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Shasgo Dental

Inspection Report

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Overall summary

We carried out this announced inspection on 15 June 2017 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 specialist dental adviser.

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

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Shasgo Dental is in Sidcup, in the Greater London borough of Bexley. It provides private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including those for patients with disabled badges, are available near the practice.

The dental team includes a dentist, a dental nurse, and a receptionist. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

Summary of findings

On the day of inspection we collected 31 CQC comment cards filled in by patients. This information gave us a positive view of the practice.

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

The practice is open on Mondays and Tuesdays from 9.15am to 12.30pm, Wednesdays from 2pm to 5.30pm, and on Thursdays and Fridays from 9.15am to 1pm.

Our key findings were:

- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- Staff knew how to deal with emergencies. Appropriate medicines were available, though some life-saving equipment as per current recommendations was absent.
- The practice was clean and well maintained in most areas, though some improvements were needed to ensure cleaning processes were in line with current guidelines.
- The practice had not established thorough staff recruitment procedures.
- The practice was not able to demonstrate that all staff had received key training.
- The clinical staff provided patients' care and treatment in line with current guidelines, though improvements were needed to ensure the necessary information was recorded in dental care records.
- The practice had safeguarding processes and staff knew their responsibilities for safeguarding adults and children, though improvements could be made to ensure staff knew whom to report concerns to externally, and policies needed to be updated with key information.
- The practice had not maintained several records pertaining to the running of the service and staff employed at the practice.
- The practice had infection control procedures in place, though improvements were needed to ensure they reflected published guidance.
- Staff felt involved and supported, and worked well as a team, though governance and leadership at the practice required improvements across several areas.

Shortly after the inspection the practice took some steps to begin to address issues identified.

We identified regulations the provider was not meeting. 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.
- Ensure specified information is available regarding each person employed.

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

Furthermore, there were areas where the provider could make improvements. They should:

- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's policies to ensure they are fit for purpose.
- Review the practice's system for documentation of actions taken, and learning shared, in response to incidents with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review the current staffing arrangements to ensure all dental care professionals are adequately supported by a trained member of the dental team when treating patients in a dental setting taking into account the guidance issued by the General Dental Council (GDC).
- Review the protocols and procedures for use of X-ray equipment, taking into account Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice's recruitment procedures to ensure persons employed remain of good character.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requirements notice ✖

We found that this practice was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Staff told us they had used learning from incidents to help them improve, though improvements could be made to ensure there was a protocol in place for reporting, formally documenting and sharing learning from incidents.

Staff knew how to recognise the signs of abuse and how to report concerns, though evidence of safeguarding training was not available for any staff member.

Staff were qualified for their roles, though the practice needed to improve its recruitment processes.

Premises were clean, though equipment was not properly maintained. The practice did not follow national guidance for cleaning of used dental instruments and in the handling and storing of sterilised dental instruments.

The practice had arrangements for dealing with medical and other emergencies, though their stock of emergency equipment was not in line with current recommendations.

Are services effective?

No action ✔

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

The dentist assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as caring, respectful and gentle. The dentist discussed treatment with patients so they could give informed consent, though this was not always recorded this in their records.

We verified that one staff member had completed key training, but some of this training had not been updated in line with current guidelines and evidence of training was not available for other staff.

The practice did not have systems to help them monitor the training needs of staff.

Are services caring?

No action ✔

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

Summary of findings

We received feedback about the practice from 31 people. Patients were positive about all aspects of the service the practice provided. They told us staff were polite, professional and considerate. They said that they were given clear explanations about dental treatment, and said their dentist listened to them. Nervous patients commented that practice staff made them feel at ease.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action ✓

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

The practice told us they took patients views seriously and valued compliments from patients.

The practice had made limited considerations to patients' different needs. This included providing level access for disabled patients and families with children in push-chairs. The practice did not have access to interpreter services or arrangements to help patients with sight or hearing loss.

Are services well-led?

Requirements notice ✗

We found that 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 Requirements Notice section at the end of this report).

The practice had arrangements to ensure the smooth running of the service, though improvements were needed in several areas, such as those for assessing and monitoring safety, ensuring appropriate policies and procedures were available and established, maintaining records, and ensuring staff received key training at regular intervals.

Risks from inappropriate infection prevention and control processes, lack of robust recruitment checks, lone working and regular equipment maintenance checks and not been suitably identified and mitigated.

