Dentart Limited

Dentart

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 June 2016 to ask the practice the following key questions: Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

Background

Dentart is located in the London Borough of Hammersmith and provides private dental services.

The staff structure of the practice comprises of three dentists two nurses, two receptionist and practice manger.

The practice was open 10.00-6.00 pm Monday to Saturday.

Facilities within the practice include one treatment rooms, a dedicated decontamination room and a waiting area.

The practice manager was the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to complete to tell us about their experience of the practice. We received comment cards from 16 patients. The feedback we received for patients gave a positive view of the services the practice provides. All of the patients commented that the quality of care was good.

We carried out an announced comprehensive inspection on 13 June 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

Summary of findings

Our key findings were:

- There were effective processes in place to reduce and minimise the risk and spread of infection.
- There was lack of appropriate systems in place to safeguard patients.
- The practice did not have arrangements in place to ensure the safety of the equipment.
- Patients told us that staff were caring and treated them with dignity and respect.
- There were processes in place for patients to give their comments and feedback about the service including making complaints and compliments.
- There was a lack of an effective system to assess, monitor and improve the quality and safety of the services provided.
- Governance arrangements in place were not effective to facilitate the smooth running of the service and there was no evidence of audits being used for continuous improvements.

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We identified regulations that were not being met and the provider must:

- Ensure that all staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Ensure staff training to manage medical emergencies taking into account guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD)
- Ensure systems are in place to assess, monitor and improve the quality of the service such as undertaking regular audits of various aspects of the service and ensuring that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.

There were areas where the provider could make improvements and should:

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review it's responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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?

Requirements notice

We found that 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 Requirement Notices at the end of this report).

There were systems in place to help ensure the safety of staff and patients. These included policies for safeguarding children and vulnerable adults from abuse and maintaining the required standards of infection prevention. However staff had not received safeguarding training appropriate to their job, there was no system in place for the control and maintenance of equipment used at the practice. The practice did not have adequate systems in place for the management of substances hazardous to health.

In the event of an incident or accident occurring, the practice had a system in place to document, investigate and learn from it. The practice did not always follow procedures for the safe recruitment of staff, and checks had not been made on the immunisation status of all clinical staff.

Are services effective?

Requirements notice

We found that 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 at the end of this report).

The practice was not assessing patients' needs and delivering care and treatment, in line with relevant published guidance, such as from the Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) Department of Health (DH) and the General Dental Council (GDC). Staff had not received Mental Capacity Act (MCA) 2005 training and did not demonstrate an awareness of their responsibilities under the Act. Patients were given health promotion advice appropriate to their individual oral health needs such as dietary advice.

Staff were supported by the practice in maintaining their continuing professional development (CPD) but some staff had not completed training in safeguarding and medical emergencies which is highly recommended by the GDC.

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations.

The patient feedback we received was very positive about the service provided by the practice. We observed that staff treated patients with dignity and respect. We found that dental care records were stored securely, and patient confidentiality was well maintained.

Summary of findings

Are services responsive to people's needs?

No action

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

Patients had good access to routine and emergency appointments at the practice. There was sufficient well maintained equipment to meet the dental needs of their patient population.

There was a complaints policy. Patients were given the opportunity to give feedback through the practice's own surveys.

Are services well-led?

Requirements notice 

We found that 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).

There was a vision for the practice that was shared with the staff. There were policies and procedures in place for monitoring various aspects of care. Risks relating to health, safety and welfare of patients and others were assessed and mitigated.

However we found improvements needed to be made in the governance arrangements and establishing an effective management structure. Clinical audits were not being undertaken appropriately and were not contributing to improvements in quality of care delivery.

Dentart

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced comprehensive inspection on 13 June 2016. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We received feedback from 16 patients. We also spoke with four members of staff. We reviewed the policies, toured the premises and examined the cleaning and decontamination of dental equipment.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had suitable processes around reporting and discussion of incidents. We saw there was a system in place for learning from incidents. There had been no incidents over the past 12 months but staff were able to explain how incidents were logged and how they have learnt from previous incidents.

