Yourdentist (Lancaster) Limited

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Inspection report

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Date of inspection visit: 10 May 2022
Date of publication: 07/06/2022

Overall summary

We carried out this announced focused inspection on 10 May 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 clean and well-maintained.
- Some infection control procedures did not follow published guidance.
- Some staff could not fully demonstrate how they would deal with medical emergencies. All appropriate medicines were available for use in an emergency, but all items of life-saving equipment, as listed in recognised guidance, were not available.

Summary of findings

- The practice had systems to help them manage risk to patients and staff; our findings were that these were not always maintained and followed.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected current legislation; these were not always followed.
- The clinical staff provided patients' care and treatment in line with current guidelines; some of the safety steps in patient treatment, were not observed and followed.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership lacked impact.
- The dental clinic had information governance arrangements, which meant patient information remained confidential.

Background

YourDentist (Lancaster) Limited is in Lancaster and provides private dental care and treatment for adults and children.

The entrance to the practice is via a set of stairs; there is no level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice in pay and display car parks.

The dental team includes the principal dentist, two dental nurses, one of whom no longer carries out dental nursing, and a dental therapist. The practice has two treatment rooms.

During the inspection we spoke with the principal dentist, the two dental nurses and the dental therapist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: 9am to 5.30pm Monday to Friday.

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

- Care and treatment must be provided in a safe way for service users.
- 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

Full details of the regulations the provider is not meeting are at the end of this report.

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?	**Requirements notice**
Are services well-led?	**Requirements notice**

Are services safe?

Our findings

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

We have told the provider to take action (see full details of this action in the Requirement Notices and Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice had infection control procedures in-place; in some areas, for example, the decontamination of instruments, did not reflect recognised guidance. The washer disinfector used for cleaning dental instruments had been removed as it was broken. There were no plans in place to replace this piece of equipment. As a result, staff were cleaning dental instruments manually, which is acceptable if relevant guidance is followed. The system in place for the manual cleaning of dental instruments did not reflect recognised guidance.

Infection control audit carried out by the practice staff, had not identified shortfalls in this area. We also observed transport of dental instruments between the dental treatment rooms and the decontamination room, and from the decontamination room to the dental treatment rooms, was carried out using trays from the autoclave, rather than a safe, lockable box.

Audit also failed to prompt checks on the levels of immunity to Hepatitis B of those staff carrying out decontamination work. The audit also failed to prompt the practice to put risk assessments in place for staff whose level of immunity to Hepatitis B had not been confirmed.

The practice had introduced additional procedures in relation to COVID-19; at the time of this inspection, these were in accordance with published guidance.

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

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

The practice had a recruitment policy and procedure to help them employ suitable staff; this was not adhered to. For example, the provider did not take up evidence of staff levels of immunity to Hepatitis B and did not hold these records on file. There were no recruitment records held in respect of the principal dentist, for example, evidence of Hepatitis B immunity. From records that were available, we could confirm that clinical staff were qualified and registered with the General Dental Council. The principal dentist could not show evidence of professional indemnity cover, as documents required to be held and produced for inspection, were not available to us on the inspection day.

The practice ensured equipment was safe to use; for example, the practice autoclave and dental chairs. We observed that X-ray equipment had been serviced in the days before our inspection, but the safety report was not available for use to review. We observed that the frequency of servicing and testing was not in line with guidance. The required radiation protection information was available for staff taking X-rays.

The gas safety check for the practice was last carried out in October 2020. This check is due annually.

Are services safe?

A fire risk assessment was carried out in line with the legal requirements and the management of fire safety was effective. Safety checks on the electrical wiring installation and on portable appliances at the practice had been carried out as required.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety. We observed staff had not been trained in Sepsis awareness; there were no Sepsis awareness prompts and posters in the practice.

Emergency equipment was not available, as described in national guidance. Items missing included clear face masks for adults and children in all sizes; a self- inflating bag for use on a child; a spacer for a salbutamol inhaler. We also noted syringes to be used for delivery of adrenaline in the case of anaphylaxis were out of date; when staff were asked if they knew the dose of adrenaline to draw up and administer to a child and adult patient, they were unable to tell the inspection team. Staff were asked if they knew the correct amount of oxygen to administer to a patient in an emergency; staff were unable to provide this information. Although training on medical emergencies and basic life support had been undertaken within the past 12 months, the training did not appear to have been effective.

