Mrs. Shirley West

# Mrs Shirley West

## Inspection report

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## Overall summary

We carried out this announced inspection on 12 February 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to follow up on concerns we identified during a Transitional Regulatory monitoring call on 9 February 2021 and to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a CQC specialist dental adviser.

To consider the concerns we received we asked the following questions

• Is it safe?

• Is it well-led?

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

**Our findings were:**

**Are services safe?**

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

**Are services well-led?**

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

**Background**

Mrs Shirley West is in the London Borough of Enfield and provides private dental care and treatment for adults and children.

# Summary of findings

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

**Our key findings were:**

- The provider had ineffective infection control procedures to reduce the risk of infections including arrangements for the management of the COVID-19 virus.
- The provider had ineffective systems to help them manage risk to patients and staff. Risk assessments were not carried out, equipment was not tested or serviced as required and there were ineffective systems to monitor procedures in relation to the use and disposal of single use dental items and dental materials.
- The provider had ineffective leadership to support a culture of openness and continuous improvement.
- There were ineffective governance systems to monitor the day to day running of the practice.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with

the fundamental standards of care.

**We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.**

**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 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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

There were ineffective systems to keep patients and staff safe,

The provider had an infection prevention and control policy. However, we identified a number of shortfalls in the infection control practices. The decontamination and storage of dental instruments were not carried out in line with guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. The brushes used to manually clean dental instruments were dirty and worn, guidance in relation to manual cleaning of dental instruments was not followed or clearly understood by the associate dentist who carried out these tasks.

We saw a number of dental instruments which had not been re-sterilised within 12 months in line with guidelines. Some dental instruments were found to be in damaged pouches and therefore could not be deemed to be sterile.

Infection control and cleaning procedures were not followed in line with HTM-01-05 guidance. There were no records maintained in relation to cleaning carried out within the practice. We found areas within the treatment room were not routinely or properly cleaned. Drawers used to store dental instruments and dental materials were visibly dirty. The worktops were cluttered, and dust and dirt were visible in the treatment room. The spittoon was very dirty, and we saw dried blood within the spittoon receptacle.

Guidance and legislation in relation to the handling and disposal of clinical waste matter were not followed. We saw one large filled sharps bin in the treatment room. This was not dated when first used. Due to the small number of patients seen and the amount of accumulated sharps waste we could not be assured that sharps were disposed of within the recommended three months. The practice owner (provider) told us that there was a contract for collection of clinical waste. However, they told us that on occasions there was nobody present at the practice on the days when waste was to be collected. We saw that the clinical waste bin was situated at the front of the property and easily accessible to unauthorised persons/ the public. The waste bin was unlocked and was not secured.

Infection prevention and control audits were not carried out to monitor infection control practices and procedures in line with Guidance.

There were ineffective systems to ensure that dental items intended for single use were disposed of properly once used. For example, we saw a number of single-use rose head burs which had been used. These were in a bur stand in the treatment room. We also saw a matrix band in a sterilised pouch dated 4 January 2021. The associate dentist told us that this item had not been used. However, we saw that there was debris on the inside of the matrix band indicating that it had been used.

There were ineffective arrangements to ensure that dental materials were not used once past the manufacturer's expiry date. There were no systems to check stock dental materials and we found a number of dental materials within drawers in the treatment room which had an expiry date from 2017. We also saw that antimicrobial hand wash had been decanted into separate container and there was no expiry date noted on the handwritten label.

There were ineffective systems to ensure that equipment used at the practice to deliver care and treatment was maintained, tested and serviced to ensure its safe and proper working.

# Are services safe?

There were no records available to show that the practice had registered with the Health and Safety Executive (HSE), no records to show that a critical examination and acceptance test had been carried out for the dental X-ray equipment and no records to show that annual electrical and mechanical tests or three yearly radiological tests had been carried out. The provider could not tell us when these tests have been carried out.

We were shown an engineer service contract document for the dental X-ray equipment. This showed that the contract had expired in 2010. The provider was unable to tell us if this had been renewed since this date.

