Amtrade Int Limited

Dentabrite Clinic

Inspection report

4 Church Street
Diss
IP22 4DD
Tel: 01379652580

Date of inspection visit: 23 August 2022
Date of publication: 15/09/2022

Overall summary

We carried out this announced comprehensive inspection on 23 August 2022 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 adviser.

We always ask five key questions :

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

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

Our findings were:

- The dental clinic appeared to be visibly clean and well-maintained.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked well as a team.
- The dental clinic had appropriate information governance arrangements in place.
- Appropriate disclosure and barring checks (DBS) had not been obtained for staff.
- A fire risk assessment had not been completed of the premises, and staff had not received fire safety training.
- Not all infection control procedures were in line with nationally recognised guidance.

Background

Summary of findings

Dentabrite Clinic provides private dental care and treatment for adults and children. The premises are not accessible to wheelchairs due to a set of steep steps leading up to the practice. There are no car parking spaces on site, but a public car park is available just opposite the practice.

The dental team includes one dentist, one dental nurse and a practice manager (who is also a registered dental nurse). The practice has two treatment rooms, only one of which was in use at the time of our inspection.

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

The practice is open on Mondays, Wednesdays and Fridays from 9 am to 5 pm.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. Full details of the regulation the provider was not meeting are at the end of this report.

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

- 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.

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.

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?	**No action** ✓
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 providing safe care in accordance with the relevant regulations.

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding children. However, there was no policy in place for protecting vulnerable adults, and not all staff had completed training in how to protect vulnerable adults. There was no information available about local protection agencies in the practice's policy.

The practice had a whistle-blowing policy, but it was not fit for purpose and gave incorrect contact details for staff wishing to report concerns about their colleagues.

The practice had infection control procedures which mostly reflected published guidance. We saw the premises were visibly clean. However**,** we noted some loose and uncovered items in treatment rooms drawers that risked aerosol contamination and local anaesthetics that had been removed from their sterile packaging. We noted worn sealant around the sink in the decontamination area and chipped paintwork on the walls. The bin was not foot operated. We noted a wire brush was used to clean dental burs, which is not in line with guidance. Floor coving was coming away from the wall in surgery one.

The practice did not use a washer disinfector or ultrasonic bath. We advised staff 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 practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, including flushing through dental unit water lines and monitoring water temperatures. The need to monitor water temperatures had been identified in the legionella risk assessment in 2018 but had not been implemented by staff until October 2021.

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

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions, although we noted that five yearly fixed wire testing had not been completed.

The practice had a recruitment policy to help them employ suitable staff, however we noted it contained reference to out of date legislation and did not state what pre-employment checks must be undertaken for prospective staff. We checked staff personnel files and noted that none of the staff had enhanced disclosure and barring service (DBS) checks as required; only the standard check. There were inadequate references available for one staff member.

Clinical staff were qualified, registered with the General Dental Council.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. However, dental radiograph audits were not undertaken as frequently as recommended, and the dentist was not using the latest coding to assess radiography quality. The practice's radiation protection adviser was not named on the local rules.

Risks to patients

The practice had undertaken a premises risk assessment in 2018, but we found some of its recommendations had not been implemented, such as the need to for staff to receive fire training and for a fire risk assessment to be undertaken. The practice had only undertaken a fire drill using its escape ladder for the first time just prior to our inspection. There was no recorded evidence to show that fire alarms were regularly tested to ensure they functioned correctly.

Are services safe?

Emergency equipment and medicines were available and checked in accordance with national guidance, although we noted there was no spacer device for inhaled bronchodilators, no size 2 oropharyngeal airway and not enough blue needles or syringes. The practice did not have an eye wash kit or mercury spillage kit.

Staff did not follow the relevant safety regulations when using needles and the dentist manually re-sheathed dirty needles. We noted there had been three needle stick injuries recorded in the practice's accident book.

The practice had assessments to minimise the risk that could be caused from substances that were hazardous to health, although this did not include information about all hazardous substances in use at the practice.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines, although we noted that tablets were removed from their protective covering before being dispensed to patients.

Track record on safety, and lessons learned and improvements

The practice did record accident and incidents, such as staff and patient accidents. However, there was no evidence to show how learning from them had been shared across the staff team to prevent their recurrence.

Prompted by our pre-inspection phone call, the practice had signed up to receive national patient safety alerts. Prior to this, they had not been receiving any.

