Tarring Dental Limited

The Tarring Dental Centre

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 14 September 2023 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which did not always reflect published guidance.
- Staff knew how to deal with medical emergencies. However, not all appropriate medicines and life-saving equipment were available. Neither had staff carried out medical emergency training suitable for treating patients under sedation.
- The practice had systems to manage risks for patients, staff, equipment and the premises but these required prompt review.
- Safeguarding processes were ineffective.

Summary of findings

- The practice had staff recruitment procedures although these did not reflect current legislation.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- 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.
- Leadership at the practice required review to ensure there was a culture of continuous improvement.
- Staff at the practice worked as a team to deliver patient care.
- Staff and patients were asked for feedback about the services provided although this was not always reviewed effectively.
- Complaints processes required improvement.
- The practice had information governance arrangements which required improvement.

Background

The Tarring Dental Centre is in Tarring and provides NHS and private dental care and treatment for adults and children.

The practice does not offer step free access to the practice for people who use wheelchairs and those with pushchairs. Patients are asked at the first point of contact if they have any accessibility requirements. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 3 dentists, 1 dental nurse who is also the practice manager, 1 trainee dental nurse, 2 dental hygienists and 1 receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with 2 dentists, 1 dental nurse/practice manager, 1 trainee dental nurse, 1 dental hygienist, 1 receptionist 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 8.30am to 5pm

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

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure patients are protected from abuse and improper treatment
- 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.

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

Summary of findings

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.
- Improve and develop staff awareness of autism and learning disabilities and ensure all staff receive appropriate training in this.
- Take action to ensure audits of record keeping and antimicrobial prescribing are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Enforcement action**
Are services effective?	**No action**
Are services caring?	**No action**
Are services responsive to people's needs?	**No action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice safeguarding processes required review. Not all staff had completed the necessary safeguarding vulnerable adults and children training or to the appropriate level for their role. Not all staff had awareness of safeguarding vulnerable adults and children and staff were unaware of which safeguarding authority to refer to in the event of a concern.

The practice had infection control procedures, but these did not always reflect published guidance issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practice. For example, instruments were not always stored appropriately as they were not secured and kept moist prior to decontamination. Checklists to assist staff with carrying out tasks were not in place. Appropriate checks of the equipment used to decontaminate dental instruments were not being carried out as per published guidance or manufacturer's guidelines.

The practice had some procedures to reduce the risk of Legionella, or other bacteria, developing in water systems. However, we noticed multiple remedial actions were required, rated as 'high risk' in the risk assessment carried out March 2022. These had not been completed.

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.

There was no recruitment policy and procedure to help employ suitable staff, including for agency or locum staff. Following the inspection, we were sent an updated policy to assist staff. Recruitment checks, including Disclosure and Barring Service checks, employment history, satisfactory evidence of conduct in previous employment and qualifications had not been consistently carried out, in accordance with relevant legislation. Appropriate vaccination records, such as for Hepatitis B were not always obtained prior to recruitment. Clinical staff had no risk assessment in the absence of full vaccinations and blood titre levels of blood borne infections.

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

The practice had not ensured that all equipment was safe to use, maintained and serviced according to manufacturers' instructions. For example, documentation was not available to evidence appropriate servicing of the air-conditioning units or equipment used to decontaminate dental instruments. The Electrical Installation Condition checks whilst last carried out September 2023 were not being carried out at the recommended 4 monthly intervals.

A fire safety risk assessment had been carried out in August 2023 in line with the legal requirements. However, the management of fire safety was ineffective. In particular, fire detection systems were not being tested weekly, fire extinguishers were not being serviced annually. The practice was required to carry out an adequate fire drill.

The practice had arrangements to ensure the safety of the X-ray equipment although the required radiation protection information was not available. There was no record of who the Radiation Protection Advisor was and actions arising from servicing of the units in November 2022 and June 2023 had not been completed.

Risks to patients

Are services safe?

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety but these required review. This included sharps safety which did not contain information necessary for staff to follow in the event of an inoculation injury and lone working which did not refer to all staff working alone in the practice.

Emergency equipment and medicines were not available or checked in accordance with national guidance. For example, there were no logs to demonstrate that equipment and medicines were checked, there was no midazolam (the medicine to treat a seizure), no means of administering adrenalin (the medicine to treat an allergic reaction. The required airways and oxygen face masks were not available. There were no paediatric defibrillator pads. Following the inspection, we saw evidence that these items had been ordered.

