Ishak Practices Ltd

Whitby Dental Care

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 16 March 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We responded to information of concern and 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 asked the following key questions:

• Is it safe?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services well-led?

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

Background

Whitby Dental Care is in Whitby, North Yorkshire and provides NHS and private dental care and treatment for adults and children.

Summary of findings

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice at local car parks for a fee.

At the time of inspection, the dental team included three dentists (one of whom was under mentorship to attain appropriate validation to work within the NHS), three chairside support staff (none of whom had commenced a dental nurse training pathway) and a receptionist. The practice has four treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Whitby Dental Care is one of the company partners.

During the inspection we spoke with two dentists, two chairside support staff and the receptionist. The registered manager and provider were also present during the inspection day. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Friday 9am – 5pm.

Our key findings were:

- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The provider had not taken into account guidance issued by Public Health England (PHE) in respect to Covid-19.
- The practice's Infection prevention and control systems and procedures were not completed in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care.
- Legionella management systems were not effectively monitored in line with Health Technical Memorandum 04-01: Safe water in healthcare premises (HTM 04-01) and the HSE HSG 274 Part 2 (2014).
- The systems in place to help staff manage risk to patients and staff were not effectively implemented or monitored for compliance, including, safer sharps handling, safety of equipment and fire safety management.
- Systems in place to maintain recruitment and training procedures and continued monitoring and oversight of associated records were not operating effectively.
- Systems for reviewing and investigating when things went wrong were not in place.
- The provider did not demonstrate a culture of continuous improvement.
- Staff did not feel involved or supported to work as a team. Staff were not confident their concerns would be heard without fear of recrimination.
- Information governance arrangements were not in place in respect to the use of CCTV.
- Effective staffing was not in place.
- We found effective leadership, governance and oversight of on-site management systems and processes were not in place.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients

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 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).

As a result of the findings of this inspection, immediate enforcement action was taken. We will report further when any enforcement action is concluded.

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

Systems to keep patients safe were not effective.

The provider had not taken into account guidance issued by Public Health England (PHE) in respect to Covid-19, namely, Covid-19: infection prevention and control dental appendix 21 January 2021 and Covid-19 related updates. For example:

- We reviewed the appointment book for all clinicians and were not assured there was appropriate fallow time in place, between patients' treatment, ('Fallow' is the term used before allowing the next patient to enter the treatment room, the room should be left in solitude for a certain period of time. It is mandatory after any Aerosol Generating Procedure (AGP) for the microorganisms in the air to have dispersed / been extracted before occupying the room again). No evidence was provided to demonstrate how fallow time was calculated.
- We were told there was insufficient clean down time for staff after an AGP procedure, after which staff remained in the treatment room to clean whilst the air was being extracted.
- We observed during the inspection day that protective clinical gowns were not donned during AGPs.
- We saw signage that stated reusable/washable protective clinical gowns would be expected to be used in the near future as opposed to the PHE recommended disposable protective clinical gowns.
- The provider could not evidence the required face mask fit test certification to confirm that all clinical staff involved in AGP procedures had adequate face protection.
- We observed staff wearing grade FFP2 face masks for AGPs and not the essential grade FFP3 face masks as recommended in the latest PHE guidance; we saw one staff member exited from an AGP area wearing a standard clinical face mask.

The practice's Infection prevention and control systems and procedures were not completed in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care (version 2, 2013). For example:

- Staff were not following recommended guidance when preparing contaminated instruments for cleaning and sterilisation.
- Heavy duty gloves were not regularly changed in line with guidance.
- Validation processes were being undertaken for the wrong equipment. No data sheet / manufacturers instruction booklet was available for clarification and no documentation has been sent to us by the provider since the inspection.
- Staff were not confident to identify the correct decontamination equipment being used and were unaware of what action to take if the autoclave sterilisation cycle failed.
- Clinical waste was left in a treatment room sink and not disposed of correctly into the clinical waste bin.
- We identified three sterilisation bags in a treatment room drawer containing clean instruments had been perforated to remove an instrument, these had not been returned to the decontamination room for repossessing.
- We reviewed the infection prevention and control audit action log; the complete audit record was not available when we asked for it and has not since been sent to us by the provider.

