Spectrum Associates (MK) Ltd

Dental Specialists MK

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 30 January 2024 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 dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which reflected published guidance.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect.
- 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.
- 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.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.
- The practice's systems to manage risks for patients, staff, equipment and the premises were ineffective. We identified shortfalls in assessing and mitigating risks in relation to fire safety, legionella management, prescription security and medicine management, radiography and the safe handling and disposal of sharps.
- The provider did not demonstrate effective leadership or support a culture of continuous improvement.
- Staff recruitment procedures did not reflect current legislation.
- Not all staff had received training on how to deal with medical emergencies. Appropriate medicines and life-saving equipment were not always available.

Background

Dental Specialists MK is in Milton Keynes and provides NHS orthodontics 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. Car parking spaces, including dedicated parking for disabled people, are available at the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 10 dentists who specialise in orthodontics, oral surgery, periodontics, prosthodontics and endodontics. 1 dentist, 1 visiting anaesthetist, 2 orthodontic therapists, 1 dental therapist, 7 qualified dental nurses, 3 trainee dental nurses, 5 receptionists, 1 office manager and 1 practice manager. The practice has 5 treatment rooms.

During the inspection we spoke with 2 dentists, 3 qualified dental nurses, 3 receptionists 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 to Friday from 9am to 5.30pm.

Saturday by appointment only.

The practice had taken steps to improve environmental sustainability. The provider had installed bicycle racks to encourage cycling for staff and patients. The practice team reduced the use of paper by using digital records. The practice had introduced virtual consultations for advice and emergency purposes to reduce carbon footprint.

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.
- 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.

Summary of findings

- 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

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

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

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

The practice had infection control procedures which reflected published guidance and had completed some infection control audits. We found that the audits had not been completed 6 monthly as per guidance. The infection control audits did not highlight areas of concerns found on the day of inspection such as split flooring in a treatment room, and damaged surfaces in the decontamination room making cleaning difficult. The decontamination room did not have a separate handwashing sink and this was not identified on the audit.

The practice systems to manage the risk associated with the development and spread of water borne bacteria were not effective. Specifically, the provider had not undertaken a required legionella risk assessment of the building and was therefore unaware of whether there were any actions required to safely maintain water systems in the premises. There was no named legionella lead or deputy lead and not all staff had received legionella training. Water testing and testing of hot and cold-water temperatures were carried out, we saw temperatures had not received adequate levels since April 2023. We were not provided with evidence that any action had been taken. Following the inspection, the provider submitted evidence that samples of water had been tested and sent to an external laboratory which confirmed no legionella was present. The practice provided further evidence that they were seeking a risk assessment and had a legionella management policy however, the policy did not accurately reflect processes in place.

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

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

The provider had a recruitment policy, but this was not followed. Recruitment procedures did not follow guidance to help ensure the practice employed suitable staff, including for locum staff.

Staff files we reviewed were incomplete. We did not find evidence that required pre-employment checks, including obtaining references, vaccinations and employment history were carried out for all staff. We found of 20 staff records 17 staff did not have references, 9 did not have evidence of employment history, 5 clinical staff did not have evidence of an enhanced Disclosure and Barring Service (DBS) check and 5 clinical staff did not have evidence of hepatitis B immunity. Following the inspection, we were provided with records of hepatitis B immunity for 3 out of 5 clinical staff which had their records missing. We were also provided with DBS checks for 4 of the 5 staff who had records missing and told by the provider 1 had been applied for. We noted that all 5 had not been obtained for staff at the point of their employment. We were also provided with some evidence of employment history which not requested at the point of their employment.

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

The practice had ensured most equipment was safe to use, maintained and serviced according to manufacturers' instructions. We were not provided with evidence that an autoclave had received a yearly servicing as per manufacture guidance since July 2022. Following the inspection, we were provided with evidence that this was serviced in January 2024. We noted there was an argon gas cylinder in an upstairs surgery which had not been risk assessed. Following the inspection, we were provided with evidence that this had now been included in the health and safety risk assessment.

Are services safe?

The procedures the practice used to ensure facilities were maintained in accordance with regulations showed scope for improvement by ensuring legionella and water safety checks were carried out.

We were not provided with a fire risk assessment on the day of inspection. Following the inspection, we were provided with an external risk assessment completed in April 2021. The risk assessment identified areas of risk and recommendations. We were not provided with evidence that action had been taken to address these issues. We were also provided with a second fire risk assessment completed after our inspection. This was not completed by a competent individual and did not identify or consider areas found in the previous risk assessment.