There was no risk assessment in place for staff member YDL 0 who confirmed they often worked alone, without the support of a chairside dental nurse, contrary to the General Dental Council 'Standards for the Dental Team.' The principal dentist used Sodium hypochlorite to irrigate during root canal treatments, without the use of a rubber dam safety device.

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

Information to deliver safe care and treatment

Dental care records were hand-written; when we reviewed a sample of patients' dental care records, we found these were not complete and did not meet the recognised standard 'General Dental Council Standards for the Dental Team'. They were compiled on blank sheets of paper and did not follow a template with prompts for required information at each patient consultation. Detail missing in each set of records we reviewed included:

- Justification for taking of X-rays;
- Grading of X-rays;
- Detail of referrals for treatment between the principal dentist and practice hygiene therapist.
- Justification or explanation for prescribing of antibiotics;
- Statement on use of rubber dam or other patient safety device and if applicable, refusal of the safety device by the patient.
- Record of checks on soft tissues;
- Record of basic periodontal examination or scoring;
- Intra-oral or extra-oral examination notes;
- Record of examination – no comment on tooth wear or gum disease examination.
- Record of anaesthetic use. To provide a double check on the recording of use of anaesthetic, we checked a recent emergency case and found that the use of anaesthetic in that case had not been recorded.

We did find the practice kept patient dental records 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. Staff could demonstrate how they tracked and checked on referrals made.

Safe and appropriate use of medicines

Are services safe?

The practice had systems for safe handling of medicines; however, the labelling of medicines dispensed by the practice to patients did not meet required standards. Antimicrobial prescribing audits were not carried out to support antimicrobial stewardship.

Track record on safety, and lessons learned and improvements

The practice had systems for reviewing and investigating incidents and accidents. As there were no significant events reported or recorded, we were unable to check the effectiveness of this process. The practice did not have had a system for receiving and acting on safety alerts. These were not received to an email address in the practice, or one that staff could access. When we asked staff about alerts from the Medicines and Healthcare Products Regulation Agency (MHRA) staff did not know what these were. Staff we spoke with confirmed that other alerts or clinical updates, for example from the National Institute of Health and Care Excellence (NICE) were not received and shared between the practice team.

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 Requirement Notices and 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 effective systems in place to keep dental professionals up to date with current evidence-based practice. Staff could not demonstrate how they received, shared and discussed updates to clinical practice. There was a lack of clinical audit at the practice, so learning from this could not be evidenced.

Consent to care and treatment

Staff told us they obtained patients' consent to care and treatment in line with legislation and guidance. Evidence provided during the inspection in relation to patient consent, did not reflect recognised guidance provided by 'General Dental Council Standards for the Dental Team'. We were shown patient records which the principal dentist considered to be patient consent. The paperwork we reviewed in clinical records did not have patient consent recorded. The information contained in these records was related solely to costs of treatment.

Staff demonstrated an understanding of 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. However, records of patient

consent were not kept, and there were no records of treatment options offered and the risks and benefits of each option for each patient.

Monitoring care and treatment

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

We saw no evidence that the principal dentist justified, graded and reported on the radiographs they took. There was no radiography audit in place in accordance with current guidance and legislation.

Effective staffing

Staff did not fully demonstrate they had the skills, knowledge and experience to carry out their roles. From the evidence presented on the inspection day, and in documents supplied ahead of inspection, we found that there were gaps in knowledge, and that training undertaken had not been effective in delivering the learning needed by all staff.

Newly appointed staff had a structured induction; evidence provided stated that clinical staff completed continuing professional development required for their registration with the General Dental Council (GDC). However, our inspection showed that there were gaps in knowledge and understanding of, for example, the consent process, standards of record keeping in line with GDC standards, delivery of medicines in an emergency and conducting effective audit to drive improvement.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver care and treatment. The dentist 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 Requirement Notices and 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

Leadership was present but required greater emphasis on continually striving to improve and on providing oversight.

Systems and processes were not embedded and there were gaps in knowledge for all staff we spoke with.

Information and evidence presented during the inspection process did not satisfy or fully answer the three key questions we inspected against.