There was a system in place for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). However, we found the practice manger was not able to describe the type of incidents that would need to be recorded under these requirements. There had been no RIDDOR incidents over the past 12 months. The practice manager told us they would familiarise themselves with these requirements.

Staff understood the importance of the duty of candour and the need to inform the appropriate bodies and patients effected of any relevant incidents [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity]..

Reliable safety systems and processes (including safeguarding)

There was a child and adult safeguarding policy that had last been reviewed in 2014 and was scheduled to be reviewed in 2017.The policies had the contact details of the relevant people to contact in the local safeguarding team if they had any safeguarding concerns. However there had been no safeguarding training of staff and there was no safeguarding lead. The practice manager told us that they had gone through the practice safeguarding policy with staff but no member of staff, including the practice manager, had undertaken safeguarding training. The practice manager was unable to explain an understanding of safeguarding issues. .

The practice did not have a system in place for receiving and responding to patient safety alerts issued from the Medicines and Healthcare products Regulatory Agency (MHRA). The practice manager told us that steps would be taken to put a system in place.

The practice had some safety systems in place to help ensure the safety of staff and patients. This included for example having infection control protocols and risk assessments. Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example risks associated with radiography, Health and Safety, the use of the autoclave and electrical equipment had been undertaken. However we found that the practice did not maintain a COSHH (Control of Substances Hazardous to Health, 2002 Regulations) folder. The practice manager advised us that immediate action would be taken to put a file in place.

The practice did not follow national guidelines such as use of a rubber dam for root canal treatments. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.]

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received basic life support training which included cardiopulmonary resuscitation (CPR) training. The practice had a medical emergency kit which included emergency medicines and equipment in line with Resuscitation Council UK and British National Formulary guidance. The kit contained most of the recommended medicines. However, we found that the kit did not contain Midazolam 10mg (buccal), one of the medications recommended by the Council. The principal dentist told us they would ensure the medicine was immediately purchased for the kit. We checked the medicines that were in the kit and we found that all the medicines were within their expiry date. The emergency equipment included oxygen and an automated external defibrillator (AED), in line with Resuscitation Council UK guidance. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Are services safe?

However, none of the staff had received appropriate life support training. We pointed this out to the practice manager who told us arrangements would be made for training to be carried out.

Staff recruitment

The practice did not have procedures for the safe recruitment of staff. In order to reduce the risks of employing unsuitable staff the provider is required to complete a number of checks. They must, obtain references and complete an up to date Disclosure and Barring Service (DBS) checks. We saw that the provider had satisfactorily carried out the necessary required checks for some of the staff. However, we found three of the four records checked had no evidence that a DBS or criminal records checks had been completed. We pointed this out to the practice manager and they advised that they were not aware that staff that were employed from abroad required such checks. We also found no evidence that two members of staff had been immunised against blood-borne viruses. We pointed this out to the practice manager who advised that these members of staff had kept records of this themselves. The practice manager told us they would speak to the relevant members of staff and obtain the proof that they had the appropriate vaccinations; following the inspection the evidence was sent to us.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A health and safety policy was in place. The practice had a risk management process which was updated and reviewed to ensure the safety of patients and staff members. The assessments included the controls and actions to manage risks. For example a risk assessment associated with use of equipment, radiation and electrics had been undertaken in May 2016.

Infection control

The practice had an infection control policy that outlined the procedure for issues relating to minimising the risk and spread of infections. This included details of procedures for hand hygiene, clinical waste management and personal protective equipment. The practice had followed the guidance on decontamination and infection control issued by the Department of Health namely, Health Technical Memorandum 01-05: Decontamination in primary care dental practices. The lead dental nurse was the infection control lead.

