Dumbledore Dental Care Limited

South Cliff Dental Group - Moulsecomb

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 08 February 2022 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 adviser.

To get to the heart of patients' experiences of care and treatment,

we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• 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:

- The dental clinic appeared to be visibly clean and well-maintained.
- The practice had infection control procedures which did not reflect published guidance.
- We were not assured staff knew how to deal with medical emergencies. Some of the appropriate medicines and life-saving equipment were available.
- The practice had some systems to help them manage risk to patients and staff.

Summary of findings

- Safeguarding processes could be improved and staff we spoke with knew their responsibilities for safeguarding vulnerable adults and children.
- The practice did not have staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff did not feel involved and supported by the company; but worked together as a team.
- The dental clinic had information governance arrangements.

Background

The provider has 27 practices and this report is about South Cliff Dental Group – Moulsecoomb.

South Cliff Dental Group - Moulsecoomb is in Brighton and provides NHS and private dental care and treatment for adults and children.

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

The dental team includes three dentists, one is the clinical lead for the South Cliff Dental Group for the Sussex area, a registered dental nurse, two trainee dental nurses, a receptionist and a practice manager. The practice has three treatment rooms.

During the inspection we spoke with a dentist, the dental nurses, the receptionist, the compliance lead for the company, the clinical lead and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

8.30am to 5pm Monday to Sunday

We identified regulations the provider was not complying with. 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.
- Ensure specified information is available regarding each person employed.

Full details of the regulations the provider is not meeting are at the end of this report.

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

Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found 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 Enforcement Actions 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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

The practice had ineffective safeguarding processes and staff were unsure of their responsibilities for safeguarding vulnerable adults and children.

The practice had information available to staff in relation to safeguarding vulnerable adults and children. However, the safeguarding lead no longer worked at the practice.

Staff had undertaken appropriate training in safeguarding vulnerable adults and children.

The practice did not have infection control procedures which reflected current published guidance

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance.

Records were not available to demonstrate that the equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment.

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

We saw the practice was visibly clean however, we noted the cleaning schedules to ensure the practice was kept clean were not always completed.

Cleaning equipment was not stored appropriately.

The practice did not have a recruitment policy and procedure in accordance with relevant Legislation.

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including agency and locum staff.

Clinical staff were qualified and registered with the General Dental Council.

We did not see professional indemnity cover for some staff.

The practice ensured the facilities were maintained in accordance with regulations.

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. The autoclaves were not subject to the checks required under the manufacturers instructions and HTM 01-05

The practice had arrangements to ensure the safety of the X-ray equipment and we saw most of the required radiation protection information was available.

Local rules did not reflect current legislation.

Are services safe?

A Radiation Protection Advisor (RPA) had been appointed, but this information had not been updated on the documents.

Risks to patients

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety. In particular relating to sharps safety and sepsis awareness.

The practice had not carried out a sharps risk assessment to help them manage risks to staff and patients.

Risks associated with sharps were not appropriately managed. For example, the infection control policy referred to the use of safer sharps. None were available in the practice and staff told us they were not used.

Some of the required emergency equipment and medicines were not available and checked in accordance with national guidance. In particular, weekly checks were not being conducted.

We found the practice did not have medicines and equipment used to manage a diabetic episode. The adrenalin had expired. There were no child size self-inflating bag or clear masks in child sizes. There was no size 0 oropharyngeal airway.

Not all staff knew how to respond to a medical emergency or had completed training in emergency resuscitation and basic life support every year. We did not see evidence of training for five of the six members of staff.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, not all of the dental materials and products used in the practice had been risk assessed.

Information to deliver safe care and treatment

The dental care records we saw were not complete or legible. In particular, two of the six records we reviewed did not have medical history information updated; two did not have a soft tissue or intra-oral check recorded. Four did not have extra oral or Temporomandibular junction checks recorded. Four did not have risk assessments for caries, oral cancer, tooth wear and periodontal condition recorded. Three did not have social history, smoking or dietary advice recorded. Two did not have recall intervals recorded. Three did not have information about consent and two did not have information regarding costs.

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 had ineffective systems for appropriate and safe handling of medicines.

Antimicrobial prescribing audits were not carried out.

We saw prescriptions were not monitored as described in current guidance.

Track record on safety, and lessons learned and improvements

The practice had systems for reviewing and investigating when things went wrong. The practice had a system for receiving and acting on safety alerts. However, both of these were ineffective. There had been an incident at the practice which staff relayed to us. Management staff had not been informed of the incident and it had not been recorded. Staff told us that the safety alerts were received by head office and sent out when the information was relevant to the practice. Staff could not tell us what alerts had been received.

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 Enforcement Actions 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. Although not all training certification was available for all the clinical staff.

Helping patients to live healthier lives

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

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives.

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.

Staff did not understand their responsibilities under the Mental Capacity Act 2005 (MCA).

Records were not available to demonstrate staff undertook training in patient consent and mental capacity.

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, we did not see, extra oral, temporomandibular joint checks, risk assessments for caries, oral cancer, tooth wear and periodontal health, social history and recall intervals in some of the records we reviewed.

There were inconsistencies in the information recorded within the dental care records we looked at. For example, two of the six records we reviewed did not have a medical history check documented.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

We saw evidence the dentists did not always justify, grade or report on the radiographs they took.

The practice had not carried out radiography audits six-monthly and therefore were not following current guidance and legislation.

Effective staffing

Evidence was not available to demonstrate some staff had the skills, knowledge and experience to carry out their roles. In particular, we did not see any information for one member of staff.

The practice did not carry out a structured induction for newly appointed staff.

