Quality Dental Care Limited

Rothwell Orthodontic Practice

Inspection report

24 Bridge Street
Rothwell
Kettering
NN14 6JW
Tel: 01536712233

Date of inspection visit: 26 October 2021
Date of publication: 19/11/2021

Overall summary

We carried out this announced inspection on 26 October 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 CQC inspector who was supported by a specialist dental adviser.

As part of this inspection we asked the following 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 that this practice was 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.

Summary of findings

Are services well-led?

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

Background

Rothwell Orthodontic Practice is well-established and offers mostly NHS treatment to children and young people. It is a referral clinic for orthodontic treatment. The dental team is small and consists of one orthodontist, one nurse and one receptionist. There is a manager who oversees the practice but who is mostly based at the provider's other practice in nearby Desborough. Free car parking is available at a public car park just opposite the practice. There is no access for wheelchair users.

The practice is open Monday to Friday from 9am to 5pm.

The practice is registered as a company and as a condition of registration must have a person registered with the CQC 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 the practice is the principal dentist at the sister practice in Desborough.

On the day of inspection, we spoke with the practice manager, the orthodontist, the nurse and the compliance consultant. We looked at practice policies and procedures and other records about how the service was managed.

Our key findings were:

- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had systems to help them manage risk to patients and staff.
- Staff felt respected and valued.
- The decontamination of dental instruments did not follow nationally recommended guidance.
- Essential staff pre-employment checks were not fully undertaken to ensure suitable staff were employed at the practice.
- Recommendations in the practice's fire safety risk assessment had not been actioned to ensure staff and patients and the premises were kept safe in the event of a fire.
- The practice appeared to be visibly clean and reasonably well-maintained.
- Comprehensive procedures had been implemented to reduce the spread of Covid-19.

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

- Improve the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. In particular, ensuring that adequate personal protective equipment is worn, instruments are kept moist whilst awaiting sterilisation and are examined correctly for residual debris.

- Take action to ensure clinicians record in the patients' dental care records or elsewhere the reason for taking X-rays, a report on the findings and the quality of the image in compliance with Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

Summary of findings

- Take action to implement any recommendations in the practice's fire risk assessment.
- Implement an effective recruitment procedure to ensure that appropriate checks are completed prior to new staff commencing employment at the practice.
- Implement systems for appraising staff performance.

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

Safety systems and processes (including staff recruitment, Equipment & 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 practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse.

Both the practice manager and registered manager had undertaken level three training in child protection and staff we spoke with knew how to report their safeguarding concerns. Information about key protection agencies was on display in the staff office area, making it easily accessible.

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

The practice 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 (HTM01-05) published by the Department of Health and Social Care. Additional protocols had been implemented to the patient journey to reduce the spread of Covid 19 and an air filtration system had been installed in the waiting area.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. One dental nurse told us they would value having more handpieces available to ease the pressure on getting them sterilised in time for patients. Despite having a washer disinfector available in the practice, staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the practice manager that manual cleaning was the least effective recognised cleaning method as it was the hardest to validate and carried an increased risk of an injury from a sharp instrument.

Staff carried out infection prevention audits and the latest audit showed the practice was meeting the required standards. However, we found several shortfalls in the decontamination process that did not reflect the audit's findings. For example, we noted that the dental nurse did not wear adequate eye protection and there was no system in place to ensure that heavy duty gloves and long handled brushes used for manually scrubbing instruments were changed regularly. Instruments were not kept moist whilst waiting to be sterilised and were not visually inspected correctly for residual debris. Dirty instruments were transported in unmarked containers.

Procedures were in place to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Staff carried out quarterly dip slide testing, as well as monthly water temperature testing, evidence of which we viewed.

We saw effective cleaning schedules to ensure the practice was kept clean. We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt, although we noted vertical blinds on the window which would be hard to keep clean.

The practice used an appropriate contractor to remove dental waste from the practice and external clinical waste bins were stored securely in an enclosed courtyard area to the side of the building.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff which reflected the relevant legislation. However, staff records we checked showed that the policy was not being followed. For example, there was no evidence that references had been obtained for two new members of staff. Records of staff interviews were not available to show they had been conducted in line with good employment practices.

The practice ensured that facilities were safe, and that equipment was serviced according to manufacturers' instructions.

Are services safe?