There was a clear flow from dirty to clean areas to minimise the risks of cross contamination. Staff gave a demonstration of the decontamination process which was in line with HTM 01-05 published guidance. This included carrying used instruments in a lidded box from the surgery, cleaning instruments suitably); placing in the autoclave, pouching and then date stamping.

There was a contract in place for the safe disposal of clinical waste and sharps instruments. Clinical waste was stored appropriately and in lockable bins. The bins were appropriately stored away from the public while awaiting collection.

The practice was visibly clean and tidy. There were stocks of PPE (personal protective equipment) such as gloves and aprons for both staff and patients. We saw that staff wore appropriate PPE. Hand washing solution was available.

However, we found that an appropriate Legionella risk assessment had not been completed. The practice manager had completed their own assessment but this did not include assessments that would be undertaken by an individual competent to undertake legionella risk assessments. For example it did not include a written scheme to prevent/control the risk of Legionella in the practice. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. When this was pointed out to the practice manager they advised that arrangements would be made for a specialist to undertake a legionella risk assessment. We also found that the practice had not put in place appropriate steps to control the spread of infection from the cleaning system. The practice manager told us cleaning was undertaken by a professional cleaner using equipment provided by the practice. There was one mop and bucket and the practice manager was unable to explain how different areas were suitably cleaned using the equipment provided by the practice.

Equipment and medicines

We found that Portable appliance testing (PAT) had been completed in March 2015 and a maintenance test of X-ray equipment had been carried out in 2015. (PAT is the name of a process where electrical appliances are routinely checked for safety). However, equipment used in the practice to clean and sterilise had not been maintained in accordance with the manufacturer's instructions. There were no records of maintenance checks carried out on this

equipment. The practice manager told us that checks had been undertaken by a technician in 2015 but no records of these checks had been kept. The practice manager told us that they would make arrangements for maintenance contracts to be taken out for the equipment.

Radiography (X-rays)

One of the dentists was the Radiation Protection Supervisor (RPS). An external organisation covered the role of Radiation Protection Adviser (RPA) and there were suitable arrangements in place to ensure the safety of the equipment. There were local rules relating to the use of the equipment. Evidence was seen of radiation training for some staff undertaking X-rays but there were gaps, with no evidence of training for some staff. A radiography audit had not been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we checked dental care records to confirm our findings. We did not see evidence of assessments to establish individual patient needs. Patients' needs were not assessed and care and treatment was not delivered in line with current guidance. For example none of the records checked had soft tissue and intra and extra oral examinations. We did not see evidence that an assessment of periodontal tissue were taken on a regular basis using the basic periodontal examination (BPE) tool. [The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums]. Only one of the eight records we checked had evidence of this assessment having been carried out. Some of the records did not contain evidence that medical history had been updated.

Health promotion & prevention

The practice manager told us appropriate information was given to patients for health promotion. They showed us examples of leaflets with information relating to health promotion including

Diet and smoking cessation. However, none of the records we checked had details of promotional and preventative advice given to patients.

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Staffing

The practice had an induction and training programme for staff to follow. We saw there were some opportunities that existed for staff to pursue continuing professional development (CPD). For example, we saw training had been undertaken for infection control and fire safety. However none of the staff had received recent medical emergencies or safeguarding training. Two members of staff involved in radiography had no recent radiography training.

Working with other services

Staff told us that referrals were made to NHS dentists where this was in the best interest of the patient. However, dental care records we looked at did not contain details of the referrals made and there was no evidence of information that was shared between the practice and the referring organisations.

Consent to care and treatment

Staff confirmed individual treatment options, risks and benefits and costs were discussed with each patient. The practice had consent forms for more complex procedures.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. None of the staff at the practice had received formal training on the MCA and did not demonstrate an awareness of their responsibilities under the Act.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 16 patients. All the feedback we received was positive. Staff were described as caring, friendly and kind. Patients said staff treated them with dignity and respect during consultations. We observed staff interaction with patients and saw that staff interacted well with patients, speaking to them in a respectful and considerate manner.

