Eastgate Dental Centre Limited

Eastgate Dental Centre

Inspection report

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Overall summary

We carried out this announced focused inspection on 24 September 2021 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 provider 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 second inspector and two specialist dental advisers.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services well-led?

Summary of findings

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

Background

Eastgate Dental Centre is in Aylesbury and provides NHS and private preventive, cosmetic and implant dentistry for both 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 near the practice.

The practice has 12 dental treatment rooms. Seven of which are based on the ground floor which is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs 12 dentists, four specialist orthodontists, five hygienists, three dental hygiene therapists, six dental nurses, four trainee dental nurses, four reception staff and two practice managers (who are also trained nurses).

The practice is owned by an organisation and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Bath

Street Dental Practice is the provider.

During the inspection we spoke with three dentists, two dental nurses, one receptionist and the practice manager.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday 8.30am - 7.00pm
- Tuesday 8.30am - 5.30pm
- Wednesday 8.30am - 5.30pm
- Thursday 8.30am - 5.30pm
- Friday 8.30am - 5.30pm
- Saturday 10.00am - 1.00pm

Our key findings were:

- The provider had infection control procedures, but improvements were needed.
- The provider had systems to help them manage risk to patients and staff, but these were not effective.
- Staff knew how to deal with medical emergencies, but the management of emergency equipment and medicines required improvement.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.

Summary of findings

- Staff treated patients with dignity and respect and took care to protect their privacy, but improvements were needed to computer security.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider did not have effective clinical and management leadership.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had information governance arrangements, but improvements were needed.

The provider accepted the clinical and managerial issues that we raised and took immediate action the day of our inspection to begin to address these. We were sent an action plan within 48 hours of our visit, which included evidence to demonstrate that many of the shortfalls have since been addressed.

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.

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

- Ensure care and treatment is provided in a safe way to patients and mitigate risks to the health and safety of service users receiving care and treatment. In particular:

safe management of radiography. fire safety, COSHH, infection control, training, medical emergencies, equipment and premises.

- 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 is at the end of this report.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services effective?	**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 act (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.

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

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures in place, but improvements were needed.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We could see no evidence of this process being validated. 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.

- Autoclave operating cycles were validated twice daily (not every cycle).
- Instrument pouch dating protocols were not followed (one was dated with the date of processing 21/09/21 and the second with the date of expiry 20/09/22).

The practice did not have systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, but improvements were needed.

Monthly hot water temperature testing records indicated that at least three temperatures were below 50oC every month for the previous two years. Guidance from the Health and Safety Executive states that hot water should be circulated at a minimum of 55oC. Since our inspection we have received evidence to confirm this shortfall is being addressed

Cleaning was carried out by an external company, but standards were not effective. When we inspected, we saw the practice was visibly dirty in places. Treatment rooms and decontamination rooms inspected had historical cobwebs, dirty chairs and dirty paintwork. Since our inspection we have received evidence to confirm this shortfall is being addressed.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, but improvements were needed. We found clinical waste not stored securely in both the ground and first floor compressor rooms.

Infection prevention and control audits were carried out twice a year. The latest audit showed the practice was meeting the required standards. However, we found that audit findings were inaccurate. Flooring damage in some of the treatment rooms and both decontamination rooms were not identified in the audit.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as, for example, refusal by the patient, where other methods were used to protect the airway, we saw this was documented in the dental care records.

Are services safe?

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at six staff recruitment records. These showed the provider followed their recruitment procedure.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.

- Five-year electrical installation certificate expired 16 June 2021. Since our inspection we have received evidence to confirm this shortfall is being addressed
- Fire safety checks not carried out for the fire alarm and emergency lighting since December 2019.
- Annual fire drills not completed since December 2019.
- Fire alarm serving not carried out. No evidence available of a previous service being carried out.
- Emergency lighting servicing not carried out. No evidence available of a previous service being carried out.
- In house fire risk assessment completed in September 2020. This was inaccurate as the lack of fire safety checks were not identified. Since our inspection we have received evidence to confirm this shortfall is being addressed

Since our inspection we have received evidence to confirm these shortfalls are being addressed.

Areas of the practice were cluttered:

- Compressor rooms on the ground and first floor were cluttered with carboard packaging.
- OPG X-Ray room cluttered with carboard packaging.

