Shelton Dental Centre

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 7 February 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 reflected published guidance. We found these were not always followed or applied effectively.
- Staff knew how to deal with medical emergencies. However, we were unable to identify whether some of the emergency medical equipment seen had passed its expiry date. Following this inspection, we were informed that replacement equipment had been ordered.

Summary of findings

- The practice's systems to manage risks for patients, staff, equipment and the premises were not effective or embedded.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected current legislation.
- Clinical staff did not always evidence they 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 was not always effective and evidence of a culture of continuous improvement was not observed
- Staff and patients were asked for feedback about the services provided. Although practice meetings were held infrequently.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

Shelton Dental Care is in Shelton, Stoke on Trent and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available in pay and display car parks near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 7 dentists, 14 dental nurses (including 5 trainee dental nurses), 3 receptionists, 2 cleaners and a laboratory technician. The practice has 12 treatment rooms.

During the inspection we spoke with 4 dentists (practice partners), 2 dental nurses, 2 receptionists. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open: Monday to Friday from 8.30am to 5pm.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation/s the provider was not meeting are at the end of this report.

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

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records and are aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.

Summary of findings

- Improve and develop the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance, and staff follow them.

- Take action to ensure that orthodontists carry out a patient assessment in line with recognised guidance from the British Orthodontic Society and that an Index of Orthodontic Treatment Need are recorded at the end of NHS orthodontic treatments.

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?	**No action** ✓
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✗

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)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Information regarding safeguarding was on display throughout the practice. One of the partners had downloaded the safeguarding application on to their phone which gave up to date local safeguarding information. Records for some staff demonstrated that they had completed safeguarding training within the last 3 years. However, evidence was not available for all staff. Following this inspection, evidence was sent to demonstrate that the required level of safeguarding training had been completed by the staff whose training certificates were not available on the day of inspection.

The practice's infection control procedures did not always reflect published guidance. For example, there was no log of change of heavy-duty gloves or brushes, staff were not using non-linting cloths, there was no ventilation in the decontamination room, the window was closed however, the door was left open. Water temperatures were not checked as there was no thermometer and a foaming detergent was being used. Some issues were identified in dental treatment rooms. For example, items seen were not always pouched such as scaler tips, matrix bands, burs, implant kits, reusable impression trays and X-ray holders. Cotton wool was not always stored in dispensers, some single use items were being sterilised such as healing abutments and healing caps. Sharps boxes were not dated, chair headrests were torn in 2 surgeries and rusty instruments were seen in 1 surgery. Following this inspection, we were informed that further staff training had been carried out at the practice regarding decontamination and an inspection of the decontamination room and surgery drawers would be completed within in a month to ensure compliance. The split chair material was to be replaced.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment. Hot water temperatures were being monitored and recorded on a monthly basis. Records showed that temperatures were below the required minimum identified in the legionella risk assessment. The boiler temperature was adjusted on the day of inspection to rectify this issue. Following this inspection, we were informed that water was now at the correct temperature.

The practice's procedures regarding clinical waste required review to ensure it was stored appropriately in line with guidance. We saw that clinical waste was not being securely stored. We were assured that action would be taken to address this issue and the waste would be kept behind a locked door.

The practice appeared clean and there was a schedule in place to ensure it was kept clean. However, one of the cleaning logs that we saw had not been fully completed on each occasion and the log had not been completed at all for 1 week due to the regular cleaner being on annual leave. We were assured that although the log had not been filled out, the cleaning tasks had been completed.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation.

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

The practice's systems to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions required review. There was no service information for the ultrasonic cleaner used in the decontamination process and the provider should check manufacturers guidance to review the frequency of servicing for this equipment.

The practice did not ensure the facilities were maintained in accordance with regulations.

Are services safe?

The provider did not have effective fire safety management procedures. In particular, an inhouse fire safety risk assessment was carried out by a member of staff at the practice. This did not fully risk assessment the in-house laboratory on the premises. The local fire and rescue service had also visited the practice in May 2022 and reviewed fire safety arrangements and left an action plan. Evidence was not available to demonstrate that all issues identified in the action plan had been addressed. There were no records to demonstrate that monthly checks were being completed on emergency lighting. There were no records of staff fire drills. The fire logbook was not fully completed to demonstrate that emergency lights, fire extinguishers, fire exits, or fire doors were checked on a regular basis. Following this inspection, we were told that the practice fire risk assessment had been updated and recorded a specific laboratory fire risk assessment; all sections of the fire records log would be monitored and logged going forward.