A fire risk assessment had been carried out in 2019, in line with the legal requirements. However, its recommendations to install internal fire doors and remove unsafe carpeting had not been implemented. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and the practice had the required information in their radiation protection file. We were provided with evidence that the orthodontist had training in dental radiography after our inspection. We noted that X-rays were not always reported on and graded in the dental care records that we reviewed.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards and detailed the control measures that had been put in place to reduce the risks to patients and staff.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support. A different medical emergency scenario was discussed at each practice meeting to ensure staff kept their knowledge and skills up to date.

We checked the practice's medical emergency kit and noted it did not contain all the equipment recommended by the UK Resuscitation Council. For example, there was not a full set of clear face masks or oxygen mask with tubing. There were no paediatric pads for the defibrillator and scissors, razors and gloves for use with the defibrillator were not kept within easy access. The glucose was in powder form and not gel, and there was not enough Midazolam available for repeated administration. All missing equipment was ordered immediately following our inspection.

There was a comprehensive Control of Substances Hazardous to Health (COSHH) Regulations 2002 folder in place containing chemical safety data sheets for the materials used within the practice.

Safe and appropriate use of medicines

The practice did not dispense or prescribe any medicines to patients.

Glucagon was stored with the medical emergency kit and its expiry date had been reduced to accommodate this.

Lessons learned and improvements

The practice had procedures in place to investigate, respond to, and learn from significant events and complaints, and staff were aware of formal reporting procedures. There had not been any significant events in the previous three years, but staff told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent their recurrence.

A system was in place to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and implement any action if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The orthodontist carried out patient assessments in line with recognised guidance from the British Orthodontic Society. An Index of Orthodontic Treatment Need was recorded which was used to determine whether the patient was eligible for NHS orthodontic treatment. The patient's oral hygiene was also assessed to determine if they were suitable for orthodontic treatment, although this was not always recorded in the dental care records we reviewed.

The orthodontist used the Peer Assessment Rating (PAR) scoring system to measure the effectiveness of treatment outcomes for patients.

Helping patients to live healthier lives

Patients were given oral hygiene support and advice by both the orthodontist and nurse and their dental health was monitored through follow-up appointments. Information sheets were given to patients about the care of their orthodontic appliances and the importance of brushing teeth with an orthodontic toothbrush. However, this information was not in a child and young person friendly format.

The practice sold dental kits at reception which contained toothpaste and orthodontic toothbrushes.

Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005 and Gillick Competence Guidelines. Staff had a satisfactory understanding of their responsibilities under these when treating adults and young people.

Effective staffing

We confirmed that all clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. Staffing levels had not been unduly affected by the Covid-19 pandemic, and additional staff were available from the provider's sister practice nearby if needed to cover any shortages.

The provider had current employer's liability insurance in place which was displayed in the staff area.

Co-ordinating care and treatment

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

Staff 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

Leadership capacity and capability

The registered manager was the principal dentist at a sister practice in Desborough**.** Staff told us that although he was approachable, he didn't often visit the practice itself. A practice manager with oversight of both this location and the practice nearby had been appointed in April 2021 and we were told they spent about half their time in each practice.

An external consultant had been employed to visit the practice three to four times a month to check on compliance issues and provide support to the practice manager.

Culture

The practice was small and friendly, and staff told us they felt respected and valued, and clearly enjoyed their job.

The practice had a duty of candour policy in place, and staff were aware of its requirements for openness and honesty with patients if things went wrong.

Governance and management

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff. However, we were told that some essential records such patient feedback surveys, some staff records and the critical examination test for the orthopantomography (OPG) machine had been lost or could not be found following the departure of the previous practice manager. This indicated that oversight of the practice by the provider needed to improve.

The practice had a policy which detailed its complaints procedure and information about how to complain was available in the waiting room, although it was not particularly visible to patients. We were not able to assess how the practice responded to complaints as we were told none had been received in the previous three years.

Engagement with patients, the public, staff and external partners

Staff told us that patient feedback surveys had been undertaken prior to Covid-19 but could not provide any evidence of this as the information had been lost. The practice also took part in the Friends and Family Test but was not offering it currently due to Covid-19 restrictions.

Continuous improvement and innovation

Clinical audits for areas such as radiography and infection control were undertaken in line with national recommendations, although these had not been effective in identifying some of the shortfalls we saw. Checklists used for the medical emergency equipment had failed to identify the practice did not have all the equipment recommended by the Resuscitation Council.

None of the staff had received a formal performance review and one dental nurse who had worked there many years told us she had never received an appraisal. Staff told us they did not have personal development plans in place.