There were no records available to demonstrate when the compressor had been serviced. The provider could not tell us when or if the compressor had been serviced.

We saw one fire extinguisher in the reception area. According to the label on this extinguisher it had been installed in 2017. There were no records available to show when the fire extinguisher had been tested. The provider could not tell us when or if the extinguisher had been tested.

There was a hand wash sink in the treatment room with a handsfree operated tap system. The associate dentist told us that this was not working as the battery unit needed to be replaced. They told us that the sink had not been used / working for a number of years.

**Risks to patients**

The provider did not have effective systems to assess, monitor and manage risks to patient safety.

There were ineffective arrangements for assessing and managing risks in relation to the spread of the COVID-19 virus. The practice owner and the associate dentist were unable to demonstrate that they understood or followed relevant guidelines. There were arrangements to carry out COVID-19 screening questions for patients prior to attending the practice for appointments. We checked eight patient dental records for patients who had attended the practice since January 2021. There were no records to demonstrate that a screening risk assessment had been completed.

We asked the practice owner (provider) and the associate dentist to tell us about the arrangements for fallow time (period of time to allow generated aerosols to settle before cleaning) and cleaning following treatments where aerosol generating procedures (AGP's) were carried out. The practice owner told us that they had installed an air purifying unit which we saw in the treatment room. They told us that the engineer who installed the unit had advised that it was suitable for the size of the room. There were no documents available to demonstrate that the relevant guidance had been referred to, such as calculating the number of air changes per hour to determine the appropriate fallow time. Neither the practice owner nor the associate dentist could confirm what fallow time they used following treatments involving AGP's.

We saw that the work surfaces within the treatment room were very cluttered with a range of items including boxes of disposable gloves, trays, various dental materials and plastic cups. We discussed with the associate dentist how this would make effective cleaning and removal of aerosol matter ineffective. The associate dentist told us that they removed all of these items and replaced them following the cleaning process. We saw areas of dust and dirt behind some items. This meant that the provider could not be assured that cleaning procedures employed were

effective, including the cleaning of any aerosol matter generated during dental treatments.

During the monitoring call carried out on 9 February 2021 the associate dentist told us that they had not had a permanent dental nurse since September 2020. They told us that since this date they worked without chairside assistance and support when carrying out dental examinations and used temporary agency nurses when carrying out dental treatments. During the inspection visit on 12 February we reviewed the dental records for a number of patients who had received dental treatments since January 2021. These treatments included root canal treatments and crown preparation work. We asked to see records or other evidence that the associate dentist had been assisted by a dental nurse during these treatments. The provider and the associate dentist then confirmed that these dental treatments had been carried out without a dental nurse.

# Are services safe?

This is contrary to the General Dental Council Standard 6.2.2 Standards for the dental team which states that with the exception of unavoidable circumstances, dentists should work with another appropriately trained person at all times when carrying out dental treatments.

The procedures for dealing with a medical emergency were ineffective and were not in accordance with the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.

Emergency medicines and equipment were not available as recommended by the Resuscitation Council. There was no automated external defibrillator (AED), portable suction equipment, self-inflating bag with reservoir, or oropharyngeal airways at the practice. There was no medicine available to treat low blood sugar in an unconscious patient and the medicine used to treat chest pain caused by angina was available in tablet form and not the recommended spray form.

We were told that the practice had an arrangement with a local supermarket that the practice could access their AED if needed in an emergency. The associate dentist told us that they could run to the supermarket to access the AED if required. We were not provided with any assurances in relation to this agreement.

The supermarket is located 0.3 mile / six minute walk from the dental practice. We asked the associate dentist if they would leave a patient unattended to go to the supermarket to access an AED in the event of a medical emergency. The associate dentist said that they would not leave the patient unattended and would call the paramedics and remain with the patient and support them without an AED.

There were limited health and safety policies and procedures and those in place were not reviewed regularly to ensure that they reflected current relevant legislation and guidance. Risk assessments were not carried to help manage potential risk.