The practice had some arrangements to ensure the safety of the X-ray equipment. Rectangular collimators were not available in each dental surgery. A rectangular collimator reduces the amount of radiation a patient is exposed to during dental intraoral X-ray procedures. The annual routine test was completed on the cone-beam computed tomography (CBCT) in February 2022. However, information regarding the regular tests and a quality assurance programme for the CBCT was not available. Following this inspection, we were informed that rectangular collimators had been ordered. We were also informed that advice had been sought from the Radiation Protection Adviser regarding implementation of a quality assurance scheme for the CBCT.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety although some required updating. For example, the information regarding sharps risk, included in the practice risk assessment was not practice specific as it recorded that the practice were using safer sharps, however the practice does not use safer sharps. Following this inspection, we were sent evidence to demonstrate that this had been amended as required.

Information regarding sepsis was on display throughout the practice and staff had completed sepsis training.

Risks associated with endodontic treatment were not appropriately managed. For example, although rubber dam was available, this was not used on each occasion and the alternative methods used were not recorded in patient records.

Emergency equipment and medicines were available, however, the self-inflating bag with reservoir for adult and clear face masks size 3 and 4 did not have an expiry date recorded, we were therefore not able to identify whether these items had passed their expiry date. An out of date ambubag was kept within the medical emergency kit. Glucagon was being stored within the medical emergency kit but had not had its expiry date amended as per manufacturers guidance. Following this inspection, we were informed that that replacement equipment had been ordered as well as a new supply of glucagon.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. The next training was booked for 5 April 2023.

The pharmaceutical bin was not dated and was full.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, control of substances hazardous to health (COSHH) safety data sheets were available for products in use at the practice, however, there was no COSHH risk assessments. COSHH products were not all securely stored. Following this inspection, we were informed that COSHH products would be moved and stored behind a lockable door. A COSHH risk assessment had been completed, although this did not record actions to be taken in case of an incident.

Information to deliver safe care and treatment

Are services safe?

The dental care records we saw were not complete or legible. In particular, we noted the care records of some clinicians lacked detail and evidence of patient consent, medical history updates and basic periodontal examination scores. Following this inspection, we were informed that discussions had been held with dentists and patient records would be re-audited at 1 and 3 months to ensure compliance with standards. Spot checks would be completed to ensure the accuracy of the audit.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice did not have an adequate stock control system of medicines which were held on site.

Although an antimicrobial prescribing audits had been carried out, this was for a very small sample size and was not clinician specific. There was no action plan or learning outcome recorded. Following this inspection, we were informed that audits would be overseen, and spot checks completed to ensure accuracy of information.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice had 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.

There was no evidence the orthodontist carried out a patient assessment in line with recognised guidance from the British Orthodontic Society. An Index of Orthodontic Treatment Need, used to determine whether a patient was eligible for NHS orthodontic treatment, was not always recorded in the dental care records we looked at.

We saw the provision of dental implants was in accordance with national guidance. However, consent forms were not being used by each clinician on each occasion and surgical kits used for dental implants were not pouched. During discussions we were informed that instruments were always sterilised prior to use but going forward would be pouched.

Helping patients to live healthier lives

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

Staff were aware of national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Dental care records we looked at showed there was a lack of consistency in staff obtaining patient's consent to care and treatment. There was not always evidence of written consent in the patient records that we looked at. Consent forms seen were general and not specific to a treatment being completed. During the inspection we were assured that consent forms would be amended to be treatment specific and following this inspection we were informed that consent would be reviewed as part of the patient record audit.

Staff understood their responsibilities under the Mental Capacity Act 2005 and mental capacity act training was planned.

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 did not keep detailed dental care records in line with recognised guidance. In particular treatment plans were not always signed. There was no evidence of consistent medical history checks, issues were identified with recording of basic periodontal examination (BPE) scores for adults and children and follow up treatment where the BPE score indicated further action. Following this inspection, we were informed that a patient record audit would be completed, and a review completed every 3 months until improvements were noted. Spot checks were to be undertaken on these audits.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability. Staff had completed training regarding learning disability and autism awareness.

We saw evidence the dentists justified, graded and reported on the radiographs they took. However, clinicians were not using the most recent grading scale for X-ray grading. Not all clinicians had carried out radiography audits; 2 clinicians had completed an audit of a very small sample size on an annual basis not six-monthly following current guidance and legislation. Following this inspection, we were informed that audits, summaries and the required action plans would be overseen by a partner at the practice and would be subject to spot checking to ensure accuracy of information.

Are services effective?

(for example, treatment is effective)

Effective staffing

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

Newly appointed staff had an induction, although induction records seen had not been fully completed or signed to demonstrate training had been completed and the trainee was deemed competent. Clinical staff completed 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 dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. The practice did not keep a log of private referrals. Following this inspection, we were informed that a private referral log had been set up.

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.

