Whalley Dental Limited

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 13 February 2024 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 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 practice had infection control procedures which reflected published guidance. Improvements were needed to ensure these protocols were consistently followed.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Improvements were needed to the systems for managing risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- The practice had staff recruitment procedures which reflected current legislation. Improvements were needed to ensure these protocols were consistently followed.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- The dental clinic appeared clean and well-maintained. Improvements were needed to the cleaning equipment storage arrangements.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

Whalley Dental Limited is part of Carholme Dental Group. The practice is in Whalley in Lancashire and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. The practice is located close to local transport routes and car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 3 dentists, 5 dental nurses (including 3 trainees), 1 dental therapist, 1 practice manager and a receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with 2 dentists, 2 dental nurses, and the practice manager. The team were supported by the area manager and group compliance lead. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Thursday from 9am to 5pm

Friday from 9am to 4pm

The practice is closed for lunch from 12.30pm to 1.30pm daily.

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:

Summary of findings

- Ensure staff are completing the audits for prescribing of antibiotic medicines accurately, taking into account the guidance provided by the College of General Dentistry. Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded. In addition, the practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.

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?	**No 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 providing safe care in accordance with the relevant regulations.

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 had infection control procedures which reflected published guidance. Improvements were needed to ensure staff adhered to guidance, including The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05). In particular:

- Instruments were not consistently bagged and dated.
- The detergent used as part of the manual scrubbing protocols was not diluted in accordance with the manufacturer's guidelines.
- The mercury spillage kit was beyond its use-by date.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment, which included monthly thermal control. We were shown the monthly water temperature records that indicated some of the temperatures were outside the recommended parameters for the last 4 months. Improvements were needed to ensure prompt action was taken to address any risks identified. In addition, flushing protocols had been introduced to manage low-use outlets and dead-legs. Records were not available to demonstrate the dead-legs were being flushed.

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

The practice appeared clean and cleaning schedules were in place; however, improvements were needed to the storage arrangements of the cleaning equipment to prevent bacterial growth.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. On the day of the inspection we looked at a number of staff records. Improvements were needed to ensure important checks were carried out for all staff at the point of recruitment. We were told risk assessments would be undertaken when there were delays in receiving a Disclosure and Barring Service (DBS) check. We noted from the records we were shown that these risk assessments had not been carried out.

Records were not available to demonstrate that all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus.

We noted the effectiveness of the vaccination had not been checked nor a suitable risk assessment undertaken for all clinical staff.

We were also shown staff induction records that had not been fully completed.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire safety risk assessment was last carried out in 2016. Recommendations were made in the assessment report; however, there was no evidence these had all been addressed and no interim arrangements were in place to manage the risk. We noted an internal door leading to the rear fire door did not open and close unimpeded as there was only 1

Are services safe?

functioning hinge and the risks around this had not been considered and mitigated. The leadership team confirmed they would arrange for a new risk assessment to be carried out and ensure any recommendations are actioned. In addition, we noted the last fire drill was carried out in March 2022. The practice manager confirmed they would carry out a fire evacuation drill with staff shortly after the inspection.

The practice had the required radiation protection information; however, improvements were needed in relation to the management of risks. On the day we were told that protocols were in place to manage the risk of unintentional radiation exposure in surgery 2; however, these differed from the protocols detailed in their safety information. There was no evidence the practice leadership team had sought guidance from their Radiation Protection Advisor (RPA) in relation to these safety protocols. In addition, we noted a risk was identified in relation to the orthopantomogram (OPG) during the last routine examination in January 2023. Records were not available to demonstrate action had been taken to address the risk and the leadership team were unaware if the risk had been mitigated. Immediately after the inspection the practice manager contacted the RPA to address these areas of concern.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety; however these did not operate effectively. The practice had a sharps risk assessment in place to consider the risks to staff from handling and disposing of dental sharps. There was no evidence staff had been made aware of the control measures in place and we noted on the day, staff were not consistently following the protocols. We also noted the risks to staff when working alone had not been considered and mitigated.

Emergency equipment and medicines were available and checked in accordance with national guidance.

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

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

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

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 in place; however these were not being completed accurately and would not enable the practice to identify areas of improvement.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice 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.

We saw the provision of dental implants was in accordance with national guidance.

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. They 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 patient care records in line with recognised guidance. We looked at 12 dental care records. Improvements should be made to ensure clinicians were consistently adhering to the current British Society of Periodontology (BSP) guidelines. We also noted the practice should reinforce with clinical staff the importance of ensuring any templates used are appropriately adjusted to accurately reflect the appointment, for example in relation to the current COVID protocols.

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

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance.

Effective staffing

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

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.

The practice shared patient feedback with the team. We were told this was reviewed and where suggestions had been made, appropriate action would be taken.

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

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

The dentists explained the methods they used to help patients understand their treatment options. These included for example study models and X-ray images.

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 and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments, including a hearing induction loop, reading glasses, and a ground floor surgery for patients with additional needs. An accessible toilet was not available and patients requiring accessible facilities were made aware of this when booking appointments. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

The practice displayed its opening hours and provided information on their website and social media page.

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. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines.

The practice displayed out of hours arrangements on notices at the front door and on the answerphone for those needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately. Staff discussed outcomes 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 practice staff demonstrated a transparent and open culture in relation to people's safety.

During the inspection, staff were open to discussion and feedback.

There was a lack of management oversight for some of the practice's systems and processes, and the inspection highlighted a number of issues and omissions.

Improvements should also be made to the oversight of the leadership team to ensure that the practice's systems and processes were followed and risks managed appropriately.

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

We saw the practice had processes to develop staff with additional roles and responsibilities; however, we noted more structured support and training may be required to ensure those staff members are able to carry out the extra duties appropriately.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

Staff stated they felt supported and enjoyed working at the practice.

Staff discussed their training needs during annual appraisals, during clinical discussions, practice team meetings and ongoing informal discussions. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had arrangements to ensure that overall, staff training was up-to-date and reviewed at the required intervals.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. However, there were ineffective systems to monitor these and ensure that the practice team followed all practice procedures.

We saw there were processes for managing risks, issues and performance; however, these did not always work effectively.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

Are services well-led?

Feedback from staff was obtained through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

The practice had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, antimicrobial prescribing, and infection prevention and control. Audits did not consistently contain reflective outcomes and action plans to drive improvement. The record card audit had not highlighted the areas of improvement noted on the day.

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. 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: • Systems for managing Legionella were not effective. When risks were identified, there was no evidence action had been taken. • All risks around fire safety had not been suitability considered and mitigated. Where recommendations were made, there was no evidence action had been taken. Fire drills were not carried out regularly. • Staff did not have access to accurate X-ray safety information for each surgery. • Where risks were identified during the routine testing of the OPG, there was no evidence action had been taken. • Staff did not consistently follow guidance in relation to infection prevention and control protocols. • Systems relating to the management of dental sharps had not been shared with staff and were not consistently followed. • Cleaning equipment was not stored appropriately. • The risks to staff when working alone had not been considered and mitigated. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the

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Requirement notices

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:

- DBS checks or appropriate risk assessments were not consistently carried out at the point of recruitment.
- Vaccination records were not available for all clinical staff members. The level of immunity had not been consistently checked following the completion the Hepatitis B vaccination course.

Regulation 17(1)