Are services safe?

Staff could not demonstrate they had adequate training to ensure infection prevention and control procedures were in line with HTM 01-05, these areas of concern were brought to the attention of the registered manager during the inspection.

We reviewed the practice's procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. We identified the following areas of concern:

- There was no legionella risk assessment available when we asked for it, and no responsible trained person on site to have oversight of Legionella management systems.
- There was no evidence legionella checks, and the supporting records were completed since 2020, and where temperature testing was completed over a period of 24 months, we saw only three occasions where the temperatures met the recommended temperature of 55 °C. This was not raised by staff as an area for further investigation.

We were told there was an ineffective stock rotation system in place. Staff told us they regularly ran out of stock and routinely bought some of their own stock to ensure they could continue treatment with patients. There was no responsible person to have oversight of the stock to ensure orders were processed and authorised by the provider in good time.

Staff told us they did not feel confident they could raise concerns without fear of recrimination.

We reviewed facilities and equipment to ensure they were safe, and equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. We identified the following concerns:

- We found an X-ray unit in an empty treatment room had been left switched on. Staff did not know if there was an isolation switch for this equipment. Local Rules were not visible or available to us, staff did not know where the Local Rules were kept. We brought this to the attention of the registered manager during the inspection.
- We saw the gas boiler was due to be serviced in January 2020, the provider told us this had been scheduled but no one came to complete the testing. We were told this had been rebooked. We asked to see supporting evidence and to date no information has been sent to the CQC.
- We saw a fire risk assessment completed by an external company had been undertaken in August 2020, the recommendations within the report had not been acted upon. There had been no in-house fire alarm testing or emergency lighting testing, or records of this between November 2020 and 9 March 2021. There was no lead or responsible person on site to manage fire checks and we saw no evidence to confirm staff members had been trained appropriately to undertake this role. We brought this to the attention of the registered manager during the inspection.
- We saw CCTV was in operation in the reception area, which recorded sound and images; there was no signage or a risk assessment in place to justify its use.

Risks to patients

The practice's systems to assess, monitor and manage risks to patient safety were not effective.

We looked at the practice's arrangements for safe dental care and treatment. We found staff were not following safe sharps procedures in line with the relevant safety regulations when using needles and other sharp dental items. For example:

- Staff across the practice told us, and we found unqualified and untrained staff handled and disposed of used needles and sharps.
- We found staff who were not trained or who had adequate personal risk assessments in place, where they were not immunised appropriately were dismantling used sharps, which was not in line with the practice policy.
- We were told that sharps injuries had occurred for one staff member.

When we brought this to the attention of the registered manager, we were told that the handling and disposal of sharps instruments is the responsibility of the clinician and should be known and understood by all staff.

Are services safe?

The provider did not have an effective system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked, evidence we reviewed showed the following concerns:

- No risk assessments were in place to mitigate role associated risks for any staff member.
- One staff member had undergone a course of Hepatitis B immunisations but was a low responder to the vaccine.
- Three staff members had no records of any Hepatitis B immunisations.
- One staff member had undergone a course of Hepatitis B immunisations; however, they had no conversation rate information to assess the level of immunity achieved.
- One staff member was in process of having a course of immunisations.

On the day of inspection staff carried out manual cleaning of dental instruments prior to them being sterilised. We discussed with the provider that manual cleaning carries an increased risk to staff of an injury from a sharp instrument, and staff are more at risk when they are not fully protected from the Hepatitis B vaccination process.

