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Macrocare Dental Health

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 29 July 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 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 form the framework for the areas we look at during the inspection.

Our findings were:

- The dental clinic was visibly clean and well-maintained.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- 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 and patients were asked for feedback about the services provided.

Summary of findings

- Complaints were dealt with positively and efficiently.
- The dental clinic had information governance arrangements.
- Staff felt involved and worked as a team.
- The clinical staff generally provided patients' care and treatment in line with the current guidelines. However, improvements were needed to ensure information related to patient care was suitably recorded within the dental care records.
- The practice did not have infection control procedures which reflected published guidance.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.
- Staff knew how to deal with medical emergencies. Some of the life saving medical emergency equipment were not available, and they were not checked in accordance with the current guidelines.
- There were arrangements in place for the servicing of dental equipment. However, improvements were needed to ensure that the premises were safe.
- Improvements were needed to ensure that all recruitment checks had been carried out, including satisfactory evidence of conduct in previous employment.
- There was ineffective leadership and a lack of effective supervision of trainee dental staff.

Background

The provider has two practices and this report is about Macrocare Dental Health.

Macrocare Dental Health is in Woking, Surrey and provides NHS and private dental care and treatment for adults and children.

The practice is not accessible to people who use wheelchairs and those with pushchairs. The practice had systems in place to communicate this to new patients before booking and they signposted people with mobility issues to nearby practices. Car parking spaces are available near the practice.

The dental team includes a principal dentist, one associate dentist, two trainee dental nurses and a receptionist. They are supported by a practice manager. The practice has two treatment rooms and a joint reception and waiting area.

During the inspection we spoke with the principal dentist, the associate dentist, one trainee dental nurse, the 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 to Friday 9am to 6pm.

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.

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

- Improve the practice`s recruitment policy and procedures to ensure that the necessary recruitment checks are carried out.
- Improve staff awareness of sepsis.

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?	**Enforcement 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 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 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.

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.

The practice did not have infection control procedures which reflected the guidance in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. We observed the decontamination process demonstrated by a member of staff and identified various shortcomings.

Used dental instruments were not kept moist after use and prior to decontamination. The practice manager told us that this was because dental instruments were processed immediately after the dental procedure. However, during the time we spent at the practice, we only saw the decontamination carried out once though the dentist saw more than one patient.

Staff used washing up liquid and not a detergent specifically formulated for the manual cleaning of instruments.

The temperature of water used for scrubbing instruments was not monitored throughout the cleaning procedure to ensure it was 450C or lower.

The area in surgery 2 used for decontamination of used dental instruments did not have a second sink or a separate bowl for rinsing. We observed that instruments were not rinsed after scrubbing.

The plug in the scrubbing sink did not seal properly, allowing the water to escape. This meant that staff could not fill up the sink to the required level to fully immerse instruments. We observed that dental instruments were scrubbed under running water and not immersed in the solution. This increased the risk of producing aerosol contamination during the decontamination process.

We observed that only instruments used for extraction were dated and pouched. Other dental instruments were not dried or pouched after sterilisation but transported immediately to the treatment room where they were stored un-pouched in a cabinet until next use. Staff could not demonstrate that un-pouched instruments stored in the clinical area were reprocessed at the end of the day or that instruments stored in the non-clinical area were reprocessed after a week in line with the current guidance.

We observed that dental instruments were stored in cluttered and soiled drawers and cabinets, preventing the retrieval of dental instruments for use without contaminating other dental instruments.

Staff could not demonstrate they had systems in place to monitor when long-handled brushes used for scrubbing used instruments were replaced.

The area used in surgery 2 for the decontamination of used instruments did not have a clear dirty to clean flow and there were no designated areas for setting down dirty instruments and pouching disinfected or sterilised instruments.

We observed that staff did not wash their hands after the removal of contaminated personal protective equipment (PPE) including their mask, apron and visor following the decontamination process.

Are services safe?

Overall, we found that infection control processes were not in line with the guidance set out in HTM01-05 and were not effective to prevent the spread of infections.

There were some systems in place to prevent the risk of Legionella or other bacteria developing in the water systems. Dental Water Unit Lines (DUWLs) in surgery 1 were flushed and disinfected regularly. However, the overall procedures around the management of risk of Legionella were ineffective. The risk assessment carried out in November 2016 had a number of recommendations. These included having systems for monitoring and recording the temperature of hot and cold-water taps. However, there were no records to indicate that these recommendations had been acted upon.

A new risk assessment had been carried out on 20 July 2022. A number of recommendations, including monthly hot and cold-water temperature checks, regular flushing of infrequently used outlets, action plan to address location of flexible hoses and consideration to lagging all hot and cold domestic pipework were made. These had not yet been acted upon.