Are services effective?

(for example, treatment is effective)

The practice did not have systems in place to ensure clinical staff had completed Continuing Professional Development as required for their registration with the General Dental Council. In particular, one member of staff had not completed safeguarding vulnerable adult training. Two members of staff had not completed medical emergency training.

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.

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 Enforcement Actions 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

The practice did not demonstrate a transparent and open culture in relation to people's safety. In particular, staff did not have time to complete risk assessments due to lack of staff and those staff having to cover other duties.

There was a lack of leadership and oversight at the practice. In particular, staff felt that they were not supported sufficiently and requests for issues identified to be rectified were not always responded to.

Due to the high turnover of staff systems and processes were not fully embedded.

The inspection highlighted some issues or omissions. For example, infection control was not conducted in line with current guidance. Audits did not highlight areas for improvement.

The information and evidence presented during the inspection process was disorganised and poorly documented. For example, the majority of information presented related to other practices in the group. We were told that all policies and procedures were held electronically and some staff told us they could not access these.

We saw the practice had ineffective processes to support and develop staff with additional roles and responsibilities. For example, staff did not feel supported and staff were not retained. The practice manager was responsible for two practices in the area. The managerial duties could not be completed as the lack of staff meant time was taken up covering other roles.

Culture

The practice did not demonstrate a culture of high-quality sustainable care.

Staff raised concerns and stated they didn't feel respected, supported and valued.

The practice did not have systems in place to adequately support staff.

The practice did not have arrangements for staff to discuss their training needs during annual appraisal or one to one meetings; we saw no evidence of completed staff appraisals.

There were no opportunities for staff to discuss learning needs, general wellbeing and aims for future professional development.

Governance and management

The provider had a complex management structure and staff told us roles and responsibilities were clear, however, they did not receive prompt or sufficient responses when highlighting issues or problems.

The practice manager was trying to implement necessary policies, protocols and oversee trainee staff However, staff shortages impacted on their ability to do this as they had to cover various other roles. The practice did not have effective governance and management arrangements. In particular, no auditing was conducted to highlight some of the issues we found at the inspection.

Are services well-led?

The practice had an ineffective clinical governance system in place.

The governance system included policies, protocols and procedures, however, we were not assured these were accessible to all members of staff and they were not tailored to meet the needs of the practice.

There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis.

The practice did not have clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

The practice did not use quality and operational information, for example NHS BSA performance information, surveys, audits, external body reviews to ensure and improve performance.

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

Engagement with patients, the public, staff and external partners

There was no evidence staff gathered feedback from patients, the public and external partners.

There was no evidence the practice gathered feedback from staff through meetings, surveys, and informal discussions.

Staff stated they rarely had the opportunity to offer suggestions for improvements to the service.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.

The practice had not undertaken audits of disability access, radiographs and infection prevention and control in accordance with current guidance and legislation.

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 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular, • Trainee staff did not receive sufficient support or training • Trainee staff were not placed on authorised training courses to gain qualification. • Staff did not feel supported • Staff did not receive appraisal or supervision. • staff had completed training for infection control, but this training was not embedded and infection control was not conducted in line with HTM 01-05 • two members of staff had not completed basic life support training • one member of the clinical team had not completed safeguarding vulnerable adults training • five members of staff had not completed sepsis awareness training • no staff had completed Mental Capacity Act training regulation 18 (2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

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 Regulation 12 Safe Care and Treatment Care must be provided in a safe way for service users. • Infection prevention and control measures were not being conducted in line with Health Technical Memorandum 01-05. Decontamination in primary dental care. • You were not prepared sufficiently to deal with a medical emergency should one occur at your practice due to lack of some essential equipment and medicine. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Actions identified on the fire risk assessment had not been completed • Fire safety measures had not been carried out such as maintenance and testing of the fire alarm and emergency lighting. • No fire drill had been conducted since 2019 and were not routinely part of inductions for new staff. Regulation 12 (1) (2) (a) (b) (c) (g) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Good Governance Systems or processes must be established and operated

This section is primarily information for the provider

Enforcement actions

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 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

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:
• Patient records were not complete or in line with current guidance

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:
• Evidence was not available to demonstrate some staff had the skills, knowledge and experience to carry out their roles. In particular, we did not see any information for two members of staff. Records for two members of staff were not available to review
• Staff had not had appraisal or any form of supervision Staff completed a short induction which did not include a fire drill. Other The practice did not carry out a structured induction for newly appointed staff.
• The practice did not have systems in place to ensure clinical staff had completed Continuing Professional Development as required for their registration with the General Dental Council. In particular, one member of staff had not completed safeguarding vulnerable adult training. Two members of staff had not completed medical emergency training. “staff had not been subject to an induction.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable

This section is primarily information for the provider

Enforcement actions

the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular:

• Policies and procedures were not readily available for staff to refer to as they did not know how to access the electronic file where they were stored.
• The policies on the electronic file did not apply to the practice specifically.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

• Auditing was not conducted; therefore you were unable to capture the issues we found on inspection
• There was limited and insufficient information to demonstrate effective management of significant events.

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 Regulation 19 Fit and proper persons. Recruitment procedures must be established and operated effectively. • We did not see any information relating to conduct in previous employment for the six members of staff employed at the practice • We did not see disclosure and barring checks for four members of staff • We did not see references, with the exception of one reference for one member of staff. This was from a colleague and not the persons previous employer. • We did not see Hepatitis B status information for three members of staff • We did not see indemnity information for two of the registered clinical staff • Staff were not subject to appraisal.

This section is primarily information for the provider

Enforcement actions

Regulation 19 (1) (b) (3) (a)