There were ineffective systems to assess and manage the risks of Legionella or other bacteria in the water systems. There was no Legionella risk assessment available. The provider could not tell us if or when a Legionella risk assessment had been carried out at the practice. We asked about the arrangements for flushing and disinfecting dental unit waterlines, monitoring the temperature of hot and cold water and periodic tests to check for bacterial growth in the water systems. The associate dentist told us that these tests and checks were not carried out.

A fire safety risk assessment was completed by a member of staff in October 2020. This was not detailed or bespoke to the practice and did not accurately assess fire risks such as lack of testing for the fire extinguisher.

# 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

**Leadership capacity and capability**

There was a lack of clear leadership and the systems for the day to day monitoring and management of the practice were not effective. The practice is owned by an individual. They told us that they were not routinely present at the practice and they had minimal oversight for the day to day management of the service.

There were ineffective arrangements for monitoring practices carried out by the associate dentist to ensure that these were in accordance with relevant legislation and guidance. There were no arrangements to ensure that the associate dentist was supported by a suitably trained dental nurse when carrying out dental treatments.

There was a lack of clear accountability, specific roles and responsibilities in relation to the management of the service. This meant that relevant legislation, guidelines and policies were not available, implemented or understood to ensure that the service was delivered in a safe way.

There were no clear procedures in relation to a number of aspects of the delivery of the service. These included procedures in relation to infection control and COVID-19, dealing with medical emergencies, Legionella management and the safe use and maintenance of equipment.

**Culture**

The culture within the practice was not such so as to encourage a culture for improvements. There were no systems to assess and monitor aspects of the service to support improvement.

There were no arrangements to monitor the completeness of patient dental care records to ensure that these included all of the relevant information was recorded. Dental care records which we looked at contained minimal information about the examinations and treatments carried out. There were no records maintained in relation to discussions with patients about treatment options, intended benefits or potential risks. The dental care records did not include any specific information in relation to COVID -19 risk assessments or screening information.

There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

**Governance and management**

There was a lack of clear and effective processes for managing risks.

The practice infection control procedures including the procedures in relation to COVID-19 were not in accordance with current guidance. There were no systems to ensure that staff were following these procedures.

There were ineffective arrangements to deal with medical emergencies in accordance with relevant guidance.

There were ineffective systems to assess and manage risks in relation to areas including fire safety, Legionella management, use and disposal of dental materials and single use dental items.

# Are services well-led?

There were ineffective systems to ensure that equipment including the compressor and the dental X-ray unit were maintained, tested and serviced in line with the manufacturer's instructions and relevant legislation and guidance.

The provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where patients required urgent or specialist dental treatments, which the practice did not provide. There were no arrangements to ensure that patients would receive this treatment in a timely manner.

The provider did not have systems in place for receiving, managing and sharing safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). The associate dentist told us that 'a dental company' would call the practice to update them on safety issues. However, they were unable to demonstrate that this was the case or tell us about any such safety information they had received.

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br>**Regulation 12**<br>**Safe care and treatment**<br>The registered person 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:<br>There were ineffective arrangements to ensure that the dentist was assisted and supported by an appropriately trained person when carrying out dental treatment in accordance with the General Dental Council Standard 6.2.2 Standards for the dental team.<br>• The dentist has been carrying out dental treatments without the assistance of a dental nurse since September 2020.<br>There were ineffective infection prevention and control arrangements to minimise the risks of cross infection including COVID-19:<br>• There were no procedures for assessing and screening patients. There were no risk assessment / COVID 19 screening questionnaires within the patient dental care records or elsewhere.<br>• There were ineffective systems to ensure that the standard operating procedures and guidance in relation to the delivery of treatments that require aerosol generating procedures (AGP's) were implemented and followed: |

This section is primarily information for the provider

# Enforcement actions

There were no arrangements for calculating fallow time following treatments involving aerosol generating procedures (AGP's).

The dental treatment rooms were cluttered making cleaning and removal or aerosol matter ineffective. Areas including work surfaces, drawers and the Spittoon were visibly dirty.

- There were ineffective arrangements to ensure that the cleaning, decontamination and storage of re-usable dental instruments were in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care.

There were ineffective arrangements manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.