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

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These broadly reflected the relevant legislation. However,improvements were needed to ensure that all recruitment checks had been carried out, including obtaining evidence of satisfactory conduct in previous employment.

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

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. Improvements were needed to ensure the facilities were safe and maintained in accordance with regulations. The provider could not demonstrate that gas safety checks had been carried out and no gas safety certificates were available for review.

Fire extinguishers were available and serviced regularly and fire drills had been carried out. However, the overall procedures around the management of risk of fire were ineffective. The provider could not demonstrate that the fire alarm and detection system had been serviced annually or at all and there was no evidence of weekly fire alarm tests.

A fire risk assessment had been carried out on 20 July 2022. A number of recommendations had been made, including weekly fire alarm tests, escape signage checks and annual smoke detector service. These had not yet been acted upon. No previous fire risk assessment was available for review and the provider could not demonstrate that fire risk assessments had been regularly reviewed by a person with the qualifications, skills, competence and experience to do so.

Fire safety arrangements within the practice did form part of the staff induction but staff did not undertake formal fire awareness training.

The practice had some arrangements to ensure the safety of the X-ray equipment. The critical examination report for the Orthopantomogram (OPG) X-Ray unit and the calibration and dosage test for the intraoral unit in surgery 1 were available. No critical examination report was available for the recently procured intraoral unit in surgery 2. The provider told us that the tests had been carried out and they were awaiting the report. The X-ray unit in surgery 2 was otherwise not in use.

The Local Rules had not been updated since the installation of the OPG unit to specify the controlled areas in respect of the new equipment. This is not in line with the requirements of the Ionising Radiation Regulations 2017 (IRR17), which states that local rules are mandatory for any work that takes place in a controlled area and must be drafted following the consultation with the Radiation Protection Adviser (RPA).

Risks to patients

Are services safe?

The provider had health and safety policies and procedures. However, improvements were needed to the practice's risk management processes.

There were no needle guards or other protective mechanisms in place to minimise the risk of accidental needle stick injury. This is not in line with the requirement of Health and Safety (Sharp Instruments in healthcare) 2013 which states that employers must substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable, incorporating features and mechanisms to prevent or minimise the risk of accidental injury.

Sepsis prompts for staff and information posters were printed on the day of the inspection. However, we were not assured that staff would recognise signs of sepsis. The provider told us that they were not aware of the requirements around sepsis awareness. Improvements could be made to ensure that staff undertook training, so they were able to triage patients effectively.

Emergency equipment and medicines were not available as described in the Resuscitation Council UK 2021 guidelines. There was no self-inflating bag for use on a child and not all sizes of clear face masks were available. Glucagon (a medicine used to treat low blood sugar) was stored in a fridge, however the fridge temperature was not monitored.

The provider did not have effective monitoring systems in place to check the medical emergency and equipment. Staff told us that they checked the medical emergency equipment, including medicines, and the Automated External Defibrillator (AED) once a month. The national guidance recommends that resuscitation equipment is checked weekly as a minimum.

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

Information to deliver safe care and treatment

Dental care records we saw were legible, kept securely and complied with General Data Protection Regulation requirements. However, improvements were needed to ensure that dental care records were complete.

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 systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The provider told us that in the previous 12 months there had been no safety incidents. The provider told us that they had systems in place to review any 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. Improvements could be made to ensure that the staging and grading guidelines published by the British Society of Periodontology were adapted.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff obtained patients' 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 did not keep detailed dental care records in line with recognised guidance. We looked at five dental care records and found that they were missing details, such as Basic Periodontal Examination (BPE) and risk assessment.

We did not see evidence the dentist justified and graded all the radiographs they took. The practice carried out radiography audits six-monthly following current guidance and legislation.

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

Effective staffing

The provider did not have suitably competent, skilled and experienced staff. Trainee nurses were not supervised effectively to ensure that shortcomings in the infection control process were identified and improved.

Newly appointed 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 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. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

Staff gave patients clear information to help them make informed choices about their treatment.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

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. It took account of patient needs and preferences.

Staff were clear about the importance of emotional support needed by patients when delivering care.

The practice had made reasonable adjustments for patients with disabilities. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

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.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff to share learning and improve the service.

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

The principal dentist had overall responsibility for the management and clinical leadership of the practice and the practice manager was responsible for the day to day running of the service. Staff new the management arrangements within the practice.

We found that the provider had the capacity, values and commitment to deliver high quality sustainable services. However, the lack of oversight and supervision, effective risk management and adherence to published guidance in respect of infection control impacted the day to day management of the service.

