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Ivory Dental and Implant Clinic

Inspection Report

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Overall summary

We carried out this unannounced responsive inspection of Ivory Dental and Implant Clinic on 1 June 2017 under Section 60 of the Health and Social Care Act 2008, after receiving concerning information about the practice. 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. A CQC inspector, who was supported by a dental adviser, led the inspection.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

• 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:

Are services safe?

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

Are services effective?

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

Are services well-led?

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

Background

Ivory Dental and Implant Clinic is a small practice based in Welwyn Garden City that provides both NHS and private dentistry to patients of all ages. The dental team includes a dentist, one dental nurse, and a receptionist. The practice had been part of a partnership with Ivory Dental Clinic, until December 2016, when it separated to become its own legal entity. It continues to operate from the same premises as Ivory Dental Clinic and both practices share computer software, decontamination facilities, and a number of running costs, including utility bills. They also have a shared contract to provide NHS dental care.

Ivory Dental and Implant Clinic has two treatment rooms and is open on Tuesdays to Fridays between 9am and 5pm.

There is level access for people who use wheelchairs and those with pushchairs, ground floor treatment rooms and fully enabled toilet facilities.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we spoke with the dentist, the dental nurse and the receptionist. We looked at the practice's policies and procedures, and other records about how the service was managed.

Our key findings were:

- Feedback we reviewed from 20 of the practice's own comment cards indicated that patients rated the dental care they received highly. Responses indicated that patients found it easy to make an appointment, that they were rarely kept waiting having arrived for their appointment, and that treatment was explained well to them.
- The practice did not have access to an automated external defibrillator and the medical oxygen available on the premises was out of date.
- The practice's sharps handling procedures and protocols did not comply with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The practice's conscious sedation procedures did not follow national guidance and put patients at risk.
- Governance procedures were limited and the practice had not completed any of its own risk assessments, equipment checks or audits.

We identified regulations that were not being met and the provider must:

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This includes ensuring appropriate medical emergency equipment is available, ensuring effective recruitment procedures, implementing systems for receiving and responding to patient safety alerts, ensuring staff understand how to minimise risks associated with the use of dangerous substances, managing legionella, and ensuring robust audits of the service are completed.
- Ensure the practice's protocols for conscious sedation are appropriate giving due regard to guidelines published by the Standing Dental Advisory Committee: 'conscious sedation in the provision of dental care 2003'.

There were areas where the provider could make improvements and should:

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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 

We found that this practice was not providing safe care in accordance with the relevant regulations. We are now taking further action in relation to this provider and will report on this when it is completed. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes

Staff knew their responsibilities for protecting adults and children and the practice followed national guidance for cleaning, sterilising and storing dental instruments. However, the practice did not have access to an automated external defibrillator and the medical oxygen available on the premises was out of date. There was no system in place to receive national patients safety alerts, recruitment procedures were not robust, risk assessment was limited and the dentist did not use a safer sharps' system.

Are services effective?

Enforcement action 

We found that this practice was not providing effective care in accordance with the relevant regulations. We are now taking further action in relation to this provider and will report on this when it is completed. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes

Feedback from the practice's own comments cards indicated that patients were satisfied with the quality of their treatment. The practice had clear arrangements when patients needed to be referred to other dental or health care professionals. However, the practice did not follow guidelines published by the Standing Dental Advisory Committee: 'conscious sedation in the provision of dental care, 2003'. here was a very small staff pool, and the dentist occasionally worked without nurse assistance if agency nurses could not be found. Staff had a limited understanding of the Mental Capacity Act and how it applied to their work.

Are services well-led?

Enforcement action 

We found that this practice was not providing well-led care in accordance with the relevant regulations. We are now taking further action in relation to this provider and will report on this when it is completed. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes

Staff told us that they enjoyed their work and felt supported by the dentist. However, the breakdown in professional relationships between them, and staff at the other practice, made it a very unpleasant environment to work in.

