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Great Northern Road Dental Clinic

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 11 December 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:

- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Improvements were needed to ensure patients' personal information was stored securely.
- Staff provided preventive care and supported patients to ensure better oral health.

Summary of findings

- The appointment system worked efficiently to respond to patients' needs and the frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Complaints were dealt with positively and efficiently.
- The dental clinic appeared generally clean yet there were areas where cleanliness could be improved for example some drawers and cupboards.
- The practice infection control procedures did not reflect published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were generally available.
- The practice did not have systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were generally in place however improvements were needed.
- The practice did not have suitable recruitment procedures which reflected current legislation.
- There was ineffective leadership and a lack of oversight of the day-to-day management of the service.
- There were ineffective systems to support continuous improvement.
- Patients were not asked for feedback about the services provided.
- The practice did not have good information governance arrangements.

Background

Great Northern Road Dental Clinic is in Dunstable and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs with the use of a ramp. Car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 4 dentists, 1 orthodontist, 4 dental nurses, 1 trainee dental nurse, 2 dental hygienists, 1 practice manager and 2 receptionists. The practice has 5 treatment rooms.

During the inspection we spoke with 2 dentists, 3 dental nurses and the practice manager. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday – Friday 9am until 5.30pm.

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.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

Summary of findings

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

- Take action to implement any recommendations in the practice's Legionella risk assessment, taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.'
- Implement protocols for the use of closed circuit television cameras taking into account the guidelines published by the Information Commissioner's Office in particular a Data Protection Impact Assessment.
- Take action to ensure audits of antimicrobial prescribing are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

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?	**Enforcement action**
Are services effective?	**Requirements notice**
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 Enforcement Actions 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.

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 vulnerable adults and children. However improvements could be made to the policy for example naming the lead and deputy for safeguarding and ensuring all details are updated on a regular basis. Additionally, the practice was not aware if staff members had completed any safeguarding training. Following the inspection, the practice showed us evidence of safeguarding training for 10 staff members. However 1 staff member's training was out of date and 2 members of staff still had no evidence of training, including the named lead for the practice. Whilst the practice had a whistleblowing policy in place, it had not been updated as it named the provider and a staff member who was no longer at the practice as first points of contact.

The practice had infection control procedures which generally reflected published guidance. However, improvements could be made to ensure compliance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. For example, there was no thermometer present to measure the temperature of the water used for cleaning, there was no log for heavy duty gloves which were currently being changed every 2-3 months which does not conform to guidelines. Additionally, the illuminated magnifier in the decontamination room was not working.

The sharps bins in use were undated and one had been overfilled, with a sharp instrument extruding through the opening. This is contrary to "Health and Safety (Sharp Instruments in Healthcare) Regulations 2013".

We saw instruments which had been through the decontamination process, had been packaged and were ready for use on patients were visible contaminated with cement or debris. We did not see any evidence of any staff training for infection prevention and control.

We saw that an Infection Prevention and Control audit had been completed in June 2023, and no previous audits were available for us to view. We found that the audit completed in June 2023 was not reflective of our findings. For example it stated that all sharps bins were dated yet this was not the case.

We saw that there were multiple materials which were available to be used on patients had expired. For example ampoules of composite (a white filling material) had expired in 2016 and multiple cartridges of local anaesthetic solution had expired in March, September and October 2023. The practice told us these products will be suitably disposed of.

We saw that there was a tear in the dental chair in one surgery and in a clinician's chair in another surgery. These had not been covered or repaired.

The practice had recently had a Legionella risk assessment carried out but the copy of the report had yet been received. We saw that regular hot and cold water temperature checks were not currently being completed.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. However, the external clinical waste bin was not lockable and was easily accessible.

The practice appeared generally clean. However, we saw that a cupboard which contained items such as gauze and cleaning products was visibly dirty. We saw that there was not a schedule in place to ensure cleaning was being undertaken at regular intervals. The practice told us that this will be implemented.

Are services safe?

The practice had a recruitment policy and procedure to help them employ suitable staff, this had been introduced in December 2023. We saw that there were no recruitment records for any staff members, including the newest staff member who was recruited in July 2023. We saw that the provider had no evidence that any staff members had immunity to Hepatitis B. Additionally, there were no records of any DBS certificates for any staff members. After announcement of the inspection, the practice applied for new DBS certificates and all but 2 were received on the day of inspection.