Arrangements for supervision of staff were not effective in that those overseeing trainee dental nurses did not identify shortcomings in the infection control process and did not ensure that the decontamination and sterilisation of instruments were carried out in line with the current guidance.

The information and evidence presented during the inspection process was clear and well documented.

Culture

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

Arrangements for staff to discuss their training and development needs at an appraisal were ineffective. We saw that two members of staff did not have annual appraisal since 2015 and 2018. The practice manager told us that annual appraisal for the trainee dental nurses were carried out by the college they were studying however; we did not see records or evidence of this.

Governance and management

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

The practice did not have effective systems for governance in relation to the management of the service. Essential safety checks, including the gas safety check were not carried out.

Improvements were needed to the risk management processes to ensure they were effective. Essential risk assessment, including the fire and risk assessment had not been undertaken and reviewed regularly in the past and they were booked in response to the CQC inspection announcement.

On the day of inspection, a legionella risk assessment carried out In November 2016 was made available for review. Not all recommendations made in the risk assessment had been acted upon. The recommendations in the legionella risk assessment carried out on 20 July 2022 had not yet been acted upon. The provider could not demonstrate that risk assessments had been regularly carried out and reviewed to allow ongoing identification and mitigation of risks associated with bacteria building up in DUWLs.

On the day of inspection, a fire risk assessment carried out on 20 July 2022 was made available for review. The recommendations made had not yet been acted upon. We noted that no other fire risk assessment was available for review and the provider could not demonstrate that risk assessments had been regularly carried out and reviewed to allow ongoing identification and mitigation of risks associated with fire.

Are services well-led?

Appropriate and accurate information

We found that accurate and appropriate information was not always shared with staff. The provider could not demonstrate that trainee nurses were effectively supervised to ensure that they carried out infection control processes in line with the current guidelines.

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

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

The practice 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 practice had some systems and processes for learning, continuous improvement and innovation.

These included audits of disability access, radiography and infection prevention and control. However, improvements were needed to ensure that audits were robust and reflective of the service to ensure that they drive continual improvement and shortcomings in relation to the infection control process and the justification and grading of radiographs were identified.

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 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 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 provider could not demonstrate that risk assessments in relation to legionella and fire had been regularly carried out and reviewed. • Monthly hot and cold-water temperature checks had not been carried out. • The fire alarm has not been serviced in line with the manufacturer`s guidance. • There was no evidence that weekly tests of the fire alarm system had been carried out. • Emergency equipment and medicines were not available as described in the Resuscitation Council UK 2021 guidelines. • Medical emergency drugs and equipment were not checked in line with the relevant guidance. • Glucagon was stored in the fridge, but the fridge temperature was not monitored. • The Local Rules had not been updated after the installation of new X-ray equipment.

This section is primarily information for the provider

Requirement notices

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 radiography and infection control audit were not reflective of the arrangements within the service
- The medical emergency drugs and equipment were not checked regularly as per current national guidance.

The registered person had systems or processes in place that operated 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:

- Dental care records were missing details such as Basic Periodontal Examination (BPE) and risk assessment.
- Radiographs were not justified and graded.

There was additional evidence of poor governance. In particular:

- Risks related to lack of suitably competent, skilled and experienced staff had not been identified and mitigated.

Regulation 17 (1)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12 Safe care and treatment** The registered person 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: • Infection prevention and control processes were not in line with the published guidance. • Used dental instruments were not kept moist after use and prior to decontamination. • Staff used washing up liquid and not a detergent specifically formulated for the manual cleaning of instruments. • The temperature of water was not monitored throughout the cleaning procedure to ensure it was 450C or lower. • Instruments were scrubbed under running water and not immersed in the solution. • The area used for decontamination of used dental instruments did not have a second sink or a separate bowl for rinsing instruments. Instruments were not rinsed after scrubbing. • Following sterilisation, instruments were not dried and were transported immediately to the treatment room where they were stored un-pouched in a cabinet until their next use. Staff could not demonstrate that un-pouched instruments stored in the clinical area were re-processed at the end of the day in line with current national guidance. • Dental instruments were stored in soiled and cluttered drawers and cabinets, preventing the retrieval of dental instruments without contaminating other dental instruments.

This section is primarily information for the provider

Enforcement actions

- Staff did not wash their hands after the removal of contaminated Personal Protective Equipment (PPE), including her mask, apron and visor following the decontamination process.
- Staff could not demonstrate that they had systems in place to monitor how long long-handled brushes were used.
- There were no needle guards or other protective mechanisms in place to minimise the risk of accidental needle stick injury.
- The provider could not demonstrate that annual gas safety checks had been carried out

Regulation 12 (1)