The practice had some arrangements to ensure the safety of the X-ray equipment. Evidence that the X-ray equipment was registered with the Health and Safety Executive (HSE) was not available on the day of inspection. Following the inspection, we were provided with evidence of registration. We noted the X-ray equipment including handheld unit had not had a three yearly performance check.

Risks to patients

The practice systems to assess, monitor and manage risks to patient and staff safety required improvement. We looked at the practice's arrangements for safe dental care and treatment. The sharps risk assessment did not reflect processes in place. For example, it stated safer sharps were used and clinicians disposed of all sharps at the point of use. We found that staff were not using safer sharps and sharps were not disposed of by the clinicians at the point of use. Following the inspection, we received evidence that safer sharps would be reintroduced for all clinical staff and then re-audited.

Not all practice staff had received sepsis training. We found staff awareness of the signs of sepsis required improvement. Following the inspection, we were provided with evidence staff had completed training.

Emergency equipment and medicines were mostly available and checked in accordance with national guidance. A size 3 face mask and nasal cannula to provide supplemental oxygen to people who have lower oxygen levels was not present. We were provided with evidence following the inspection that this was ordered. We found the provider had not risk assessed the requirement of a second oxygen cylinder. The practice building was across two levels and offered sedation. Following the inspection, the provider submitted evidence they had purchased a second oxygen cylinder.

Not all staff had completed training in emergency resuscitation and basic life support every year. Immediate life support training was not completed by all staff providing treatment to patients under sedation. We were told by the practice that sedation would not be offered to patients until training was completed.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. We found signs on treatment rooms warning that there was an oxygen cylinder present. We found that the oxygen was not always present in these rooms.

Information to deliver safe care and treatment

Patient care records were mostly complete, legible, kept securely and complied with General Data Protection Regulation requirements. There was scope to ensure these were more detailed.

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

Safe and appropriate use of medicines

The practice systems for appropriate and safe handling of medicines required improvement. Medicines were removed from their blister packs and dispensed without appropriate labelling including details of the practice name and address.

Prescriptions were kept securely but the practice did not have a system to track and monitor the use of NHS prescription pads.

Are services safe?

Antimicrobial prescribing audit had been conducted on one dentist, there was scope to include auditing all clinicians who prescribed antimicrobials.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents.

The practice had a system for receiving and acting on safety alerts. This required improving as we noted that not all recent safety alerts had been reviewed.

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 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.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. We reviewed 2 patient clinical notes for the endodontist specialist and did not see evidence that a rubber dam (a device used to protect the patient airway) during treatment had been used as per guidelines issued by the British Endodontic Society. The reason for not using had not been risk assessed and documented in the records.

The practice offered conscious sedation for patients. The practice's systems included checks before and after treatment, medicines management and sedation equipment checks. We noted the practice had not risk assessed the need for a second oxygen cylinder to ensure emergency equipment was available. Following the inspection, the provider submitted evidence they had purchased a second oxygen cylinder.

Evidence of immediate life support training (ILS) was not present on the day of inspection for clinicians and supporting nurses. Following the inspection, we were provided with evidence that this was completed for clinicians and dental nurses had completed online training.

We found 1 clinician out of 3 who provided sedation treatment did not have evidence of continuing professional development (CPD) in sedation. We were provided with evidence following the inspection that this would be completed in March 2024.

The specialist carried out a patient assessment in line with recognised guidance from the British Orthodontic Society.

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.

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 obtained patients' consent to care and treatment in line with legislation and guidance. They understood their responsibilities under the Mental Capacity Act 2005.

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 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 justified, graded and reported on the radiographs they took. The practice told us they carried out radiography audits 6-monthly following current guidance. However, we were provided with a radiograph audit which was not dated and did not include the sample size, learning points or action plan.

Are services effective?

(for example, treatment is effective)

Effective staffing

We found there was a variation in the evidence recorded in dental care records to confirm that professional guidance was always followed. For example, there was a lack consistency in detail regarding risk assessments.

Evidence that staff had the skills, knowledge and experience to carry out their roles was not always available. Systems were not in place to ensure newly appointed staff had a structured induction or that clinical staff completed continuing professional development required for their registration with the General Dental Council. Recommended training including learning disability and autism, legionella, medical emergencies, infection control, sepsis, sedation and fire were not always completed. There was limited evidence of completion of other training by clinical staff including Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017, medical emergencies and immediate life support. Following the inspection, we were provided with evidence that some training had been completed.

