Orion Dental Ltd

Park Dental Studio

Inspection report

9 Algitha Road
Skegness
PE25 2AG
Tel: 01754764700

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Overall summary

We carried out this announced focused inspection on 29 June 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 usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

- The dental clinic was visibly dirty, was not well-maintained. Cleaning procedures were not effective.
- The practice infection control procedures where ineffective and did not reflect published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were not available. In particular; clear face masks for self-inflating bag all sizes from 0 to 4 were missing. There was no size 0 oropharyngeal airway. There was no spacer device for the asthma medication. Both the midazolam (a medication that is commonly used as emergency treatment for seizures) and the Epi pen (a medication that can help decrease the body's allergic reaction) were past their expiry date..
- The practice systems to manage risk to patients and staff were not robust or effective.
- There were safeguarding processes in place. However, not all staff had received training in, or could demonstrate an understanding of their responsibilities for, safeguarding vulnerable adults and children.
- The practice staff recruitment procedures did not reflect current legislation.

Summary of findings

- Clinical staff did not always provide or record patients' care and treatment in line with current guidelines.
- We did not see evidence that staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership was not effective and did not demonstrate a commitment to developing a culture of continuous improvement.
- Staff and patients were asked for feedback about the services provided.
- Complaints were not dealt with positively, efficiently or in an open manner. The provider and staff did not have an understanding of or commitment to Duty of Candour.

Background

The provider has one practice under this registration and this report is about Park Dental Studio.

Park Dental Studio is in Skegness, Lincolnshire and provides NHS and private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice. The practice has made some reasonable adjustments to support patients with additional needs.

The dental team includes three dentists, three trainee dental nurses, one dental hygienist, one dental therapist, a practice manager and two receptionists. The practice has four treatment rooms.

During the inspection we spoke with two dentists, two dental nurses, one receptionist, the practice manager and a manager from the providers other location, which is registered under a different name. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday from 8am to 6.30pm.

Tuesday from 8am to 8pm.

Wednesday from 8am to 6.30pm.

Thursday from 8am to 6.30pm.

Friday from 8am to 8pm.

Saturday from 9am to 12:30pm.

Sunday from 9am to 1pm (every other week).

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

Ensure care and treatment is provided in a safe way for service users.

Summary of findings

Ensure standards of hygiene appropriate for the purposes for which the premises were being used are in place.

Ensure that all premises used by the service were properly maintained

Ensure systems and processes that enable the registered person to assess, monitor and improve the quality and safety of the services being provided are in place.

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 effective?	**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). 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 in place. We found that not all staff were aware of their responsibilities for safeguarding vulnerable adults and children. We noted that not all staff had undertaken appropriate training in safeguarding vulnerable adults and children. Two of the three dentists had not completed relevant training for more than three years.

The practice did not have infection control procedures which reflected current published guidance.

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. We identified multiple, rusty, tarnished and visibly dirty instruments prepared and ready for use in all treatment rooms. We noted that some instruments were kept in an open box in the decontamination room rather than sterile pouches and taken for use in treatment rooms. Staff we spoke with were unaware of who the lead for infection control and decontamination was. This was of particular concern as all of the nurses employed at the service are trainees who are not registered with the GDC.

Training records we viewed showed that three of the eight clinical staff had not completed training in infection prevention and control as recommended.

Records were not available to demonstrate that the equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. Staff were not aware of the processes used to ensure all decontamination cycles were completed successfully and could not demonstrate the correct programme cycle used to ensure effective decontamination of instruments.

Hand washing facilities were not adequate as soap and towel dispensers were placed away from sinks and waste bins.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment.

The practice did not have policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Clinical waste bags were not marked in a way that would identify the practice if required. Clinical waste bins were not kept locked or secured to prevent unauthorised use. The area where clinical waste bins were stored was very dirty with evidence of vermin infestation on and around the bins. We observed staff entering and leaving this area to dispose of waste without using appropriate personal protective equipment and then immediately return to clinical areas. This posed an increased risk of spread of infection to people using the service.

We observed the practice was not visibly clean and systems were not in place to ensure the practice was kept clean. We noted visibly dirty floors and work tops in all clinical areas along with used chewing gum stuck to the stair bannister and visibly dirty communal areas. We observed a large pigeon's nest outside treatment room three. This had resulted in the window of this room and the room below being covered in pigeon excrement. We saw that the blind of this room was covered in thick grey dust and that the interior of the window and window sills where covered in an unidentified substance. Further, the floor fan in this room was also covered in a very thick layer of dust and we noted items on the floor had not been moved during cleaning leading to a build up of dirt and grime. We noted that none of the floors in clinical areas were sealed in a manner which aided effective cleaning.