There was a clear management structure and staff felt supported and appreciated, though we found that several of the practice's governance processes needed improvements.

The practice team stored patient dental care records securely, though improvements were needed to ensure they contained the necessary information.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have any policies or effective procedures for reporting, investigating, responding to or learning from workplace accidents, incidents and significant events (with the exception of inoculation injuries). Staff did not demonstrate an understanding of what would constitute a significant event. The practice had an exercise book which was used as an accident book.

The practice did not have any systems in place for receiving national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). They were not aware of any recently circulated alerts. Shortly after the inspection the dentist told us they had signed up to receive MHRA alerts.

Reliable safety systems and processes (including safeguarding)

Staff knew about the signs and symptoms of abuse and neglect, and how to report concerns though none of the staff members had completed safeguarding training.

They were aware of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances.

Improvements could be made to ensure contact details of relevant external safeguarding teams were available, as none of the staff members were able to locate them during the inspection.

The practice had a safeguarding children policy, though it needed to be updated with relevant information such as actions to take in reporting concerns, and relevant contact information for external organisations. There was no policy for safeguarding adults.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included a health and safety risk assessment template which had not been modified to be practice-specific. It had not been reviewed at regular intervals; it was last printed in 2012 and had been reviewed only once on 12 June 2017 just before our inspection.

The fire safety risk assessment undertaken by the dentist was not comprehensive and had not been reviewed regularly. It had not identified that staff had not completed fire safety training.

The practice had not conducted any risk assessments relating to Legionella.

The Control Of Substances Hazardous to Health (COSHH) risk assessment had not been updated. Actions to take in the event of exposure to some chemicals had not been included. There was no assessment in place for a hazardous chemical used for root canal treatment.

The practice followed relevant safety laws when using needles and other sharp dental items, though they had not carried out a sharps risk assessment.

The dentist told us they did not use rubber dams, which was not in line with guidance from the British Endodontic Society when providing root canal treatment. The dentist told us they had not become accustomed to using rubber dams but did not describe any alternative method used to prevent the inhalation of endodontic instruments.

Medical emergencies

Staff knew what to do in a medical emergency, though there was no evidence to demonstrate that staff, with the exception of the dental nurse, had completed training in emergency resuscitation and basic life support every year.

Some emergency equipment and medicines were available, though there was no automated external defibrillator, child-sized oxygen mask, spacer, or size 4 airway as described in recognised guidance. Midazolam, a medicine used for managing epileptic seizure was available, but it was not the recommended type to be used orally.

The practice had not formally assessed the risks related to the absence of this equipment. They told us they had ordered the equipment (except the defibrillator) shortly after the inspection.

Staff kept a record of the expiry dates of medicines and equipment, though they did not keep records of regular equipment checks or medicines to make sure these were available, within their expiry date, and in good working order.

Are services safe?

Glucagon was available and stored in a refrigerator as per recommended practice. Improvements could be made to ensure the fridge temperature was checked and logged to ensure the medicine was stored within the recommended temperature range.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff, though it needed to be updated to reflect the relevant legislation. For example it did not contain details about seeking certain background documentation prior to staff commencing work at the practice.

The practice had not conducted a Disclosure and Barring Service check for the dental nurse that had returned to the practice in 2016 after a five year period of absence. They had not formally assessed the risks in relation to this. The dental nurse had ported over a DBS check conducted in 2015 from a different practice.

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

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were up to date, though the assessment was a generic template created in 2012 that had been reviewed only once since in June 2017, just before the inspection. It contained information that was not consistent with what was happening in the practice; for example it referred to the practice manager although there was no such role. It had not identified that tests of electrical equipment were overdue, and referred to a healthcare waste policy which was not in place.

The health and safety policy covered general workplace and specific dental topics, though it did not reflect what was happening in practice and needed to be reviewed and updated. For example, spaces indicating how often the compressor should be serviced and inspected had been left blank; it stated that fire and smoke alarms should be checked weekly but staff told us this was done monthly. It also stated staff should receive emergency resuscitation training yearly but this was not done.

Checks of the fire and smoke alarms were not logged.