Staff password protected patients' electronic care records and backed these up to secure storage. Paper records were not always securely stored, including some medical history forms seen within 1 treatment room.

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 and information leaflet 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 and videos.

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.

The practice had made reasonable adjustments, including ramped access to the front of the building, a hearing loop and access to translation services for patients with access requirements. 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 and patient information leaflet.

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. Patients had enough time during their appointment.

The practice's 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 responded to concerns and complaints. There was no evidence that the last complaint received had been finalised or investigated fully. A discussion was held, and it was noted that appropriate follow up action had been taken. We were assured that complaint records would be updated to demonstrate follow up action.

Information for patients on how to make a complaint was on display. Staff discussed outcomes to share learning and improve the service. Staff had completed training regarding complaint handling.

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 Requirement Notices 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 was a lack of effective leadership and oversight at the practice. Oversight and day to day running of the practice was now the responsibility of the partners as the practice manager had recently left. We noted that there were some gaps in oversight, for example logs seen for the daily, weekly and monthly checks of fire safety equipment did not include checks of emergency lighting, fire extinguishers, fire doors or fire exits. The logbook provided by Staffordshire Fire and Rescue had not been fully completed. Staff were not always following guidance detailed in HTM 01-05 regarding decontamination processes, systems for monitoring emergency medical equipment did not identify equipment with no expiry date recorded. There was no regular testing or quality assurance processes in place regarding the Cone-beam computed tomography machine (CBCT).

Culture

Staff stated they felt respected and valued. They were proud to work in the practice. Staff said that everyone was supportive and helpful and worked well as a team.

Staff discussed their training needs during annual appraisals, although these were overdue for completion. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had some arrangements to ensure staff training was up-to-date and reviewed at the required intervals. A newly developed training matrix was used to demonstrate training undertaken and required. The provider was able to review the training completed by staff using the online training portal. However, clinicians had not completed operator or referrer training for the use of the CBCT. Following this inspection, we were informed that the clinicians would enrol on the relevant course.

Governance and management

There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis. There was no evidence of regular review or update of information contained within the staff handbook and some policies recorded out of date or incorrect information. Following this inspection, we were forwarded a copy of the staff handbook which recorded a review date of February 2023.

The practice did not have clear and effective processes for managing risks, issues and performance. For example, the practice had not completed a risk assessment regarding substances hazardous to health and hazardous products were not all securely stored. The sharps risk assessment was not practice specific as it recorded that the practice was using safer sharps, however the practice did not use safer sharps. Following this inspection, we were informed that the required action would be taken regarding the above issues.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

Are services well-led?

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback. The results of the Friends and Family Test for January 2023 showed a high response rate with 84% recording very good and 14% recording a good score for the practice.

There was limited evidence the practice gathered feedback from staff through meetings and informal discussions. We were told that there had been no formal staff meetings recently and meetings were held infrequently during 2020, there were no recorded meetings in 2021 and only 1 meeting in 2022. We were told that informal meetings were held as required to discuss any important information or updates. Staff told us that they were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

The practice was also a member of a good practice certification scheme.

Continuous improvement and innovation

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement. The practice had not completed audits of infection prevention and control and radiography at the required frequency. The radiography audit was not completed by all clinicians and was for a very small sample size. The antimicrobial prescribing audit was not clinician specific and was only for a very small sample size. The record keeping audit did not reflect issues identified during the inspection. Action plans were not developed to support and monitor improvements. Following this inspection, we were informed that audits, summaries and the action plans needed would be overseen by a partner and would be subject to spot checking to ensure accuracy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had systems or processes in place that 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: • There were limited systems for monitoring and improving quality. For example, completed audit activity was not analysed with supporting action plans and did not result in improvement to the service. Audits were not all completed at the required frequency or for an adequate sample size. 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: • The practice's infection control procedures did not always reflect published guidance. For example, there was no log of change of heavy-duty gloves or brushes, staff were not using non-linting cloths, and staff were not monitoring the temperature of the water when manual cleaning of instruments was completed. • Routine fire safety checks were not completed regarding emergency lighting, fire extinguishers, fire exits, or fire doors and there were no records to demonstrate that staff fire drills had taken place.

This section is primarily information for the provider

Requirement notices

- The sharps risk did not record information specific to the practice and did not record details of all sharps objects in use.
- The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health, there was no control of substances hazardous to health (COSHH) risk assessment and COSHH products were not all securely stored.
- The provider had not ensured that cone beam computed tomography (CBCT) was subject to routine quality assurance systems and checks. Clinicians who operated the CBCT had not completed operator or referrer training for its use. Rectangular collimators were not available for all X-ray machinery at the practice.

Regulation 17 (1) (2)