

Mr Saad Al-Haboubi

Derwent Street Dental Practice

Inspection report

14 Derwent Street
Consett
DH8 8LU
Tel: 01207503079

Date of inspection visit: 09 November 2021
Date of publication: 30/11/2021

Overall summary

We carried out this announced inspection on 9 November 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 specialist dental adviser.

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 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 providing well-led care in accordance with the relevant regulations.

Background

Derwent Street Dental Practice is in Consett and provides NHS and private dental care and treatment for adults and children.

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

The dental team includes the principal dentist, three trainee dental nurses (one of whom is also the practice manager) and one dental hygiene therapist. Reception work is carried out by the dental nurses. A visiting implantologist provides implant treatment. The practice has two treatment rooms, one of which is on the ground floor.

The practice is owned by an individual provider 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.

During the inspection we spoke with the provider, the practice manager, two trainee dental nurses and the dental hygiene therapist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday and Thursday 8.30am to 4pm

Tuesday 9am to 6pm

Wednesday 8.30am to 5pm

Friday 8.30am to 1pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- The provider had implemented standard operating procedures in line with national guidance on COVID-19.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were not available in line with guidance. We saw evidence that these were ordered on the inspection day.
- The provider had systems to help them manage risk to patients and staff. The systems for managing fire risk were not in line with national recommendations.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider should review their staff recruitment procedures in line with current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines, with the exception of options for periodontal treatment on the National Health Service (NHS).
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.

Summary of findings

- The provider had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had information governance arrangements.

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

- Take action to ensure that all clinical staff have adequate immunity for Hepatitis B or complete a risk assessment to mitigate the risk of working in a clinical role when the immune status is unknown.
- Take action to review the practice's fire risk assessment and ensure ongoing fire safety management is effective.
- Implement an effective recruitment procedure to ensure that appropriate checks are completed prior to new staff commencing employment at the practice. In particular, the provider should document a risk assessment for not undertaking a Disclosure and Barring Service check, and recruitment checks should be completed for agency or locum staff.
- Take action to ensure the clinicians take into account the guidance provided by NHS England and the College of General Dentistry when completing dental care records.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	No action	✓
Are services effective?	No action	✓
Are services well-led?	No action	✓

Are services safe?

Our findings

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

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

Staff had clear systems to keep patients safe.

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. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that 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.

The provider had implemented standard operating procedures in line with national guidance on COVID-19. Screening and triaging were undertaken prior to patients attending the premises and immediately upon arrival to identify COVID-19 positive individuals and those who may have been exposed to the virus.

The staff had 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, in line with a risk assessment. All recommendations in the assessment had been actioned and records of water testing and dental unit water line management were maintained. The provider was no longer using the same water line disinfectant that was in use when the risk assessment was carried out. A different disinfectant solution was used once a week and we discussed the importance of ensuring this was accounted for in a risk assessment. The provider explained they would re-introduce the original disinfectant to maintain the risk assessment's validity.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean.

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

The provider lead carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

Are services safe?

The provider had a Speak-Up (Whistleblowing) policy. Staff felt confident they could raise concerns without fear of recrimination.

The provider used dental dam 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, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place staff. These reflected the relevant legislation. We looked at all staff recruitment records. These showed the provider followed their recruitment procedure, with the exception of carrying out a Disclosure and Barring Service (DBS) check for the practice manager prior to employment. A risk assessment was carried out however this was not documented. The provider occasionally used agency staff; they relied upon the agency to undertake recruitment checks for the staff but did not request evidence to show these had been completed. We discussed the importance of having this assurance with the provider.

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

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, however the fixed wire electrical safety inspection was overdue. This, together with portable appliance testing, were scheduled to be carried out two days after the inspection. Gas appliances were serviced appropriately.

A fire risk assessment had been carried out by the provider; however, it did not account for all combustible materials within the practice. The provider told us they had not undergone any training in order to complete a fire risk assessment competently. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. A fire safety company had recommended the provider to install call points on the 1st floor landing and basement, and to ensure the fire alarm had two sounders in line with British Standards. The provider had not actioned these. Fire extinguishers and fire alarms were serviced by an engineer annually. The fire alarm was tested weekly by the provider however they did not carry out visual inspections for the fire extinguishers, fire exits and emergency lighting. Fire drills were not carried out though staff were aware of evacuation procedures and ensuring patients' safety in the event of a fire. We were assured by the provider that they would seek advice from a competent person, review their risk assessment and complete checks from now on.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. The provider had registered with the Health and Safety Executive in line with changes to legislation relating to radiography. Local rules for the X-ray units were available in line with the current regulations. The provider used digital X-rays.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits following current guidance and legislation.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

Are services safe?