We found a significant number of shortfalls in the three key questions we inspected, indicating that governance procedures were not robust.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff we spoke with were not aware of any policies regarding the reporting of untoward events, or any process in place to ensure learning from them was shared formally. However, we noted a recent incident where a patient had required an ambulance following their collapse had been fully written up and investigated.

There was no system in place to ensure that national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) were received or actioned. Therefore staff were unaware of recent safety alerts affecting dental practice

Although staff were not aware of their requirements under Duty of Candour legislation, they told us they followed the principles of being open and honest with patients if things went wrong.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had a generic safeguarding policy in place, although it did not contain any details of local protection agencies.

Staff spoke knowledgeably about action they would take following a sharps' injury and only the dentist handled sharps. A sharps risk assessment had not been completed for the practice. The dentist was unaware of recent legislation affecting the use of a safer sharps system and was using conventional syringes and matrix bands. We noted that the sharps box in the decontamination room was dated October 2016 and staff were unaware of the need to dispose of sharps boxes after a period of three months.

Medical emergencies

Staff had received recent training in cardiopulmonary resuscitation, and knew where emergency equipment was located. Both practices shared the medical emergency equipment and emergency medicines. However, there was some dispute between them as to ownership of the equipment and emergency drugs and who was therefore responsible for it. The dentist told us he owned half of the equipment, whilst staff at the other practice told us it was entirely theirs.

We checked the equipment and found that both oxygen cylinders were out of date, despite having been checked regularly by staff. The practice did not have its own AED and there was no adult self-inflating bag available. This was of particular concern as the practice carried out the conscious sedation of patients and therefore could not respond effectively in the event of a medical emergency.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice and those we checked were in date for safe use. We noted that Glucagon was stored in the practice's fridge, but that the fridge temperature was not monitored to ensure it operated correctly.

Staff recruitment

We checked recruitment files for two members of staff. One file contained appropriate information to ensure they had been recruited in line with regulations. The other file did not contain any references or photographic ID for the staff member, or a record of their recruitment interview to demonstrate it had been conducted fairly. There was no evidence that they had received an induction to their role.

Monitoring health & safety and responding to risks

The practice had not completed any of its own risk assessments for the service. A general practice risk assessment was available on site however, this was only in relation to the other practice (Ivory Dental Clinic), who shared the same location.

A legionella risk assessment had been completed by the other practice, however staff of this practice were not aware of its content or how legionella was being managed within the premises. We viewed some water temperature testing logs in place for the practice, but these had not been completed since January 2016. Staff were not managing dental unit water lines in line with HTM01-05 guidance.

Both the nurse and dentist were unaware of Control of Substances Hazardous to Health legislation and were not aware of data information sheets in relation to substances they used at the practice.

Are services safe?

The practice did not have a business continuity plan describing how it would deal events that could disrupt the normal running of the service.

Infection control

The practice's waiting area, toilet and staff areas were clean and uncluttered. An external cleaner had been contracted to clean the premises three times a week. However as this was organised by Ivory Dental Clinic, staff at this practice were unsure of the specific arrangements in place, or how the quality of the cleaning was monitored. The practice had not conducted any of its own infection control audits so it could assure itself it met essential quality requirements.

We checked the main treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The room had sealed work surfaces so they could be cleaned easily. Staff's uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination, although we noted that the nurse had long, painted, pink fingernails that compromised good hand hygiene. Records showed that dental staff had been immunised against Hepatitis B.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05, although staff did not wear aprons when decontaminating instruments. The decontamination facility was shared between the two practices and it was unclear who had overall responsibility for validating the equipment. Relations between staff at each practice had broken down in recent months and because of this, information from the autoclave's data logger was not being downloaded for monitoring purposes.

Equipment and medicines

The practice did not hold any records of its own equipment maintenance and servicing, relying on the practice manager of the other practice to organise all service checks. Therefore, they were not able to assure themselves that these were being conducted appropriately or their outcome.

The practice had suitable systems for prescribing and storing medicines, although the name and address of the practice was not detailed on the medicine's label as required. The dentist was not aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines.

Radiography (X-rays)

The practice did not have its own radiation protection file, and relied on the other practice do maintain all paperwork in relation to IRMER 2000 Regulations requirements. It was not clear if the health and safety executive had been informed of the recent changes in the legal entity of the practice.