We saw the practice did not have effective processes to support and develop staff with their roles and responsibilities. For example, there was no oversight of infection control audit results, to check that the audit had been completed correctly. As a result of this, it was not identified that the process in place for decontamination of dental instruments, did not follow recognised guidance. There was no system in place to indicate which audits are highly recommended or mandatory. For example, there was no audit of X-ray imaging and no audit of antibiotic prescribing.

Culture

The practice was patient focussed; staff retention meant staff knew their patients well.

The practice had arrangements to ensure staff training was up-to-date and reviewed at the required intervals. However, evidence from this inspection identified gaps in staff knowledge, across several subjects. No evaluation of the effectiveness of training had been undertaken by the practice.

Governance and management

Staff understood their responsibilities and roles. Evidence from this inspection demonstrated that systems of accountability to support good governance and management, were not effective, and not always followed or sufficiently embedded

The practice had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. These were reviewed on a regular basis, but did not offer the correct prompts to staff, for example, for timely audit of particular areas of the practice, for prompting of required Health and Safety checks, for example on gas safety, and timely mechanical testing and servicing of X-ray equipment. Systems and processes in place did not offer effective management of risks, issues and performance.

Appropriate and accurate information

Staff were not always accessing appropriate and accurate information, for example, they did not have access to updates in NICE guidance and were not aware of the MHRA or their alerts.

Engagement with patients, the public, staff and external partners

The staff did not carry out any patient satisfaction surveys. When we made checks on-line, we saw there had been five positive on-line reviews from patients, submitted over a five-year period. There were no staff surveys completed; staff told us they were happy to discuss anything with the principal dentist as it was a small practice with limited staff numbers meaning direct communication was easy.

Continuous improvement and innovation

Are services well-led?

The practice did not have systems and processes for learning, continuous improvement and innovation. There was a lack of audit in all areas other than infection prevention and control. However, the audit we reviewed for infection prevention and control, had failed to highlight some of the issues we found on this inspection. There was no system of clinical supervision, for example, between the principal dentist and dental hygiene therapist. There was no patient record card audit.

The systems and processes we inspected and interrogated, did not support governance and did not promote continuous improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 Good governance** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the Regulation was not being met The registered person had systems or processes in place that 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: Patient records created and maintained were not in line with recognised guidance 'General Dental Council Standards for the Dental Team'. Information missing from these records, included: • justification for taking of X-rays; • grading of X-rays; • information on referrals for treatment between the principal dentist and staff member YDL 0; • justification or explanation for prescribing of antibiotics; • statement on use of rubber dam or other patient safety device and if applicable, refusal of the safety device by the patient. • record of checks on soft tissues; • record of basic periodontal examination or scoring; • intra-oral or extra-oral examination notes; • record of examination; • tooth wear or gum disease examination and notes; • record of anaesthetic use.

This section is primarily information for the provider

Requirement notices

All information in relation to patient consent to treatment was missing from patients' dental records. Paperwork we reviewed related purely to costs of treatment. Essential areas of the consent process that were missing included the patients' treatment options and the risks and benefits of treatment.

There were no systems or processes to assess, monitor and improve the quality and safety of services. There was no audit of X-ray, as required by The Ionising Radiation Regulations 2017 (IRR17). There was no audit of patient records and no audit of antibiotic prescribing. In the case of infection control audit, this was not effective. It had failed to highlight that checks on staff immunity to Hepatitis B had not been performed, and the process for decontamination of dental instruments by manual cleaning did not follow recognised guidance.

Systems for checks on emergency medicines and equipment were ineffective; staff did not have a list of required items, as referred to in recognised guidance, to make checks against; staff did not have knowledge or sight of the recognised guidance.

Systems and processes for identifying training and evaluation of benefits of training and continuing professional development for staff were ineffective. The training matrix completed by the principal dentist immediately before inspection listed areas staff had received training in recently, including on basic life support and in medical emergencies. Findings from inspection demonstrated that staff knowledge in this area was insufficient.

Systems in place to ensure accurate, complete and contemporaneous patient clinical records were ineffective. Records reviewed as part of the inspection were not maintained in line with the recognised guidance 'General Dental Council Standards for the Dental Team'.

Systems and processes in place failed to ensure that medicines dispensed by the principal dentist, were labelled as required, in line with Schedule 25 of the Human Medicines Regulations 2012.