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.

The practice was a referral clinic for dental implants, orthodontics and endodontics. We saw staff monitored and ensured the dentists were aware of all incoming referrals.

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.

Patients said 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. We noted that whilst the reception and waiting room areas were open plan, staff were discreet in person and on the telephone. We were told patients were offered an alternative area to speak privately should they wish.

The practice had installed closed-circuit television to improve security for patients and staff around the practice and in treatment rooms.

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 photographs, study models, videos 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 2 fish tanks in the waiting area practice staff told us that nervous patients and patients with a learning disability or autism found the fish tank calming.

The practice had made reasonable adjustments, including having level access, ground floor treatment rooms, a hearing loop, reading glasses and access to translation services for patients with access requirements. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

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

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 information leaflet 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 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.

Leadership capacity and capability

Clinical management and oversight of procedures that supported the delivery of care were ineffective. The practice told us they had experienced a difficult period during 2022 to 2023.

We identified shortfalls in relation to the practice's risk assessing relating to fire, legionella, sharps, prescription security, medicines management and radiographs which indicated that governance and oversight of the practice required strengthening.

In the period leading up to and immediately following our inspection, the practice manager had worked hard to address some of the shortfalls we identified demonstrating the practice's commitment to improving the service.

Systems and processes were not embedded which resulted in missed opportunities for providing safe services. For example, there was no legionella risk assessment, concerns found in the fire risk assessment had not been addressed, medical emergency equipment were not always available in line with guidance, X-rays machines had not received performance testing.

The information and evidence presented during the inspection process was not always clear and well documented.

Culture

Staff stated they were proud to work in the practice. Many of the practice staff were long standing.

We were not provided with evidence that annual appraisals were undertaken. The manager told us they discussed training needs during 1 to 1s but these discussions were not documented. They told us they also discussed learning needs, general wellbeing and aims for future professional development. We were told by staff they had the support and opportunities to develop and take on additional roles and responsibilities.

Arrangements to ensure staff training was up-to-date and reviewed at the required intervals were not in place.

The management of staff recruitment, staff training and required maintenance of equipment and premises required improvement.

Governance and management

The practice manager had overall responsibility for the management and clinical leadership of the practice. Whilst the practice had taken steps to improve systems and processes these required embedding.

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff. The management of radiography, fire safety, health and safety, audits, legionella, training and equipment required improvement.

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff.

Appropriate and accurate information

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

Are services well-led?

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 and innovation

The practice did not have clear oversight of staff training. Staff confirmed that the inspection had highlighted periods where continuous professional development and training had not been completed.

Audits of infection prevention and control and radiograph audits were not completed at recommended intervals and did not highlight areas of concerns found during the inspection or include any learning or action plans to improve the practice.

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 Treatment of disease, disorder or injury Surgical procedures	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 were no system in place to ensure an effective induction for new staff, including information about practice systems and safety procedures. • There were no systems in place to ensure an effective process established for the on-going assessment and supervision of all staff. • There was no system in place to ensure essential staff training was up-to-date and reviewed at the required intervals. • There was no system in place to ensure staff received formal appraisal and feedback about their working practices. Regulation 18 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 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 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:

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Requirement notices

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- There was no evidence a risk assessment had been completed in relation to the lack of a second oxygen cylinder.
- There was no evidence a risk assessment had been completed in relation to the Argon cylinder.
- Staff performing sedation did not have evidence of qualifications, continuing professional development or life support training.
- Not all safety alerts had been reviewed and actioned.

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 improve the quality and safety of the services being provided. In particular:

- Audits of radiography and infection prevention and control were not undertaken at required intervals, and had failed to identify concerns found and were not used to improve the quality of the service.

Regulation 17 (1)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures	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 2008 (Regulated Activities) Regulations 2014 was available for each person employed. 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 did not have an effective recruitment procedure, there were not always records of staff employment history or references.

This section is primarily information for the provider

Requirement notices

- Enhanced Disclosure and Baring Service checks had not been obtained prior to employment for 5 clinical members of staff. There was no evidence of Enhanced Disclosure and Baring service checks for 5 clinical staff members.
- There was not always evidence to ensure clinical staff had adequate immunity for vaccine preventable infectious diseases.

Regulation 19 (3)