The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentist on three days out of five when they treated patients. The dentist told us they worked without the assistance of a nurse on Thursdays and Fridays.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe, though we observed during the inspection that they did not always follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

The kitchen was located in the decontamination room and we observed crockery and a kettle had been left on the counter. There was no demarcation between the kitchen and decontamination area, and no signage to indicate clean and dirty zones in the decontamination room.

Flooring in the treatment room was not coved.

The clinical waste bin in the decontamination area was not pedal-operated, and we observed that the bag used to collect clinical waste in the treatment room was not the designated orange clinical waste bag.

Tap water was used in water bottles used for dental treatment. The bottle was not disinfected with the appropriate solution at the end of the working day.

None of the staff had completed regular infection prevention and control training. Records showed that the dentist last completed this training in 2013. The dental nurse completed this training in January 2016 but it was not updated in January 2017.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments but several of these were not in line with HTM01-05.

We found equipment staff used for cleaning and sterilising instruments was not maintained and used in line with the manufacturers' guidance. For example, staff told us they did not run a test cycle on the autoclave prior to sterilising dental instruments. We were told the autoclave had been inspected yearly by an engineer; we requested but were not provided with any servicing records.

Are services safe?

Dental instruments were not immersed in water during decontamination, and some were left exposed to aerosols on counters.

Staff used a bur brush to clean soiled dental instruments.

Instruments that should be autoclaved (such as X-ray film holders, needle guards and glass dappens pots), and disposable resin bristle brushes, were cold-sterilised. Shortly after the inspection the dentist told us they had ceased cold sterilising the X-ray holders.

Staff told us they did not store dental instruments in sealable, dated bags. During the inspection they told us they would begin to bag the instruments.

We observed staff washing their hands in the sink used to scrub dirty instruments. We observed the dental nurse removing sterilised dental instruments from the autoclave without wearing any gloves.

Staff told us they disposed of contents of the spittoon filter, which may have contained amalgam, in the sink.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards, though it had not identified these shortcomings.

The practice did not have procedures in place to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment.

The practice was clean when we inspected and patients commented that this was usual.

Equipment and medicines

We requested, but were not provided with, servicing documentation for any of the equipment used. Staff told us they carried out visual checks of the equipment but there was no documented evidence of this.

Portable appliance testing (PAT) was last carried out in January 2014 and had not been updated after a three year interval in line with guidance.

The practice had suitable systems for prescribing medicines. They stored and kept records of NHS prescriptions as described in current guidance.

Radiography (X-rays)

The practice had some arrangements to ensure the safety of the X-ray equipment. They had the required information in their radiation protection file, but did not always meet current radiation regulations as the dentist told us X-ray equipment had not been serviced.

A radiological survey had been carried out every three years, though the dentist had not addressed recommendations in the last 2014 report, such as equipment maintenance servicing by a suitably qualified engineer and changing the collimation from circular to rectangular. The dentist told us they had been advised that this servicing was not required.

We saw evidence that the dentist justified, graded and reported on the X-rays they took. The practice carried out X-ray audits every year following current guidance and legislation, though there was no resulting action plan for improvements.

Clinical staff had not completed continuous professional development in respect of dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist assessed patients' treatment needs in line with recognised guidance.

The practice kept dental care records but all of the records we checked did not containing key information about assessments of the patients' oral health, preventive advice, current dental needs, historic treatment, medical histories, lifestyle habits and justification for treatments.

Health promotion & prevention

The practice told us they delivered preventative care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Improvements could be made to ensure checks of patients' gum conditions were recorded in their dental care records.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child.

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments, though there was no evidence of this in the dental care records we checked. The practice provided health promotion leaflets to help patients with their oral health.

Staffing

The practice had not recently recruited any new staff. A dental nurse previously employed by the practice returned to work in 2016 after a five year absence; the dentist told us the dental nurse had undergone a period of induction but this was not based on a structured induction programme and had not been documented.

There was no evidence to confirm clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Staff told us they discussed their general progress during informal discussions with the dentist, though they did not have appraisals. Training needs were not discussed.

Working with other services

The practice had referral forms in place for referring patients to specialists in primary or secondary care.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment, though we found this was not recorded in any of the dental care records we reviewed. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions, though we did not see evidence of this in dental care records. Patients commented that the dentist listened to them and gave them clear information about their treatment.

The practice's consent policy did not contain information about the Mental Capacity Act 2005, though the dentist understood their responsibilities under the Act when treating adults who may not be able to make informed decisions. The policy did not refer to Gillick competence, though the dentist was aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were polite, professional and considerate. Nervous patients said staff made them feel at ease.