Staff had completed training in emergency resuscitation and basic life support within the previous year; however, no staff had completed Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) in order to provide treatment to patients under sedation.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements although we saw instances where basic periodontal examinations were not always documented.

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 had some systems for appropriate and safe handling of medicines; however, staff were not aware of how to dispose of out-of-date drugs. Following the inspection, a log was implemented to ensure prescriptions were monitored effectively. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

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

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was 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.

The practice offered conscious sedation for patients although this was not in line with national guidance. There was no evidence that pre-operative checks were carried out, for example, justification for sedation, American Society of Anaesthesiologists (ASA) status, social history or an assessment of anxiety. There was also no evidence that vital signs were monitored throughout recovery until discharge and no evidence that consent was suitably gained. We did not see documentation regarding the availability and use of reversal agents and no evidence that equipment used for sedation was maintained in accordance with the schedule described by the manufacturers. The practice's systems required review and following the inspection the provider told us they were stopping the provision of sedation at the practice.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff obtained patients' consent to care and treatment although this was not always in line with legislation and guidance. For example, we did not see that informed consent had been obtained for patients receiving treatment under sedation. Staff 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 detailed patient care records in line with recognised guidance although improvements could be made to ensure that all necessary information was documented.

Staff conveyed an understanding of supporting more vulnerable members of society and staff were due to complete training on autism and learning disabilities.

We saw evidence the dentists justified, graded and reported on the radiographs they took. However, there was no radiography audit which is a 6-monthly requirement.

Effective staffing

We did not see evidence that all staff had the skills, knowledge and experience to carry out their roles. The systems for monitoring and tracking staff training and Continuing Professional Development (CPD) requires improvement. For example, not all staff had been suitably inducted upon commencing their role and not all staff completed their CPD training necessary for their ongoing registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Following the inspection, the practice told us they would implement a log of referrals for monitoring and tracking purposes.

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.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

We did not see evidence of registration with the Information Commissioners Office and brought this to the attention of staff.

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 provided patients with information about the range of treatments available at the practice.

The dentists explained the methods they used to help patients understand their treatment options. These included for example 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.

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.

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.

The practice's website 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 had some systems to respond to concerns and complaints and these required improvement. For example, there was no complaints information visible for patients as per General Dental Council (GDC) standards; and it was not always clear whether complaints had been reviewed. We did not see evidence of learning from complaints or concerns.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the 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

There had been a lack of oversight and leadership at the practice which had led to omissions and ineffective systems.

Following the inspection, the provider demonstrated they had taken on board the feedback related to the identified shortfalls. They told us of their plans to improve and ensure that appropriate systems are implemented and recognised the need for these to become embedded over time.

Culture

The practice staff demonstrated a transparent and open culture.

Improvements were required to ensure that staff received suitable appraisal, supervision and that staff training was up-to-date and reviewed at required intervals.

Governance and management

Systems to support good governance and management required improvement. For example, policies required updating and systems of communication to ensure staff were kept updated required review.

The provider told us of their step-by-step plans to ensure that all areas of governance were reviewed systematically.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice had some information governance arrangements and staff were aware of the importance of protecting patients' personal information. Staff told us they would review their arrangements for registration with the Information Commissioner's Office following the inspection.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, but there was no evidence of reviewing such feedback for the purposes of learning and improving.

Feedback from staff was obtained through meetings and informal discussions and improvements were underway to enhance communications systems in the practice.

Continuous improvement and innovation

The practice was required to review their processes for learning, quality assurance and continuous improvement. For example, infection prevention and control audits were not completed 6 monthly as per current guidance and action points were not documented. We did not see evidence of 6 monthly radiography audits.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Care and treatment were not being provided in a way that protected service users from being degraded. In particular: • Information available for staff on safeguarding vulnerable adults and children had not been updated since 2021. Staff did not know the local arrangements in the event of a safeguarding concern. • Not all staff had completed safeguarding training or training to the level required for their role. • Inductions for staff did not include raising safeguarding awareness.

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. How the Regulation was not being met 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: • There were no systems to receive and review Medicines and Healthcare Products Regulatory Agency (MHRA) alerts to ensure recalls and rapid responses where relevant. • The system for reporting and learning from accidents and incidents was ineffective.