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

The practice ensured some equipment was safe to use, maintained and serviced according to manufacturers' instructions. However, the one piece of equipment (the statim machine) used to sterilise dental instruments was last serviced in 2018 and was therefore significantly overdue, although daily checks and maintenance were still being carried out.

The risks related to fire safety had not been assessed, mitigated or reviewed by a person with the qualifications, competence and experience to do so. We saw that the limited risk assessment was not reflective of our findings. For example, it stated that the risk level from the gas boiler was 1 (lowest risk), yet it had not been serviced since April 2022. Just prior to our inspection, the boiler had broken; this was fixed and serviced during the inspection. We were told that periodic in-house checks on fire alarms were not carried out. Additionally, there was no emergency lighting in the practice which is over 3 floors, and this had not been discussed in the risk assessment. There was no evidence of any staff training in fire safety.

Whilst we were told that the practice had previously had an Electrical Installation Condition Report, this was unable to be located and the provider told us that this will be carried out in the near future.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available.

Risks to patients

The practice had not fully implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety and lone working, for which there were no risk assessments. Safer sharps were not being used. There were no resheathing devices for clinicians to use with these traditional sharps to decrease the risk of an inoculation injury. Additionally, we were told that nurses were dismantling used sharps, not the clinician as per NICE guidance. We were told that one hygienist worked without chairside assistance, yet no lone working risk assessment had been completed.

Emergency equipment and medicines were generally available and checked in accordance with national guidance, yet this was not documented. Additionally, the pads for the Automated External Defibrillator had expired and there was no spacer.

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

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health, yet this had not been updated since 2012.

Information to deliver safe care and treatment

Patient care records were complete, legible and complied with General Data Protection Regulation requirements. However, we saw that one computer screen in an unattended surgery had been left open on a patient record and the room was freely accessible. Therefore improvements could be made to the safety and security of patient records.

The practice had systems for referring patients with suspected oral cancer under the national 2-week wait arrangements.

Are services safe?

Safe and appropriate use of medicines

The practice did not have systems for appropriate and safe handling of medicines. NHS prescription pads were pre-stamped and not stored securely. We saw that a log of prescriptions was being completed. However, the reason for prescribing 2 courses of antibiotics had been documented as “tooth decay” which does not conform to current guidelines. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice did not have a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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.

Effective needs assessment, care and treatment

The practice did not have a system in place to keep dental professionals up to date with current evidence-based practice. The practice did not have any oversight of staff training. One clinician who we spoke with, was unaware of the guidelines and limitations surrounding the provision of amalgam restorations.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. However, we did not see any evidence of staff training on consent.

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

Monitoring care and treatment

The practice kept detailed patient care records in line with recognised guidance.

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.

We saw evidence the dentists generally justified, graded and reported on the radiographs they took. The practice did not carry out radiography audits 6-monthly following current guidance.

Effective staffing

Newly appointed staff did not have a structured induction, and there was no oversight regarding the completion of continuing professional development required for registration with the General Dental Council.

Co-ordinating care and treatment

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, patients we spoke with told us they found booking an appointment straightforward and staff very helpful.

Patients said staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were generally aware of the importance of privacy and confidentiality, however, we saw that a computer had been left open on a patient record, the room was unattended and could easily be accessed by an unauthorised person. Additionally, we saw no evidence that the practice had completed a Data Security and Protection Toolkit which is a contractual requirement specified in the NHS England Standard Conditions contract.

The practice had installed closed-circuit television to improve security for patients and staff. A CCTV policy was in place, yet there was no completed Data Protection Impact Assessment.

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

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 and information leaflet 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 for example X-ray images and photographs.

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, including downstairs surgeries and a ramp to access the practice for patients with access requirements. However, staff had not carried out a disability access audit. Additionally, some staff were unaware of any available translation services.

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 answerphone provided telephone numbers for patients needing emergency dental treatment when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. 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.

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 by the provider.

Leadership capacity and capability

We found that there was lack of sufficient oversight and an ineffective leadership which impacted on the practice's ability to deliver safe, high-quality care.

We found that staff members worked well together, though improvements were needed to ensure information about systems and processes were communicated effectively between management and staff.

The information and evidence presented during the inspection process was not always well documented. Improvements were needed to ensure that records in relation to the management and provision of regulated activities were readily available and easily accessible to all members of staff and those who would need to review them.

Culture

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

There were no records to demonstrate that individual training needs during appraisals or clinical supervisions had been discussed.