Since our inspection we have received evidence to confirm this shortfall has been addressed

- Compressor servicing evidence was not available No evidence available of a previous service being carried out.

Since our inspection we have received evidence to confirm that two of the three compressors have been serviced. Servicing to one compressor remains outstanding.

We were told that clinical staff completed continuing professional development in respect of dental radiography, but we only found evidence of this for three staff.

We saw evidence the dentists justified, graded and reported on the radiographs they took.

The practice did not have arrangements to ensure the safety of the X-ray equipment.

- No Radiation Protection Advisor contract in place since 2015.
- Three-year radiological surveys available for only two of the eight X-ray sets.
- No annual X-ray servicing evidence available. Since our inspection we have received evidence to confirm this shortfall has been addressed.
- Rectangular collimators found on two of the eight X-ray sets. Since our inspection we have been advised seven collimators have been located and one will be ordered.
- X-ray switches in main reception area and not secure to unauthorised use. Since our inspection we have received evidence to confirm this shortfall is being addressed.

The provider carried out radiography audits, but the most recent audit was not scored or analysed.

Risks to patients

Are services safe?

The provider had implemented systems to assess, monitor and manage risks to patient safety but improvements were needed.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items.

- A sharps risk assessment was not available. There was no evidence available of a previous risk assessment being carried out.

Since our inspection we have received evidence to confirm this shortfall has been addressed.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Eight clinicians had completed sepsis awareness training.

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

Emergency equipment and medicines management required improvement:

- Medical emergency kit was missing GTN spray, portable suction and a child self-inflating bag.

Since our inspection we have received evidence to confirm this shortfall has been addressed

- Clear masks for self-inflating bags had passed their expiry dates.
- The oxygen cylinder size was 425ltr. National guidance states cylinder size should be 460ltr.

Since our inspection we have received evidence to confirm this shortfall has been addressed

- Medical emergency kit checks carried out monthly not weekly.
- Oxygen cylinder inspection checks not carried out.
- Defibrillator inspection checks not carried out.

A dental nurse worked with the dentists and the dental hygienists when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider's risk management to minimise the risk that can be caused from substances that are hazardous to health (COSHH) required improvement. We found:

- COSHH risk assessments had not been reviewed since 2019.
- COSHH control sheets were split between hard copies and on computer. Access to the computer was not possible when the manager was not working as it was password protected.
- COSHH products were not stored securely in first floor storeroom as there was no lock on the door.

The practice occasionally used agency staff. We were told these staff received an induction to ensure they were familiar with the practice's procedures.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded.

Are services safe?

We looked at a selection of dental care records with clinicians to confirm our findings and observed that medical history updates and verbal consent was not routinely recorded in patient notes.

Dental care records we saw were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by the National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The dentists were aware of current guidance with regards to prescribing medicines.

We saw that staff stored and kept records of NHS prescriptions, but this did not follow current guidance.

- Prescription logs were not completed by any dentist and prescriptions were not stored securely in treatment rooms.

Since our inspection we have received evidence to confirm this shortfall has been addressed

Antimicrobial prescribing audits were not carried out annually to evidence that the dentists were following current guidelines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong.

We were told that in the previous 12 months there had been no safety incidents.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Dental implants

The practice offered dental implants. These were placed by one of the dentists at the practice who had undergone appropriate post-graduate training in the provision of 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 in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. However, verbal consent was not routinely recorded in care records.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age. However, knowledge of Gillick Competence was limited among the staff questioned.

The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

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 dental care records containing information about the patients' current dental needs and past treatment and medical histories. Medical history reviews were not routinely added to care records. The dentists assessed patients' treatment needs in line with recognised guidance.

Are services effective?

(for example, treatment is effective)

The provider had quality assurance processes to encourage learning and continuous improvement. Patient dental care records had been audited in 2019 but no audits had been carried out since.

Effective staffing

Staff new to the practice including agency staff had a structured induction programme.

Training was not monitored, or certificates stored effectively. We were unable to find evidence of training, in line with guidance, that it had been completed for all appropriate staff.

Hygienists did not receive formal appraisals.