Are services safe?

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including agency and locum staff. Valid references to confirm satisfactory conduct in previous employment were not available for all staff.

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

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. Evidence of regular maintenance of the autoclave was not available.

The practice did not ensure the facilities were maintained in accordance with regulations. Guidance for monitoring from an asbestos risk assessment completed in 2014 had never been carried out. The practice did not have a valid fixed wiring electrical safety certificate. An unsatisfactory certificate obtained in July 2021 identified multiple defects including one rated as, C1 Risk to life. The provider had not taken any action to remedy this severe risk thereby exposing all people using the service to serious risk of harm from electrocution.

The practice did not have arrangements to ensure the safety of the X-ray equipment. We noted that two versions of local rules were displayed in treatment rooms including names of staff who no longer worked at the service. Rectangular collimators, used to direct the beam of radiation and prevent unnecessary exposure to patients, were not available. Evidence of completion of required continuous professional development in radiography was not available for any staff.

Risks to patients

The practice had systems to assess, monitor and manage risks to patient and staff safety, however we found that these were not implemented, and assessments had not been completed.

In particular we noted that the practice had opened documents for, but not carried out, a range of risk assessment to help them manage risks to staff and patients including, asbestos, general health and safety, security, data protection, first aid, lone working and manual handling.

Staff did not demonstrate an awareness of the warning signs of sepsis.

Fire risk assessments and monitoring were not effective. We were not provided with contemporaneous evidence of weekly fire alarm monitoring checks for the practice. We noted that fireproof doors were not maintained, we noted the smoke proof seals were in a poor state of repair. Not all staff had completed fire safety training in the past 12 months.

Emergency equipment and medicines were not available. In particular; clear face masks for self-inflating bag all sizes from 0 to 4 were missing. There was no size 0 oropharyngeal airway. There was no spacer device for the asthma medication. Both the midazolam (a medication that is commonly used as emergency treatment for seizures) and the Epi pen (a medication that can help decrease the body's allergic reaction) were past their expiry date. There were no scissors, razors or gloves available with the Defibrillator. Checks of these were not undertaken in accordance with national guidance. There were no logs retained to monitor the availability or condition of this equipment or the emergency medicines.

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

The dental care records we saw were not complete or legible. In particular, clinical records lacked consistency across clinicians and did not always reflect GDC guidance principle 4. X-rays were not always graded and justified, Basic Periodontal Examination (BPE) was not always recorded. New periodontal guidelines were not used despite a poster displayed in surgery 3. Not all staff were carrying out BPE on children aged 7 and up. Patients medical history was not

always recorded or updated. X-rays were not always taken when clinically necessary. Options for treatment and cost were not always discussed or recorded. Post-operative instruction was not always given following extraction. Use of local anaesthetic was not always recorded. We found that pre-treatment assessments were not robust. For example, x-rays were not always taken prior to bridge placement.

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 did not have systems for appropriate and safe handling of medicines.

Antimicrobial prescribing audits were not carried out. Numerous out of date dental materials and medicines were available and ready for use in treatment rooms. The provider did not display any awareness or understanding of the yellow card medicines information system or its relevance.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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). We will be following up on our concerns to ensure they have been put right by the provider.

Effective needs assessment, care and treatment

The practice did not have systems in place to ensure dental professionals were up to date with current evidence-based practice. In particular, we noted that evidence of completion of Continuing Professional Development (CPD) in radiography, implantology and infection control and decontamination was not available.

The practice could not assure us that the performing clinician had undergone training in the provision of dental implants.

Helping patients to live healthier lives

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

Consent to care and treatment

Dental care records we looked at showed there was a lack of consistency in staff obtaining patient's consent to care and treatment.

Staff did not demonstrate an effective understanding of their responsibilities under the Mental Capacity Act 2005 (MCA).

Records were not available to demonstrate staff undertook training in patient consent and mental capacity.

Staff were unable to describe how they involved patients' relatives or carers when appropriate and did not ensure they had enough time to explain treatment options clearly. In particular evidence to confirm that treatment options, including costs and possible side effects were not always recorded.

Monitoring care and treatment

There were inconsistencies in the information recorded within the dental care records we looked at. For example, clinical justification for patients being refused NHS funding and obliged to access private treatment was not recorded. Staff and clinicians we spoke with could not provide evidence or justification to say why NHS funded treatment was withheld.