Staff were aware of the importance of privacy and confidentiality. They stored paper records securely.

Involvement in decisions about care and treatment

The dentist told us they gave patients clear information to help them make informed choices, though we did not see evidence of this in dental care records we checked. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice did not have a website at the time of the inspection. Information leaflets and posters were available for patients to read.

Staff also used visual aids and dental X-rays to explain treatment options to patients needing more complex treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were usually seen on the same or following day.

Staff told us that they currently had no patients for whom they needed to make adjustments to enable them to receive treatment.

Promoting equality

The practice had made some adjustments for patients with disabilities. This included step free access. Improvements were required to ensure the practice reviewed the needs of people with a disability, including those with hearing difficulties.

The practice was not able to provide information in different formats and languages to meet individual patients' needs. They did not have access to interpreter/ translation services. The dentist told us they would use body language or hand gestures to try to explain things to the patient.

Access to the service

The practice displayed its opening hours in the premises.

The practice was committed to seeing patients experiencing pain on the same or following day. The answerphone provided a telephone number for patients needing emergency dental treatment when the practice was not open.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint, though it contained outdated information and needed to be reviewed and updated. They told us they had not received any complaints in the last year.

The dentist was responsible for dealing with complaints. Staff told us they would tell the dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice, and for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities, though they did not demonstrate a good understanding of significant events.

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff; however, several of these required a review. There were limited arrangements in place to monitor the quality of the service and make improvements.

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

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the dentist was approachable, would listen to their concerns and act appropriately.

Staff discussed concerns and non-clinical updates at informal discussions. It was clear the practice worked as a team and dealt with issues professionally, though they told us they did not hold formal or documented staff meetings.

Learning and improvement

The practice had limited quality assurance processes in place to encourage learning and continuous improvement. The practice had not assessed the quality of dental care record keeping, such as by conducting record keeping audits.

They had conducted X-ray audits, though there were no regular audits of infection prevention and control. They had clear records of the results of the X-ray audit, though improvements were needed in creating a resulting action plan for improvements.

The principal dentist did not demonstrate a commitment to learning and improvement, though they valued the contributions made to the team by individual members of staff.

The dentist told us they discussed general wellbeing at informal discussions though none of the staff members had received any formal appraisals.

Some staff told us they had not completed key training. We reviewed staff records and found there was no evidence of basic life support, safeguarding, fire safety, radiation protection or information governance training for two members of staff. Infection control training had been completed by the clinical staff, but this had not been regularly updated.

The dental nurse told us they had not received any formal training support from the practice, though they had completed training in information governance, infection control and basic life support.

The General Dental Council requires clinical staff to complete continuous professional development; we found there were records of non-verifiable CPD for the dentist, but none that were verifiable.

Practice seeks and acts on feedback from its patients, the public and staff

The practice used verbal comments to obtain staff and patients' views about the service.

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 Requirements in relation to 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. **How the regulation was not being met** The service provider 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: • A Legionella risk assessment had not been conducted. • The fire safety, health and safety, and Control Of Substances Hazardous to Health (COSHH) risk assessments had not been regularly reviewed. • Equipment had not been serviced in line with the manufacturer's guidance. • Staff were not following recognised national guidance when carrying out general cleaning, disinfecting and storing dental instruments. • Risks from the lack of suitable recruitment processes had not been identified and mitigated. • Risks from the lack of an automated external defibrillator had not been identified and mitigated. The service provider 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:

This section is primarily information for the provider

Requirement notices

- Recommended actions from the radiological survey had not been addressed.
- The infection control audit had not been conducted in line with recognised national guidance.
- The practice had not audited their facilities to ensure they complied with the Equality Act 2010.

There were no systems or processes that enabled the service provider to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Patients' dental care records did not contain the necessary information.

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 Requirements in relation to staffing. **How the regulation was not being met** The service provider had failed to ensure that persons employed in the provision of a regulated activities 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: • Continuous professional development records were not available for several staff. • Clinical staff had not completed key training. • Staff had not received appraisals or personal development plans. • Policies were not appropriate. • Infection prevention and control training and associated staff supervision were ineffective as staff were not following national guidance while cleaning used dental instruments. **Regulation 18 (2)**