes for managing risks, issues and performance but these were not followed which resulted in poor risk management at the practice.

The management of radiography, fire safety, equipment and premises, COSHH, infection control, sharps and emergency medicines and equipment required improvement.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice's information governance arrangements required improvement.

Engagement with patients, the public, staff and external partners

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

Feedback from staff was obtained through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement

The provider had quality assurance processes to encourage learning and continuous improvement, but these were not operated effectively.

Antimicrobial prescribing, infection control and disability access audits were not carried out correctly.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **Regulation 12** **Safe Care and Treatment** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: **Infection Control** • An open pack of paper hand towels were stored on the worktop in the decontamination room. • Protocols for the regular changing of scrubbing brushes and gloves used by staff for cleaning instruments prior to being sterilised were not available. • Treatment room floors and skirtings were damaged in places which prevented appropriate cleaning. • Peeling paint was present on window sills which prevented appropriate cleaning. • Woodwork (skirtings and window frames) paintwork appeared visibly dirty. • Drawer handles in the sedation room were visibly dirty. • Cleaning schedules for weekly and monthly cleaning were not available. • Cleaning equipment storage did not follow national infection control standards. • A material covering to the sedation treatment recovery room door glass panel and a privacy screen in the sedation room were visibly dirty. **Equipment** The practice manager's office contained 2 fridges.

This section is primarily information for the provider

Requirement notices

- Fridge 1's temperature was not checked to ensure temperature levels remained between 2 and 8 degrees Celsius.
- Fridge 2's temperature exceeded the recommended level of 8 degrees Celsius on the day of our visit. No action was taken as a result.
- Both fridges were severely iced up.
- Fridge 1 contained a quantity of syringes of antibiotic solution which displayed June 2022 'use by' dates.
- Fridge 2 contained a quantity of out-of-date dental materials.

Fire Safety

- A fire risk assessment was carried out in 2019. Annual reviews had not been carried out since that date.
- Fire drills were not carried out.
- The automatic fire alarm was inspected annually. British standards state inspections should take place every 6 months.
- Fire exits and fire escape routes were not signed appropriately.
- A fire risk assessment was carried out by an individual who could not demonstrate fire safety management competence. The provider assured us they would source a professional fire risk assessment as soon as practicably possible.

Radiography

- The practice had 5 x-ray machines. One machine was fitted with a rectangular collimator. A rectangular collimator reduces the amount of radiation a patient is exposed to during dental intraoral x-ray procedures by reducing scatter radiation. Two further rectangular collimators were found in drawers during our visit. The practice was unable to locate the remaining 2.
- Radiography audits were not fully completed to include detailed analysis, outcomes or plans.

Sharps

- Staff manually scrubbed instruments. This procedure was not included in the sharps risk assessment.
- Sharps injury action posters did not include any contact details for accident and emergency and occupational health services.

Medical emergencies

This section is primarily information for the provider

Requirement notices

- Glucagon, a hormone used to treat low blood sugar levels, was present in the practice managers room fridge. It was marked with an expiry date of 2017. The practice was unable to locate any further Glucagon.
- Evidence was not available to confirm Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) had been carried out in the previous 12 months for any of the staff who supported sedation.

Health and Safety

- Window blind adjustment looped cords were not tethered to window frames and may pose a risk of choking to young children in the waiting area.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

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:

Infection Control

- The most recent infection control audit indicated the practice was meeting the required standards. However, we found that audit findings were inaccurate.

This section is primarily information for the provider

Requirement notices

Recruitment

We looked at 3 staff recruitment records and evidence presented to us found:

- Two did not have evidence of their employment history (CV)..

Control of Substances Hazardous to Health (COSHH)

- Risk assessments were not available for all the COSHH identified products used in the practice.
- Two yellow clinical waste bins at the rear of the practice were not tethered to a fixed point to prevent being removed from the building car park.

Medicines

- Prescription pad stock controls were not in place.

General Data protection Requirements (GDPR)

- A pre-General Data Protection Regulation (GDPR) accident book was in use.
- Completed accident records were not removed and stored securely**.**

Staffing

- We noted that the required 5 hours of Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) training was not available for one clinician.

Privacy and Dignity

The practice had installed closed-circuit television to improve security for patients and staff. Relevant protocols were not in place. In particular:

- A closed-circuit television (CCTV) Data Protection Impact Assessment (DPIA) was not available.
- Information for patients to explain the purpose of CCTV recording images was not available
- The name and contact details of those operating the CCTV surveillance scheme were not displayed.
- Glass partitioning on treatment room doors did not fully protect patients' privacy and dignity.

Equality Act 2010

- The wheelchair accessible toilet had a foot operated sanitary bin.
- The front door threshold ramp was not available.

This section is primarily information for the provider

Requirement notices

- The mirror in the wheelchair accessible toilet was out of reach of a wheelchair user.
- Disability access audits were not carried out correctly. Findings did not reflect current practice.