Staff knew how to respond to a medical emergency. Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

Effective staffing

We reviewed all staff recruitment files and established the recruitment and training procedures and continued oversight of documents was not operating effectively in line with Schedule 3 of the Health and Social Care Act 2008, for example:

- Staff recruitment files were not held securely at the practice.
- Three staff members did not have a disclosure and barring service check.
- The provider held a disclosure and barring service check completed by a previous employer for one staff member.
- Where associated risk assessments should have been undertaken to mitigate risks, these had not been completed.
- The provider could not evidence the required recruitment checks for three clinical staff members to show they were registered with the General Dental Council (GDC), and that all registrations were up to date.
- We were told that the clinical mentee had not received any mentor sessions from the appointed in-house mentor for the past two months.
- The clinician under mentorship was not working with an appropriately trained member of the dental team, contrary to GDC Standards.
- We found the chairside support staff had received insufficient oversight, mentoring and training to ensure they were suitably competent in their role prior to being enrolled on a dental nurse training pathway.
- We were told there was a high turnover of support staff at the practice leading to instability, inexperience, lack of continuity, staff anxiety and frustration.

We observed that clinical staff had professional indemnity cover.

We identified additional concerns relating to effective staffing: We saw evidence and were told of occasions where chairside support staff would work between two treatment rooms to support two dentists. A dentist had worked several sessions without chairside support and had to cancel several days of clinics due to a shortage of support staff. We were told that the dental receptionist covered chair side support to cover staff absence.

These working practises are not in line with General Dental Council Standards for the Dental Team; risk assessments were not in place when the dentist had worked without chairside support. These incidents were not raised or flagged for investigation or remedy to ensure clinicians worked safely and patients were not inconvenienced in the future.

Track record on safety, and lessons learned and improvements

We found the systems for reviewing and investigating when things went wrong were not in place.

Are services safe?

On the day of inspection, we observed and were told of instances where systems and processes were going wrong or were not being followed correctly and no action had been taken to address areas of concern. For example:

- Ineffective systems in place to ensure infection, prevention and control and Covid-19 procedures were compliant with guidance.
- Ineffective oversight of legionella, fire safety management checks and equipment servicing and maintenance.
- Ineffective processes to ensure X-ray equipment is switched off after use to prevent accidental use.
- Support staff were manually cleaning instruments without adequate protection from the Hepatitis B vaccination.
- Safe sharps systems were not being followed in line with the practice policy.

We saw no evidence that a suitably robust system was in place to ensure staff could raise their concerns and they would be addressed.

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). As a result of the findings of this inspection, immediate enforcement action was taken. We will report further when any enforcement action is concluded.

Leadership capacity and capability

We found leaders lacked the capacity to deliver high-quality, sustainable care.

Leaders understood the challenges faced by the practice but could not demonstrate to us how they were addressing them.

Leaders at all levels were not regularly visible or approachable. Staff told us they did not work closely with them to make sure they prioritised compassionate and inclusive leadership.

Culture

Staff stated they did not feel respected, supported or valued. Staff told us of a blame culture at the practice and did not feel they could raise concerns without fear of recrimination. Staff told us they felt pressured to perform and they were aware that mistakes were being made.

Governance and management

The provider and registered manager had overall responsibility for the management and leadership of the practice.

There was no day-to-day leadership, management or oversight of the practice, staff training, mentoring and support was lacking. The limited knowledge base of the staff meant it was difficult to ensure the safe running of the practice.

We found the provider had limited oversight of clinical governance. This included ensuring policies, protocols and procedures were up to date and were being followed by staff. When we asked, some staff were unaware of the location of documents available to help them in their role.

We identified that overall leadership, oversight and the management of systems and processes were not effective:

- The management and oversight of COVID-19 related protocols, updates and statutory requirements in line with PHE guidance: COVID-19: infection prevention and control dental appendix 21 January 2021.
- The oversight and management of infection prevention and control systems in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care (Version 2, 2013).
- Effective systems to ensure the safety of staff in respect to the Hepatitis B vaccination and associated risks and ensuring essential staff checks are in place in line with their role and in line with Schedule 3 of the Health and Social Care Act 2008.
- Effective oversight and management of legionella, safer sharps and fire safety management systems.
- Leadership, oversight and management of suitably qualified, competent, skilled and experienced staff working at the practice.
- Leadership, oversight and management of staff to ensure support, training, professional development and supervision was in place to enable staff to undertake their role safely and effectively.
- Effective oversight of the mentorship program to ensure the correct support and mentorship is available to clinicians to enable them to meet the requirement of their program.