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 dental care provided was evidence based and focussed on the needs of the patients. The practice kept records of the care given to patients including information about treatment and advice given. However, we noted that patients' risk level of caries, cancer and tooth wear had not always been recorded, and that radiographs and not always been justified and graded in the sample of dental care record we reviewed. There was scope to improve the recording of further detail about patients' consent to treatment

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

The practice had specific policies in place in relation to the Mental Capacity Act 2005 (MCA) and Gillick competence guidance, and staff had a satisfactory understanding of their responsibilities under them.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council, although we noted the dentist had not undertaken recent essential training in infection control, legionella management or safeguarding vulnerable adults.

Co-ordinating care and treatment

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. The practice did not have a system in place to ensure referrals made to other dental health care providers were monitored and tracked to ensure their timely management.

Are services caring?

Our findings

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

Kindness, respect and compassion

In the practice feedback cards we reviewed, patients described the staff as caring, attentive and explained treatment options well to them. One patient stated that staff worked particularly well with young children. Staff gave us specific examples of where they had gone out of their way to support patients.

The practice manager told us they knew their patients well, and often sent cards for milestone events such as birthdays and marriages, and condolence cards if needed. The practice manager was a volunteer with a national dental aid charity and had provided dental support both abroad and to a local homeless shelter. The dentist was a volunteer blood/plasma transporter.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. The practice manager told us that patient phone calls could be taken in the back office if needed to maintain confidentiality.

Paper records were stored securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care, evidence of which we viewed in the dental care records. Staff gave patients clear information to help them make informed choices about their treatment. The practice manager told us she frequently answered patient queries at the weekend.

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 had made some adjustments for patients with disabilities., although it was not accessible to wheelchair users due to a steep set of stairs. Information was not available in large print for patients, although reading glasses were kept behind the reception desk for patients to use.

Staff were clear about the importance of emotional support needed by patients when delivering care.

Timely access to services

The practice was open three days a week between 9am and 5pm only. There were no out of hours appointments available.

The practice was accepting new patients at the time of our inspection, although routine appointments were not available until October 2022. There were emergency slots available each day for patients in dental pain.

The practice had a reciprocal arrangement in place with another local private dentist, at times when its staff were on holiday.

Listening and learning from concerns and complaints

The practice told us they had not received any patient complaints, since opening 12 years ago. We noted that there was no information in the waiting room or on the practice's website informing patients how they could raise their concerns.

.

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 Notice 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 dentist had overall responsibility for the clinical leadership and was supported by the practice manager who took on responsibility for day to day running of the practice, supported by the dental nurse.

We identified several issues in relation to the practice's safeguarding procedures, recruitment procedures, infection control management, the medical emergency kit, staff training and risk assessing which indicated that governance and oversight of the practice needed to be strengthened.

Culture

This was a small friendly practice with just three staff members, all of whom had worked together a long time. Staff told us they felt well supported and enjoyed their work; they described the dentist and practice manager as approachable and supportive to their needs. The practice paid for staffs on-line training, General Dental Council (GDC) registration and indemnity, something they greatly appreciated.

Staff were aware of the duty of candour and the requirements it placed upon them.

Governance and management

The practice had a system of clinical governance in place which included some policies, protocols and procedures that were accessible to all members of staff and had been reviewed on a regular basis. Despite this, we noted that some of these policies such as the recruitment, safeguarding and whistle blowing ones, contained out of date or missing information.

There were regular practice meetings attended by all, which staff told us they found useful as a means of sharing information and raising any concerns they had.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

The practice had recently re-introduced surveys for patients to give feedback, 14 had been completed by the time of our inspection. Responses we viewed showed that patients were happy with the service they received. Prior to this a patient survey had last been conducted in 2016.

Continuous improvement and innovation

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiography, and infection prevention and control. Although the dentist had done a range of training relevant to the dental treatment he provided, he had not undertaken some essential training in areas such as safeguarding adults, infection control and information governance.

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: • Staff recruitment processes were not in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The practice's recruitment policy was not fit for purpose and enhanced disclosure and barring service (DBS) checks had not been obtained for clinical staff. References had not been sought for one staff member. • Not all staff had received appropriate training in the protection of vulnerable adults and there was no practice policy in place for this. The registered person had systems or processes in place that operated ineffectively in that 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 might be at risk. In particular: • The provider had not ensured the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council. • The practice's sharps procedures were not in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • There was no system in place to ensure that staff followed infection control procedures and protocols

This section is primarily information for the provider

Requirement notices

taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

- There was no system in place to ensure that recommendations from the practice's risk assessment had been implemented.
- Five yearly fixed wire testing had not been completed to ensure the premises were kept safe.
- A fire risk assessment had not been completed for the premises to ensure adequate fire safety management. Staff had not received formal fire training and fire alarms were not regularly tested to ensure they operated effectively.
- There was no evidence to show how learning from accidents and incidents had been shared across the staff team to prevent their recurrence.