This section is primarily information for the provider

Requirement notices

There was no system in place to ensure medical alerts and updates, and updates on clinical treatment protocols were received at the practice and shared and discussed with staff. We asked staff members about their access to and sight of Medicines and Healthcare Products Regulatory Agency (MHRA) and about updates from the National Institute of Health and Care Excellence (NICE). Staff members YDL 1 and YDL 2 confirmed they did not receive or discuss these and told us they did not know who or what the MHRA is.

The systems and processes for referral of patients from the principal dentist to staff member YDL 0 were ineffective. There was no record within patient clinical records, of treatment required by the dental hygienist. The patient notes made by staff member YDL 0 on treatment provided in patient clinical records, did not reflect recognised guidance 'General Dental Council Standards for the Dental Team'. The lack of clinical record audit by the principal dentist, meant that this had not been identified.

Systems and processes for the management, servicing and periodic checking of radiography equipment were ineffective. There was no system of periodic checks in place or documenting of these. Systems to identify the point in time when professional maintenance and functional testing was due for this equipment, was ineffective. The time period between professional mechanical testing and maintenance of this equipment, which we established at inspection, was four years, which is beyond the period recommended.

Systems and processes in place to prompt timely safety checks, were ineffective. The gas safety check for the premises was last conducted in October 2020; this safety check is required annually.

When reviewing systems and processes to support staff recruitment and holding of recruitment records, we observed that the required check on immunity to Hepatitis B had not been undertaken for two staff members; there were no records available to us in relation to the employment of the principal dentist.

This section is primarily information for the provider

Requirement notices

We were unable to check indemnity cover for the principal dentist, the extent of this and whether this covers dental nurses. There was no prompt in place to remind you that these records should be held by you and should be available for inspection.

Regulation 17 (1)(2)

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 Care and treatment must be provided in a safe way for service users. 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: Arrangements in place for the manual cleaning of dental instruments did not reflect recognised guidance 'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM01 – 05). Transport of dental instruments between the dental treatment rooms and the decontamination room, and from the decontamination room to the dental treatment rooms, was carried out using trays from the autoclave, rather than a safe, lockable box. Recruitment checks on staff were incomplete. Checks on the levels of immunity of clinical staff to Hepatitis B had not been carried out and were prompted by the announcement of this inspection. Risk assessments had not been put in place, in line with the duties carried out by these staff members. There was no risk assessment in place for staff member YDL 0 who confirmed they often worked alone, without the support of a chairside dental nurse, contrary to the General Dental Council 'Standards for the Dental Team '. Items were missing from the medical emergency kit; all items, as recommended by the Resuscitation Council UK guidance were not available for use. These included: clear face masks for adults and children in all sizes; a self-inflating bag for use on a child; a spacer for a salbutamol inhaler. Staff who made checks on this kit confirmed they were not aware of the guidance provided by The Resuscitation Council UK and had not been provided with a list to make checks against.

This section is primarily information for the provider

Enforcement actions

The syringes to be used for delivery of adrenaline in the case of anaphylaxis were out of date.

The principal dentist confirmed they did not know what the dose of adrenaline was for a child and for an adult.

All required information for the labels used to dispense medicines, was not provided by the principal dentist. When asked to list the information that should be on a label of medicines dispensed by the practice, in accordance with Schedule 25 of the Human Medicines Regulations 2012, the principal dentist confirmed he did not know what the full information was.

X-ray equipment at the practice had not been serviced in line with the recommended timeframes. The X-ray at the practice had been serviced and tested on 6 May 2022, prior to our inspection. Previously, the last servicing and testing carried out was in 2018. Servicing and testing should be carried out every three years. There was no record of periodic checks made on the equipment by the principal dentist.

Safety alerts and clinical updates were not being received into the practice, shared and discussed between staff, for example, from the Medicines and Healthcare Regulatory Agency (MHRA) and from the National Institute of Health and Care Excellence (NICE).

Recommended safety devices, used to protect the patient airway during examination, were not being used. There was no evidence from patient consultation notes as to whether alternative safety devices were offered or whether this was due to refusal by the patient.

The principal dentist used Sodium hypochlorite to irrigate during root canal treatments, without the use of a rubber dam safety device.

Regulation 12(1)(2)