Are services well-led?

- Effective oversight and management of equipment validation, maintenance and servicing to ensure these were serviceable in line with manufacturer's instructions.
- Management of systems for reviewing and investigating when things went wrong
- Oversight and management of systems to ensure quality assurance processes were in place to encourage learning and continuous improvement.
- Management and documentation to support the appropriate use of CCTV.
- Effective oversight and management of stock control and rotation at the practice.

At the time of inspection, we found there was no oversight of training and supervision in place for the chairside support staff from the dentists who are the only General Dental Council (GDC) registrants working at the practice. When this was discussed with the provider and registered manager, they could not demonstrate that all chairside support staff were suitably enrolled onto a dental nurse training pathway as required by the GDC. The chairside support staff did not have the necessary supervision they required at the practice in accordance with the GDC guidance for employers of trainees/ students and the Standards for the dental team (2013), which are designed to protect patients and the public.

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. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The 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: We found concerns with insufficient numbers of suitably qualified, competent, skilled and experienced staff working at the practice. We found insufficient support, training, professional development and supervision in pace to enable staff to undertake their role safely and effectively. During the inspection we found all dental nurses were unqualified with no oversight of training or supervision in place from the dentists who are the only General Dental Council registrants working at the practice. Staff members told us they were not aware of any responsibilities to ensure training and development was in place for dental nurses, who were waiting to enrol on a training course or to support any whom were. We were told over the past 18 months there had been over 15 unqualified dental nurses joining and leaving the practice. Dentists who were part of a mentor program shared their concerns that they were not receiving the correct support and mentorship to enable them to meet the requirement of their program. Recruitment procedures and continued oversight of documents established were not operating effectively: • Staff files were not held secure at the practice. • Staff members A, B & C did not have a disclosure barring service check and there was no associated risk assessment to mitigate any potential risk.

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Enforcement actions

- The provider held a disclosure barring service completed by a previous employer that had not been risk assessed for Staff member D.
- The provider had no evidence of staff members E, F & G to show they we in date with their registration with the General Dental Council.
- Staff member F had undergone a course of Hepatitis B vaccinations but was a low responder and no risk assessment was in place to address this.
- Staff member B, C & E had no records of any immunisations and no supporting risk assessments in place.
- Staff member D had undergone a course of immunisations however had no conversation rate information or a supporting risk assessment.
- Staff member A was in process of having a course of immunisations, there was no risk assessment in place.

We found the provider was failing to provide safe care and treatment in line with statutory requirements, considering PHE guidance and Covid-19 related updates. We observed the daybook of appointments for all surgeries covering 9 -11 March 2021 and were not assured there was appropriate fallow times in place in line with PHE guidance. When we asked the registered manager for evidence to support how they had calculated the fallow time, we were not provided with any assurance, as no supporting standing operating procedures or policies were available, and staff were not aware of how fallow times had been calculated.

We observed staff not wearing suitable personal protective equipment (PPE) to undertake aerosol generated procedures (AGPs) during our inspection. There were no fit testing certificates for staff members A, D and G. We observed staff wearing FFP2 masks for AGPs and not the essential FFP3 masks as recommended in the latest PHE guidance and we saw one staff member wearing a standard surgical mask after leaving an AGP area. It appeared no gowns were donned during AGPs. We also saw signage that states washable gowns would be used in the near future as opposed to the recommended disposable gowns, which had been provided to the practice, this is not in line with PHE guidance.

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Enforcement actions

We found appointment times were short, which could prove difficult to ensure patients' needs were fully met. When we reviewed the daybook, we found back to back 5-minute examination appointments. This posed a potential risk of harm to patients and staff as there was insufficient time to clean the surgery effectively between patients. We saw evidence and were told of times when one dental nurse was working between two surgeries to support two dentists leaving one room without a chaperone. We were also told there was minimal clean down time for staff after an AGP procedure after which staff remained in the room to clean whilst the air was being filtered, this is not in line with guidance. Staff member G did not leave the treatment room during the time we were on site and we witnessed they were undertaking AGPs.