There was no evidence to show that the dentist had received training for core radiological knowledge and he could not remember when he had last completed it.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Although the dentist was not fully aware of NICE and FGDP guidance, it was clear he was mostly providing treatment to patients in line with their recommendations. Patients' medical histories were clearly recorded and regularly updated. Basic periodontal examinations were carried out for patients and those with high risks were referred appropriately to a hygienist. Dental records contained evidence that the dentist had justified, graded and reported on the X-rays he took. However, it was not always clear that appropriate dental risk assessments had been completed on examination and when completed by the dentist clinical records were not always clear or legible

The practice carried out conscious sedation for some patients undergoing implant treatment and a visiting oral surgeon completed both surgery and sedation. We viewed the notes in relation to two procedures completed in 2016. We noted a number of shortfalls in the records which indicated that guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists were not being followed. For example;

- The dentist in this practice appeared to have no knowledge of current guidelines in relation to the conscious sedation of patients.
- There was no evidence to show that the assisting nurse had received appropriate training in conscious sedation or implants.
- The patient's assessment and consent appeared to be on the same day as the sedation procedure.
- There was no evidence of immediate life support training or equivalent for staff in the sedation team. The practice did not have an AED and oxygen cylinders were out of date.
- There was no record of a patient assessment prior to the procedure.
- There was no evidence that the patient's pre, during and post-operative blood pressure, oxygen saturation levels and pulse had been recorded and monitored. There were no notes on the patient's recovery.
- There was no evidence that the patient received written pre and post sedation instructions or that the patient's escort was given written instructions.
- There was no separate area for patient recovery and no assessment had been completed for access by ambulance staff in the case of an emergency.
- The practice did not hold any information about the visiting oral surgeon such as his qualifications, training, GDC registration or indemnity cover.

Health promotion & prevention

A hygienist was available at the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease. The dentist told us he regularly discussed smoking cessation and alcohol consumption with patients, which the nurse confirmed.

Staff were not aware of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention', although the dentist was providing treatment to patients in line with its recommendations.

Staffing

The staff team was small, consisting of just the dentist, one nurse and a receptionist. The dentist relied on locum dental nurses to cover any staff absences and we were told had worked without any nurse support on occasion.

It was not clear if appropriate employer's liability was in place at the practice, as the certificate on display only covered staff for the other practice based at the same site.

Working with other services

Staff confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure a specialist saw patients quickly.

Consent to care and treatment

The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. However it was not always possible to tell what had been discussed with patients from the dental care records we reviewed

Are services effective?

(for example, treatment is effective)

Staff had a limited understanding of the Mental Capacity Act and Gillick guidelines and could not evidence any training in them to ensure they knew how to manger patients who could not make decisions for themselves.

Are services well-led?

Our findings

Governance arrangements

The practice had purchased a quality compliance system, consisting of three folders of generic policies and practice risk assessments. However, none of these had been made specific to the practice and there was no evidence that staff had actually read the policies or implemented any of the protocols.

Governance systems that that had been in place under the previous partnership, had not been implemented for this practice now they had separated. The practice had not completed any of its own risk assessments, audits or equipment servicing checks and it did not have employer's liability insurance in place. We were told that professional relationships with staff at the other practice had completely broken down to the extent that staff now refused to communicate with one another. As a result, the other practice no longer shared essential governance documentation and paperwork for the premises with them.

The practice did not hold any formal recorded staff meetings, although they met informally and staff told us that communication between them was good. Staff told us they felt supported by the dentist but found the difficult relations with staff at the other practice upsetting and very stressful. Staff from both practices told us that patients had picked up on the hostility between them.

Practice seeks and acts on feedback from its patients, the public and staff

The practice used comment cards to obtain patients' views about the service. We viewed twenty completed cards and noted that all respondents had rated the practice and its staff highly.

There was no information available about the practice's complaints procedure in the waiting area or practice's website, to ensure that patients knew how to raise their concerns.