Evidence was not available to demonstrate that all dentists justified, graded and reported on the radiographs they took.

The practice had not carried out radiography audits six-monthly following current guidance and legislation.

Complaints received were not monitored or reviewed to identify themes and trends. We reviewed complaints and information received prior to our inspection that indicated concerns with communication, consent to treatment plans and quality of treatment provided. On the day of our inspection we identified a further four complaints which the provider had not shared with us that further confirmed these themes, trends and concerns.

Effective staffing

Evidence was not available to demonstrate staff had the skills, knowledge and experience to carry out their roles. In particular evidence of completion of satisfactory training in implantology for the lead dentist carrying out implants, was not available. None of the nursing staff had completed their training period and gained registration with the General Dental Council (GDC).

Are services effective?

(for example, treatment is effective)

The practice did not have systems in place to ensure clinical staff had completed CPD as required for their registration with the GDC. We did not see evidence that confirmed newly appointed staff had completed a structured induction period.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the 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.

Leadership capacity and capability

The practice, provider and senior leadership team did not demonstrate a transparent and open culture in relation to people's safety. In particular, we found evidence that some information presented during our inspection was not an accurate record of events and other documentation was brought from the providers other practice in a coordinated and determined attempt to deceive our inspection team.

There was a lack of leadership and oversight at the practice. In particular, the practice manager had only been in post for three weeks at the time of our inspection and had not been able to implement robust governance and oversight systems. The provider was on site one day per week and did not provide effective monitoring of the service or support any leadership to the staff team.

The inspection highlighted some issues or omissions. For example, daily check lists for cleaning, decontamination and fire safety were not present or not an accurate reflection of events. Pre employment recruitment checks were not always completed.

Culture

The practice did not demonstrate a culture of high-quality sustainable care.

Staff raised concerns and stated they didn't feel respected, supported and valued.

The practice did not have systems in place to adequately support staff.

The practice did not have arrangements for staff to discuss their training needs or performance issues. We did not see evidence that annual appraisals, one to one meetings or clinical supervision meetings were held.

There were limited opportunities for staff to discuss learning needs, general wellbeing and aims for future professional development.

Governance and management

The practice did not have effective governance and management arrangements. In particular;

The practice had an ineffective clinical governance system in place.

The governance system included policies, protocols and procedures however we were not assured these were accessible to all members of staff.

There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis.

The practice did not have clear and effective processes for managing risks, issues and performance. For example, asbestos, fire, lone worker and electrical safety risks were not effectively assessed or mitigated against. A lack of formal supervision or appraisal meetings and irregular staff meetings meant the provider did not have a process for gathering feedback from or monitoring performance of staff. Complaints were not reviewed, and trends and themes were not analysed.

Appropriate and accurate information

Are services well-led?

The practice did not use quality and operational information, for example surveys, audits or external body reviews to ensure and improve performance.

Engagement with patients, the public, staff and external partners

There was no evidence staff gathered feedback from patients, the public and external partners.

There was no evidence the practice gathered feedback from staff through meetings, surveys, and informal discussions.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.

The practice had not undertaken audits of disability access, radiographs, antimicrobial prescribing and infection prevention and control in accordance with current guidance and legislation.

There was no evidence staff kept records of the results of these audits and any resulting action plans and improvements.

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 Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • Assessment to manage and mitigate risks to staff and patients including, asbestos, general health and safety, security, data protection, first aid, lone worker and manual handling, were not carried out. 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: • The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. We identified ,multiple stained, tarnished and dirty instruments that had been through the decontamination process prepared and ready for use. • Infection prevention and control processes were not effective. Clinical and communal areas were visibly dirty. Vermin infestation and associated waste had not been addressed. • Medical emergency equipment was not available as recommended.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had failed to ensure that all premises used by the service were properly maintained. In particular:

This section is primarily information for the provider

Enforcement actions

- A satisfactory fixed wire electrical system safety certificate had not been obtained. An unsatisfactory certificate indicating defects that posed immediate risk to life risk had not been addressed or issues rectified.
- The provider had not implemented recommendations from the practice's Asbestos risk assessment to carry out six monthly checks on the condition of areas of the building that may be contaminated with asbestos.

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 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 • Audits were not completed in recommended timescales and action plans not developed from these. • Records of activities to assure risk monitoring tasks were undertaken were not a complete or accurate record of events. • A process to monitor and respond to complaints or accidents and incidents was not in place.