We reviewed the arrangements to maintain infection prevention and control and found they were not in line with The Health Technical Memorandum 01-05: decontamination in primary dental care practices (HTM 01-05) published by the Department of Health and Social Care. Staff were not confident to identify the correct decontamination equipment, we had concerns they had inadequate training to ensure infection control procedures were in line with HTMO-105. Validation process were being undertaken for the wrong equipment and staff were not aware of maximum water temperature for manual cleaning if the need arose.

We found used clinical waste including gloves and a cup that had not been disposed of in surgery 2, the waste was left in the hand washing sink. We brought this to the attention of the registered manager during the inspection. Detergents required to support the decontamination of instruments was not used in line with manufactures instructions, measurement were not used. In a drawer in surgery 2 we found sterilisation bags with clean instruments that had been perforated to remove an instrument, these had not been sent to the decontamination room for repossessing. We brought this to the attention of the registered manager during the inspection.

We identified that a safer sharps system was not being followed at the practice. We found staff who were not trained or who had adequate personal risk

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assessments in place, where they were not immunised appropriately were dismantling used sharps, which was not in line with the practice policy. Dental nurses confirmed they handled and dismantled used sharps despite clinicians being aware of the correct process to follow and were responsible for dismantling used sharps. Due to this, we were told inoculation injuries had occurred for one staff member. We brought this to the attention of the registered manager during the inspection.

We found an X-ray unit in staff member 7 surgery left switched on with no isolation switch for this machine. Staff were not aware if there was an isolation switch for this equipment. Local rules were not visible or available to us within the practice, staff were unfamiliar where the local rules were kept. We brought this to the attention of the registered manager during the inspection.

We saw CCTV was in operation in the reception area of the practice, this recorded sound and images. The registered manager did not inform us if the signal of the images received were encrypted; there was no signage in the practice to state CCTV was in operation.

The registered manager could not provide a risk assessment including the necessity or proportionality of why audio was undertaken to review the justification of the CCTV and if this was in line with the Information Commissioners Office (ICO) code of practice.

We saw a fire risk assessment completed by an external company had been undertaken in August 2020, the recommendations within the report had not been acted upon. There had been no in-house fire alarm testing or emergency lighting records since November 2020 to date. There was no lead or responsible person on site to manage fire checks and we did not see evidence to support any staff member had been trained appropriately to undertake this role. We brought this to the attention of the registered manager during the inspection.

We saw the gas boiler was due to be serviced in January 2020, the registered provider told us this had

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been scheduled but no one came to complete the testing. We were told this had been rebooked, we asked to see supporting evidence and to date no information has been set to the CQC.

We were told there was ineffective stock rotation systems in place. Staff told us they regularly ran out of stock and some staff told us they routinely bought some of their own stock to ensure they could continue treatment with patients. There was no responsible person to have oversight of the stock to ensure orders were processed and authorised by the provider in good time.

There was no legionella risk assessment available when asked during the inspection. We identified areas within the Legionella management system where processes were not taking place or being completed correctly. There were no evidence Legionella records were completed since 2020., and where temperature testing was completed over a period of 24 months, we saw only three occasions where the temperatures met the recommended temperature of 55 °C, this was not raised as an area for further investigation. There was no responsible trained person on site to have oversight and management of legionella awareness and management. The impact on patient safety in respect to safe water systems at the practice is significant if legionella management is not fully understood or managed appropriately.

There was no day to day leadership or management and oversight of the practice procedures, staff training, mentoring, support Staff lacked knowledge to ensure the smooth running of the practice. We were told staff were not suitably trained to complete dental care records, including charting for the dentists as there are concerns that if charting would be wrong and if another dentist saw the patient it would be difficult for them to pick up the treatment stages. The clinicians were concerned the dental care records were not complete.

We were told of a blame culture and staff did not feel they could raise concerns to the registered manager or provider without fear of recrimination. Staff told us

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they felt pressured to perform and mistakes were being made. Staff told us they were always not treated with dignity and respect and the registered manager did not treat patients with respect.

Regulation 12(1)