Adelphi Dental Care

Adelphi Dental Centre

Inspection report

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Date of inspection visit: 4 October 2022
Date of publication: 26/10/2022

Overall summary

We undertook a follow up focused inspection of Adelphi Dental Centre on 4 October 2022. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Adelphi Dental Centre on 14 June 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe or well led care and was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Adelphi Dental Centre on our website www.cqc.org.uk.

When 1 or more of the 5 questions are not met, we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

Is it safe?

Is it effective?

Is it well-led?

Our findings were:

Are services safe?

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

Summary of findings

The provider had made improvements to put right the shortfalls identified in our inspection of 14 June 2022 but had not responded in full to the regulatory breaches identified.

Are services effective?

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

The provider had made insufficient improvements to put right the shortfalls identified at our inspection of June 2022 and had not fully responded to the regulatory breaches found.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls identified at our inspection of June 2022 and had not fully responded to the regulatory breaches found.

Background

Adelphi Dental Centre is in Preston, Lancashire and provides NHS and a small amount of 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 are available near the practice. The practice has made adjustments to support patients with additional needs. For example, through the provision of permanent ramp access to the practice and a hearing loop for patients with hearing difficulties.

The dental team includes 2 dentists, 5 dental nurses, 2 of whom are trainees, a dental hygiene therapist, a receptionist and a practice manager. The practice has 3 treatment rooms.

During the inspection we spoke with both of the dentists, 2 dental nurses, a receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open Monday, Wednesday and Thursday from 8.30am to 5.30pm, Tuesday from 8.30am to 7pm and on Friday from 8.30am to 5pm.

We identified regulations the provider was not meeting. 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.

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 implement any recommendations in the practice's Legionella risk assessment, 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 to take steps to find whether the air conditioning system at the practice should be included in the Legionella risk assessment.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services effective?	**Requirements notice** ✖
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

We found that this practice was not providing safe care and treatment and was not complying 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).

At the inspection on 4 October 2022 we found the practice had made the following improvements to comply with the regulations:

- All nurses and clinicians had provided evidence of immunity to blood borne diseases. For newly recruited staff, or those whose immunity was lower than expected, risk assessments were now in place.
- Dental unit water lines were being managed in accordance with manufacturer's instructions. Staff had received training specific to this and were now familiar with the operating processes of a 'closed' system.
- Local Rules were now available for the X-ray equipment at the practice. Information sheets with the names of the Radiation Protection Advisor and Radiation Protection Supervisor were included within the Local Rules.
- A new Legionella risk assessment had been commissioned; this identified that hot water temperatures should reach 55 degrees centigrade. Staff were following instructions provided and records were held of water temperature tests, carried out weekly.
- Air conditioning units had been serviced; however, the engineer appointed had not indicated whether these needed to be considered as part of the Legionella risk assessment.
- Signage was now displayed in the practice indicating that medical gases are stored on site (for the benefit of emergency services entering the building).
- All items of medical emergency equipment and medicines were available and ready for use as detailed in recognised guidance. This included sufficient supply of medical oxygen, for use in an emergency.
- All recommended testing on decontamination equipment was now in place and recorded in logbooks. This included soil tests for the ultrasonic bath; protein residue testing on dental instruments; and steam penetration testing on the vacuum cycle of the autoclave.
- Remedial work had been carried out on the fixed electrical wiring within the practice, to ensure electrical safety within the building. Paperwork to support this was available for inspection.
- Information on products used within the practice was now available for staff to refer to, in compliance with regulations on the Control of Substances Hazardous to Health (COSHH).
- NHS prescription pads were now being managed in line with recognised guidance and record logs were available to support this.
- Medicines management in terms of stock control had improved; we saw that medicines received into the practice were logged, stored securely and used in order of dates of expiry.
- Staff access to essential safety notices and medicines alerts was now improved. Staff were made aware of any relevant safety alerts through a shared practice email address. This was supported by the practice manager who also received alerts direct to their own email address and shared this information with all staff.