One dentist told us they sometimes used amalgam on children under 15 years of age. The use of amalgam on children under 15 years of age should not occur unless the dental practitioner thinks that it is strictly necessary. The dentist was unaware of the change in regulation in 2018.

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 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 act (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

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective. The provider, who was also the registered manager, visited the practice regularly but their management oversight of the business was not effective.

Culture

Staff discussed their training needs at an annual appraisal. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

We saw the provider had systems in place to deal with staff poor performance.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

The registered manager had overall responsibility for the management and clinical leadership of the practice. The two practice managers were responsible for the day to day running of the service. One of the practice managers had been absent from the practice for some months leaving the second manager to cover both managers roles.

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

We saw there were clear and effective 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, COSHH, infection control, training, medical emergencies, equipment and premises required urgent improvement.

Appropriate and accurate information

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. However, we found a computer in one surgery was not locked or the surgery door closed when left unattended.

Engagement with patients, the public, staff and external partners

The provider told us they used patient surveys and encouraged verbal comments to obtain patients' views about the service.

The provider gathered feedback from staff through meetings, surveys, and informal discussions.

Continuous improvement and innovation

We noted the system for monitoring staff training required improvement to ensure staff could evidence their competency in core recommended subjects

Are services well-led?

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control but improvements were needed to ensure that clinical audits were analysed effectively.

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 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: • Medical history updates not routinely recorded in patient notes. • Some staff did not have knowledge of Gillick Competence. • Verbal consent not routinely recorded in patient notes. • Hygienists did not receive formal appraisals. • Training not monitored, or certificates stored effectively. • One dentist told us they sometimes used amalgam on children under 15 years of age and were unaware of the change of regulation in 2018. • PC in one surgery not locked when left unattended. • Clinical records audited in 2019, none carried out since. Regulation 17(1)

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

This section is primarily information for the provider

Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 12

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

How the regulation was not being met:

The registered persons 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:

- No Radiation Protection Advisor contract in place since 2015.
- The three-year radiological survey was not available for six of the eight X-ray sets.
- No annual X-ray machine servicing evidence available.
- Five-year electrical installation certificate went out of date on 16 June 2021.
- Fire safety checks not carried for fire alarm and emergency lighting since December 2019.
- Annual fire drills not completed since December 2019.
- Fire alarm serving not carried out. No evidence available of any previous servicing.
- Emergency lighting servicing not carried out. No evidence available of any previous servicing.
- In house fire risk assessment completed in September 2020 is inaccurate (lack of fire safety management checks not identified).
- COSHH risk assessments not reviewed since 2019.
- COSHH control sheets stored in hard copy and on PC. PC unavailable when manager is not working as password protected.
- COSHH products not stored securely in first floor store room (no lock on door).
- Clinical waste not stored securely. Bag found in first floor store room, sharps bins and bags found in downstairs compressor room.
- Compressor rooms cluttered with carboard packaging and clinical waste.
- OPG room cluttered with carboard packaging.
- Medical emergency kit was missing GTN spray, portable suction and a child self-inflating bag.

This section is primarily information for the provider

Requirement notices

- Clear masks for self-inflating bags were out of date.
- Oxygen cylinder 425ltr – national guidance states cylinder size should be 460ltr.
- Oxygen cylinder inspection checks not carried out.
- Medical emergency kit checks carried out monthly not weekly.
- Defibrillator inspection checks not carried out.
- Compressor servicing evidence not available. No evidence available of a previous service.
- Autoclaves validated twice daily (not every cycle).
- Heavy reliance on manual scrubbing. No evidence of process validation.
- Infection control audits inaccurate. Damage to flooring not identified up in audit carried out in April 2021.
- No protocols in place for decontaminating incoming dental lab work.
- Hot water temperatures recorded below 50 degrees Celsius in at least three areas of the practice every month for over two years.
- Instrument pouch dates conflict. One pouch seen was dated 21/09/21 the second 20/09/22.
- Sharps risk assessment not available. No evidence available of a previous risk assessment.
- Treatment rooms: Cracked vinyl floor covering, historical cobwebs, dirty chairs, dirty paintwork found.
- Decontamination rooms: Wall and floor units delaminated, vinyl floor covering missing in places, dirty floors, shelving and woodwork, windowsills and historical cobwebs found.

Regulation 12 (1)(2)