Seedat and Ahmed

KS Dental Sale

Inspection report

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Overall summary

We carried out this announced focused inspection on 24 January 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 provider 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 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 practice appeared to be visibly clean.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. The system for ensuring medical emergency medicines and equipment reflected recognised guidance was not effective.
- The risks associated with fire and Legionella had not been appropriately managed.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation. Improvements could be made to this process.
- The clinical staff provided patients' care and treatment in line with current guidelines.

Summary of findings

- Staff provided preventive care and supported patients to ensure better oral health.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had information governance arrangements.

Background

KS Dental Sale provides NHS and private dental care and treatment for adults and children. The service offers dental implants.

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 dental team includes six dentists, five dental nurses, three dental hygienists, five receptionists, a practice manager and an area manager. The practice has six treatment rooms. The practice was undergoing building work to add an additional three surgeries. We were told that this is due to be completed in March 2022.

During the inspection we spoke with three dentists, one dental nurses, one dental hygienist, one receptionist, the practice manager and the area manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Thursday from 9:00am to 4:00pm

Friday from 9:00am to 4:00pm

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 the provider was not meeting are at the end of this report.

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

- Implement an effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** ✓
Are services effective?	**No action** ✓
Are services well-led?	**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 provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The provider had infection control procedures which reflected published guidance. However, we noted the heavy-duty gloves were not always changed on a weekly basis.

The provider had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

The provider had some procedures to reduce the possibility of Legionella or other bacteria developing in water systems. A Legionella risk assessment had been carried out in February 2021. Not all recommendations made in the risk assessment had been actioned. The risk assessment had identified the incoming mains water supply contains lead pipework. This was deemed as being a priority one risk and required urgent action. The provider was advised to contact the local water supplier about the removal of these pipes. This had not been done. After the inspection, the provider contacted the local water supplier for advice about the lead pipework.

The provider 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 and there was an effective cleaning schedule to ensure the practice was kept clean.

The provider had a recruitment policy and procedure to help them employ suitable staff. However, we noted the service had applied for nine Disclosure and Barring Service (DBS) checks prior to the inspection. We were told by staff that this was as the current DBS checks were not available. We discussed the importance of ensuring a valid DBS check is sought at the time of commencement of employment. In addition, we noted five clinical members of staff did not have evidence of immunity to the Hepatitis B virus. After the inspection we were sent evidence of two members of staff which confirmed they were immune, however for the other members of staff there was no evidence of immunity.

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

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

The provider did not have effective fire safety management procedures. A fire risk assessment had been carried out in April 2021. Recommendations made in the risk assessment had not all been actioned. For example, the risk assessment recommended that emergency lighting be fitted as there was none; this was deemed as a medium risk recommendation and needed to be addressed within 2 months. Staff were relying on the presence of reflective signage, though no advise had been sought from a fire protection expert if this was sufficient. In addition, the risk assessment stated installation of fire-doors as a high-risk recommendation and needed to be actioned within one month. This had not been done. We were told by staff that the company who had done the fire risk assessment had given a verbal assurance that this was not required as they had a fire alarm installed. We were later sent evidence the provider had contacted a competent person about the emergency lighting and fire doors who advised this could be postponed until the building work had been completed in March 2022.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. During the inspection we noted that the X-ray machine for one surgery could be turned on and operated from outside the surgery. We discussed this with staff and the risks associated with it.

Are services safe?

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety. Including: the use of dental dam and sepsis awareness.

The system for ensuring medical emergency medicines and equipment reflected recognised guidance was not effective. We noted the aspirin was not of the dispersible variety, there were no sizes 0, 3 and 4 face masks for the self-inflating bag and there was no log of the fridge temperature where the glucagon was stored.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

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

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out annually.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. However, this was not always working effectively. We saw evidence of three instances of when dental nurses had sustained sharps injuries in the last 12 months. It was not always clear in all the cases what steps had been taken after the injury, for example, visiting another healthcare professional for blood tests. We were told that the events would be discussed at staff meetings. We were shown minutes of the staff meeting where the incidents would have been discussed. In these minutes there was no detail of the discussion.

The provider 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.

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, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

Staff understood their responsibilities under the Mental Capacity Act 2005.

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 kept detailed dental care records in line with recognised guidance.

Staff conveyed a good 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 justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation.

Effective staffing

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

Staff had a structured induction and 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.

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.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs at annual appraisals. They also discussed learning needs, general wellbeing and aims for future professional development.

Governance and management

Staff had clear responsibilities roles and systems of accountability to support good governance and management.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

Improvements could be made to the processes for assessing and managing the risks associated with the carrying out the regulated activities.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider 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

Staff involved patients, the public, staff and external partners to support the service.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The provider had systems and processes for learning continuous improvement and innovation.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access, radiographs and infection prevention and control. However, the infection prevention and control audit had not identified that the heavy-duty gloves were not changed on a weekly basis.

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 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 system for checking medical emergency medicines and equipment was not effective. • Recommendations in the fire risk assessment had not been actioned in a timely manner and advice had not been sought from a competent person as to whether the recommendations could be postponed while building works were carried out. • Recommendations in the Legionella risk assessment had not been actioned in a timely manner and advice had not been sought as to whether the recommendations could be postponed while building works were carried out. • The process for ensuring all clinical staff have evidence of immunity to the Hepatitis B virus was not effective. Regulation 17(1)