This section is primarily information for the provider

Enforcement actions

- The system for acting on complaints was ineffective and there was no evidence of learning from complaints.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Infection prevention and control audits were not completed 6 monthly as per guidance and there was no action plan in place.
- There was no evidence that radiography audits were carried out in line with national guidance.
- The system for obtaining patient feedback did not ensure that it was reviewed for the purposes of learning and driving improvement.

There was additional evidence of poor governance. In particular:

- Systems to review practice policies and disseminate changes to staff to ensure that the quality and safety of the services provided were assessed, monitored and improved were ineffective.
- There was no evidence of a Patient Group Direction to ensure the safe supply and administration of medicines by all relevant staff.
- There was no evidence of registration with the Information Commissioner's Office.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 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:

This section is primarily information for the provider

Enforcement actions

- There was no system in place to monitor or log staff training to ensure that staff completed all necessary training as required by the dental professionals' registration body, the General Dental Council (GDC).
- 3 staff had not completed training in infection prevention and control or radiography.
- Not all staff had completed training in fire safety or Legionella awareness.
- There were no induction records for 6 staff members.
- Not all staff received an appraisal.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • Disclosure and Barring Service (DBS) checks had not been carried out at the time of employment for all members of staff. • There were no records in respect of proof of identity, a full employment history, qualifications or satisfactory evidence of conduct in previous employment (references) for all members of staff. • Evidence of Hepatitis B immunity was unavailable for 3 members of staff and there were no risk assessments in place.

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 The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Medical emergency drugs and equipment were not available in line with the guidance issued by the British

This section is primarily information for the provider

Enforcement actions

National Formulary and the Resuscitation Council (UK). For example, the medicine to treat epileptic seizures (midazolam) and the means to administer the medicine for anaphylaxis (adrenalin) were missing. Not all airways and self-inflating bags were present or in date. The equipment was not secure and was accessible to members of the public.

- Weekly checks of the emergency drugs and equipment were not carried out as recommended by the Resuscitation Council (UK).

Decontamination did not always follow guidelines set out by the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices'. In particular:

- Instruments were not always kept moist and secured prior to decontamination.
- Hand hygiene was not practiced at key stages during decontamination.
- Heavy duty gloves were not changed weekly as per national guidance.
- Servicing of the autoclave had not been completed annually.
- Tests and servicing of the ultrasonic bath were not completed in line with guidance or in line with manufacturer's guidelines.
- There was no evidence that air conditioning units or the compressor had been serviced annually or in line with manufacturer's guidance.
- Electrical installation condition checks were not carried out at the recommended intervals.

The risks associated with water systems were not regularly reviewed and mitigated. In particular:

- There was no evidence that the Legionella risk assessment had been reviewed or actioned. Several 'high risk' actions had not been completed.

There were ineffective arrangements to manage the risks associated with fire safety:

- The fire detection system was not being tested on a weekly basis.
- Fire extinguishers were not serviced annually or checked monthly.

This section is primarily information for the provider

Enforcement actions

- Suitable fire drills had not been completed.

There were ineffective arrangements to ensure the use of X-ray equipment was in accordance with Ionising radiation Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17):

- The Radiation Protection Advisor was not documented on the local rules and staff were not aware of who this was.
- The Health and Safety Executive certificate for radiation was in the name of a former provider.
- Actions and recommendations from performance checks had not been completed. For example, the report dated 12 June 2023 stated that the exposure dose for children was being exceeded in surgery 2.
- There was no evidence that electro-mechanical testing was carried out annually or in line with the manufacturer's guidelines for any X-ray unit.

The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment delivered under conscious sedation. In particular

- Team members involved in the provision of treatment to patients under conscious sedation had not taken appropriate life support training.
- There was no evidence that pre-operative checks were carried out. In particular, reasons for the use of sedation, American Society of Anaesthesiologists (ASA) status, social history or an assessment of anxiety. There was also no evidence that vital signs were monitored throughout recovery until discharge.
- There was no evidence that consent was gained.
- There was no evidence on the availability and use of reversal agents such as flumazenil.
- There was no evidence that equipment used for sedation was maintained in accordance with the schedule described by the manufacturers.

There was additional evidence that safe care and treatment was not being provided. In particular:

This section is primarily information for the provider

Enforcement actions

- The practice did not have systems for appropriate and safe handling of medicines as staff were not aware of the procedures for disposing expired or sedation drugs.
- There was no information for staff on what actions to take in the event of an inoculation injury and when an injury had occurred there was no evidence of learning to prevent reoccurrence.