Involvement in decisions about care and treatment

The practice displayed information about fees in leaflets. We also saw that the practice had a website that included information about dental care and treatments, and opening times.

We spoke with the practice manager, a dentist a dental nurse and the receptionist on the day of our visit. There was a culture of promoting patient involvement in treatment planning which meant that all staff ensured patients were given clear explanations about treatment. Staff told us that treatments, costs, risks and benefits were discussed with each patient to ensure that patients understood what treatment was available so they were able to make an informed choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Staff told us there was enough time to treat patients, and that patients could generally book an appointment in good time to see a dentist. Feedback from patients confirmed that patients felt they could get appointments when they needed them. There were arrangements in place for out of hours appointments. The practice manager told us if a patient called out of hours the call would go through to a mobile where arrangements would be made for them to see one of the dentists, or they would be advised to contact NHS 111, depending on the nature of the issue.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had staff fluent in different languages. The practice manager told us that they would use a language line if they ever needed to communicate with any patients that did not speak a language spoken by the practice staff. We saw the practice was accessible for patients with mobility problems and had a toilet that was accessible for patients with mobility issues.

Access to the service

The practice was open 100.00 – 6.00pm Monday to Saturday. The practice manager told us they would also arrange for appointments outside of these hours if patients requested this.

Concerns & complaints

The practice had effective arrangements in place for handling complaints and concerns. There was a complaints policy, and information for patients about how to complain was available in the reception area. The policy had last been reviewed in November 2014 and was scheduled to be reviewed in 2017. There had been no complaints in the last year. The policy included contact details of two external organisations that patients could contact if they were not happy with the practice's response to a complaint. This included the General Dental Council and the Dental Complaints Council.

Are services well-led?

Our findings

Governance arrangements

The practice did not have good governance arrangements in place. There was no evidence that audits had taken place. For example there were no infection control, radiation or record keeping audits. Typically infection control audits are completed every six months in order to monitor the effectiveness of infection control protocols with a view to keeping staff and patients safe.

There was no COSHH Regulations (2002) file available at the time of the inspection and actions needed to minimise the risks associated with hazardous substances had not been disseminated effectively amongst staff. We spoke to the practice manager about this and were told steps would be taken to put a file in place.

Leadership, openness and transparency

Staff we spoke with said they felt the practice culture was one of openness and a place where all staff felt included.

Staff told us they were comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so. They described the culture encouraged candour, openness and honesty.

Learning and improvement

We found that the practice did not have a formalised system of learning and improvement. There was no schedule of audits at the practice and the dentist confirmed they had not undertaken any audits including on infection control, record keeping and X-rays. Staff meetings were not held and there were no formal mechanisms to share learning.

Practice seeks and acts on feedback from its patients, the public and staff

Patients had the opportunity to provide feedback through the provider's own surveys. There was also feedback from patients on the practice website. The practice manager told us that the patient feedback forms for 2015/16 would be analysed when they had a sufficient number to make an assessment and inform on potential business development areas.

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 How the regulation was not being met: • The provider had not ensured that the equipment used for providing care or treatment to a service user was safe for such use and used in a safe way. Regulation 12(1)

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 How the regulation was not being met: • The practice did not have, and implement, robust procedures and processes to ensure that people were protected from abuse and improper treatment. • Not all staff had received safeguarding training that was relevant to their role. • There was no safeguarding lead in place. Regulation 13(1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The provider did not have effective systems in place to :

- Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
- Ensure that their audit and governance systems remain effective.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • The provider did not always ensure all staff members received appropriate support, training and supervision necessary for them to carry out their duties. **Regulation 18(2) (a) (b)**

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

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

• The provider did not have an effective recruitment procedure in place to assess the suitability of staff for their role. Not all the specified information (Schedule 3) relating to persons employed at the practice was obtained.

Regulation 19 (1) (3)