- There was no automated external defibrillator (AED) and no risk assessment as to how people would be treated in the event of a cardiac emergency. There was no portable suction equipment, self-inflating bag with reservoir, or oropharyngeal airways at the practice for use in the event of a medical emergency.
- There was no medicine available to treat low blood sugar in an unconscious patient and the medicine used to treat chest pain caused by angina was available in tablet form and not the recommended spray form.

There were ineffective radiation protection arrangements at the practice in accordance with relevant legislation and guidance – Ionising Radiation (Medical Exposure) Regulations 2000/2018 (IRMER 2000/2018) and Ionising Radiation Regulations 2017 (IRR 2017).

- There were no records available to show that the practice had registered with the Health and Safety Executive (HSE), no records to show that a critical

# Enforcement actions

examination and acceptance test had been carried out for the dental X-ray equipment and no records to show that annual electrical and mechanical tests or three yearly radiological tests had been carried out.

- The provider could not tell us when these tests have been carried out. The provider could not be assured that the dental X-ray equipment was operating safely.

**There were ineffective arrangements to ensure that equipment was checked, tested and serviced in accordance with the manufacturer's instructions and other relevant legislation and guidelines.**

- There were no records available to demonstrate when the compressor had been serviced. The provider could not tell us when or if the compressor had been serviced. The provider could not be assured that this equipment is serviced in line with the manufacturers' instructions to ensure that it is operating safely.
- There were no records or other assurances available to show that the extinguisher had been serviced or tested since it was installed in 2017. There were no records available to show when the fire extinguisher had been tested. The provider could not tell us when or if the extinguisher had been tested. The provider could not be assured that this equipment would work effectively in the event of a fire.

**There were ineffective arrangements to assess and protect people against the risks of avoidable harm.**

- The associate dentist told us that they did not use a rubber dental dam when carrying out root canal treatment in accordance with guidelines issued by the British Endodontic Society. There were no risk assessments carried out to assess and minimise risks to patients where a rubber dental dam was not used.

- The associate dentist told us that they did not use matrix bands when carrying out restorative dental treatments. They told us that they would cut the band

# Enforcement actions

and place a piece of the metal between the tooth being treated and the adjacent tooth. There were no risk assessments recorded to identify and manage risks to patients associated with this practice.

12 (1)

## Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

## Regulation

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.

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:

There was a lack of leadership within the practice and the systems to assess and monitor day to day management were not carried out:

- During the inspection visit the provider

acknowledged that there was a lack of management for the practice. They told us that you did some administrative work in relation to the dental practice. They told us they did not routinely spend time at the dental practice.

This section is primarily information for the provider

# Enforcement actions

- There were ineffective systems in place for receiving, managing and sharing safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). The associate dentist told us that 'a dental company' would call the practice to update them on safety issues. However, they were unable to demonstrate that this was the case or tell us about any such safety information they had received.

- There were ineffective systems in place to monitor or follow up on referrals to other dental / health providers where patients required urgent or specialist dental treatments which the practice did not provide. The provider could not be assured that patients would receive this treatment in a timely manner.

**There were ineffective governance systems to assess and manage risks in relation to the service:**

- There were ineffective systems to ensure that dental items intended for single use are disposed of properly once used. We saw a number of rose head burs which had been used in a bur stand in the treatment room. We also saw a matrix band in a sterilised pouch dated 4 January 2021. The associate dentist told us that this item had not been used. However, we saw that there was debris on the inside of the matrix band indicating that it had been used.

- There were ineffective systems to assess and manage risks of Legionella in accordance with the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and have regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.'

This section is primarily information for the provider

# Enforcement actions

There was no Legionella risk assessment available and no arrangements for flushing and disinfecting dental unit waterlines, monitoring the temperature of hot and cold water and periodic tests to check for bacterial growth in the water systems.

• A fire safety risk assessment was completed by a member of staff in October 2020. This was not detailed or bespoke to the practice and did not accurately assess fire risks such as lack of testing for the fire extinguisher.

There were ineffective arrangements for monitoring and quality improvement.

- There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

17 (1)