Areas that required further improvement included:

- Prescribing of antibiotics; this did not follow recognised guidance. Prescribers did not demonstrate up to date knowledge of applicable prescribing protocols.
- Infection control; we found some staff did not always adhere to recognised guidance in the use of personal protective equipment when carrying out examination and treatment of patients.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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 the report).

At the inspection on 4 October 2022 we found the practice had not made sufficient improvements to comply with the regulations. Areas around clinical record keeping required greater focus.

- From a sample of patient dental treatment records reviewed and discussed with the dentist during our inspection, our finding was that patients were not given treatment plans that were sufficiently detailed. These did not adequately set out the different risks and benefits of treatments, the different treatment options available and the duration of courses of treatment.
- We were unable to confirm that full periodontal checks and scoring were effectively recorded, or that any areas of concern and treatment options were discussed with patients.
- Some improvement in audit had been made. We were able to confirm the dentists justified, graded and reported on all radiographs they took. Awareness of audit requirements for radiography, in line with current guidance and legislation, was improved.
- Dentists were unable to show evidence of required or recommended topics of continuous professional development (CPD). For example, we asked for evidence of CPD in respect of dental radiography and oral cancer. Items submitted after the inspection showed one dentist had completed on-line training in oral cancer immediately after this follow-up inspection. No other evidence of CPD was provided.

Are services well-led?

Our findings

We found that this practice was not providing well-led care. 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).

Day to day management of the practice had improved. A permanent practice manager was now in place and this aided day to day governance. At the inspection on 4 October 2022 we found the practice had made the following improvements to comply with the regulations:

- A training matrix was in place to allow the practice manager to oversee training undertaken by staff and when other training was due. Dentists had not adhered to this system, meaning the practice manager could not prompt the dentists when certain subjects were due for refresher training. Dentists were unable to show evidence of their continuous professional development.
- There were improvements in audit within the practice. We saw infection control audit was carried out in a timely manner and radiography audit was in place. However infection control audit had failed to identify that there were times when patients had been examined without the use of appropriate personal protective equipment.
- There was no system or processes in place to review and evaluate audits on prescribing and record card audit; learning points and areas for improvement were not identified.
- A system of record keeping in respect of medicines and prescription pads was in place.
- Systems and processes to receive, share and act on alerts and updates were in place.
- Radiation management had been reviewed to ensure staff had access to the appropriate information in a timely manner. Details of key contacts in relation to radiation management, were now available in the practice.
- The practice had adopted a system of clinical governance which included policies, protocols and procedures that were accessible to all members of staff. However, some staff had not adapted to this system. As a result this was not embedded within the practice, for example, in providing evidence and details of continuous professional development to aid effective oversight of this for the practice.
- Systems and processes to reduce risk were in place, for example, in respect of checks on fixed wiring in the building.
- A system of daily checks had been introduced for emergency medicines and equipment and on processes and validation testing in the decontamination room.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure safe care and treatment at all times. In particular: • Prescribers did not demonstrate up to date knowledge of applicable prescribing protocols. Antibiotic prescribing did not follow recognised guidance. • Staff did not always adhere to recognised guidance in the use of personal protective equipment when carrying out examination and treatment of patients, for example, by examining patients without the use of gloves. **Regulation 12(1)**

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 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: The lack of effective systems to audit patient records meant errors and omissions were not identified.

This section is primarily information for the provider

Requirement notices

- Patients were not given treatment plans that were sufficiently detailed. These did not adequately set out the different risks and benefits of treatments and the duration of treatments.

Standards of clinical record keeping did not reflect required standards.

- From a sample of patient treatment records reviewed, it could not be confirmed that full periodontal checks and scoring were effectively recorded, and where applicable, any identified areas of concern and relevant treatment options were discussed with patients. Audit had failed to identify this.
- Systems and processes to review and discuss audits were insufficient. Learning points and areas for improvement were not identified.
- Infection control audit and review of clinical practice had not identified patients had been examined and treated without the use of full personal protective equipment.

The lack of adherence to new governance systems implemented by the practice manager, meant oversight of training and ongoing professional development was not effective.

- Clinicians were unable to demonstrate that continuous professional development was undertaken at the required rate or intervals.

Regulation 17(1)