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 had been undertaken and was updated annually. We observed the contact details for staff to seek medical assistance in the event of a sharps' injury had not been updated. This was discussed with the provider.

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. The provider's checks for the effectiveness of the vaccination was inconsistent amongst staff. For example, we found two members of staff had reduced immunity levels however a risk assessment was not completed to mitigate the risks of working in a clinical role.

Staff were aware of sepsis and the need to effectively manage patients who present with dental infection and where necessary refer patients for specialist care

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 were not available as described in recognised guidance. The medicine required to manage a seizure had expired a few days prior to the inspection, and the provider did not have a child-sized self-inflating bag with reservoir, a child-sized bag mask and valve or sufficient face masks to provide medical oxygen. The medicine and equipment were purchased, and we received confirmation of this the following day.

We found staff kept records of their checks to make sure they were available, within their expiry date, and in working order. We discussed the need to review the checking system to ensure it was effective.

A dental nurse worked with the dentist and the dental hygiene therapist when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment was in place for any occasion when the dental hygiene therapist would work without chairside support.

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

The practice occasionally used agency staff. We observed that 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. We looked at dental care records with clinicians to confirm our findings and observed that individual records were written or typed and managed in a way that kept patients safe. Dental care records we saw were, legible, 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 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 provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentist was aware of current guidance with regards to prescribing medicines.

Are services safe?

Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

Where there had been a safety incident, we saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

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.

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 the provider and dental hygienist therapist assessed patients' needs in line with current legislation, however delivery of periodontal care and treatment was not always in line with national standards and guidance. We viewed patient dental care records and found options for NHS periodontal treatment were not documented.

The practice offered dental implants. These were placed a visiting clinician who had undergone appropriate post-graduate training in the provision of dental implants.

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 dental professionals where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. This was evident from the dental hygiene therapist's dental care records; however, the dentist did not document this in the records we viewed with them.

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

The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dental hygiene therapist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

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 patients' consent to treatment. 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. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this was not documented in the patients' dental care records that we viewed with the provider.

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.

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

Are services effective?

(for example, treatment is effective)

The provider's record keeping was not in line with recognised guidance. In the dental care records, we viewed, we did not see information recorded about the patients' diagnosis, treatment options, consent including benefits and complications, and their risk of dental disease. We also saw referral prescriptions were not sufficiently detailed for the dental hygiene therapist to carry out their work. We explained to the provider that we would be sharing our concerns in relation to this, and provision of periodontal care, with NHS England.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice staff had a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their 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 dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There was no system in place, such as a record or logbook, to monitor referrals and we discussed the importance of this with the provider. Dental implant referrals were actioned by the visiting implantologist.

Are services well-led?

Our findings

We found this practice was providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability

We found the provider had the capacity and skills to deliver high-quality, sustainable care, however there were issues identified during our inspection which required addressing. The provider was open to discussion and feedback during the inspection. They understood the challenges and demonstrated that they were keen to address them.

Staff told us they found the provider and the practice manager very approachable. Staff told us they worked closely with them to make sure they prioritised compassionate and inclusive leadership.

We saw the provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Culture

The practice had a culture of high-quality sustainable care.

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

Staff discussed their training needs with the provider and practice manager at individual meetings, and during clinical supervision. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

The staff focused on the needs of patients. We were told of an example whereby emergency care was provided to a patient who could not access care elsewhere and travelled several miles to attend here.

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

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The provider had overall responsibility for the management and clinical leadership of the practice and the practice manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

We saw there were processes for managing risks, issues and performance however the provider's systems for managing risks associated with fire, immune status and medical emergency provision needed review.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example NHS BSA performance information, surveys and audits, were used to ensure and improve performance. Performance information was combined with the views of patients.

Are services well-led?

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

Engagement with patients, the public, staff and external partners

The provider used patient surveys, comment cards and verbal comments to obtain staff and patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used. The most recent results showed us 100% of respondents would be highly likely to recommend the practice to other people.

The provider gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of radiographs and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements.

The provider showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.