There were no systems in place to monitor staff training to ensure continuing professional development. Additionally there was no system or process in place to ensure other training requirements relevant to staff in carrying out their role were up-to-date and reviewed at the required intervals. The system in place was therefore not effective to identify if a staff member was or was not up to date with their required training. We noted that apart from annual Basic Life Support training certificates, there were no other training certificates available for any staff members. Following the inspection, the practice showed us certificates for safeguarding training and radiography which had been completed for some staff members.

Governance and management

The practice did not have effective governance and management arrangements. The provider could not demonstrate that policies and procedures were up to date and regularly reviewed. We were not assured that the fire risk assessment had been carried out by a competent person.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as recruitment of staff, sharps, lone working, COSHH and fire safety. The practice's Health and Safety policy had been recently updated on 1 December 2023, yet some actions were marked as being completed by a staff member who was no longer at the practice.

Appropriate and accurate information

Staff did not act on appropriate and accurate information. For example, safety data sheets of all hazardous materials and COSHH risk assessments had not been updated since 2012. Additionally, we were told that the practice did not have regular staff meetings to discuss important information.

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

Engagement with patients, the public, staff and external partners

Are services well-led?

The practice could not demonstrate that they were actively seeking the views of people who used the service about their experience. We were told that service users could complete an NHS Friends and Family form, but this was rarely completed.

Additionally, the practice could not demonstrate that feedback from staff was obtained through meetings or surveys, as these were not carried out.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, quality assurance, or continuous improvement.

There was no evidence that radiography audits or antimicrobial prescription audits had been carried out in line with the relevant national guidance and improvements could be made to the infection prevention and control audit.

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 There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular • The provider was not carrying out any patient or staff feedback. 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: • The provider had not ensured that a radiograph audit had been completed by any clinicians. • Infection Prevention and Control audit had been incorrectly completed and was not completed on a regular basis. • The safeguarding policy was unclear and lacking in detail. • The provider had not completed a Data security and protection toolkit. • The provider had not completed a disability access audit. 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 may be at risk. In particular: • The provider could not provide evidence of a previous Electrical Installation Condition Report.

This section is primarily information for the provider

Requirement notices

- The provider had not serviced the equipment for sterilising used dental instruments in line with guidelines.
- Safety alerts were not being received, the COSHH folder was out of date, a lone worker risk assessment had not been implemented and the health and safety risk assessment had been incorrectly completed.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • There was no evidence that staff received a formal structured induction, appraisals, supervisions or had completed continuing professional development apart from CPR training. Regulation 18 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • The provider had not undertaken any identification checks, checks of satisfactory conduct in previous employment, and evidence of antibody blood tests to demonstrate immunity to Hepatitis B for any members of staff.

This section is primarily information for the provider

Requirement notices

- Prior to our inspection, the provider did not have DBS certificates for any staff members.

Regulation 19 (3)

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 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: • The decontamination process demonstrated by staff did not reflect the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices' (HTM01-05). • There was no thermometer to monitor the water temperature during the cleaning of used dental instruments. • There was no log for changing the heavy duty gloves used in the decontamination process. Gloves were being used for 2-3 months rather than changed on a weekly basis as per guidelines. • The illuminated magnifier used in the decontamination room was not working. • Sharps bins were undated and one bin was overfilled. • Instruments which had been through the decontamination process were pouched, ready for use and were still visibly dirty. • There was no evidence that staff had completed infection prevention and control training. • There was no cleaning schedule to ensure cleaning was being undertaken at regular intervals. • Cupboards which stored stock such as gauze and cleaning products were visibly dirty. • There were multiple expired materials which were being used on patients, for example local anaesthetic cartridges and composite ampoules. • Safer sharps were not being used and there was no associated risk assessment. There were no resheathing devices present. We were told that nurses were dismantling used sharps.

This section is primarily information for the provider

Enforcement actions

- No water temperature checks were being carries out to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment.
- The risks associated with fire had failed to be assessed.
- The fire risk assessment had not been completed by a person with the qualifications, skills, competence and experience to do so.
- The risk assessment had been incorrectly completed.
- There was no reference to the lack of emergency lighting in the practice, which is over 3 floors including a cellar.
- There were no records of in-house checks of the fire safety equipment or fire alarms.
- Staff had not completed fire safety training.
- Prescriptions were not stored securely and had been pre-stamped.

Regulation 12 (1)