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You Smile Dental Care

Inspection Report

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Overall summary

We carried out this unannounced focussed inspection on 13 May 2019 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 provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook an inspection in response to concerns received.

We asked the following two questions:

• Is it safe?

• Is it well-led?

These questions form part of the framework for the areas we look at during a comprehensive 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 well-led?

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

Background

The practice is in Market Rasen, a town within the West Lindsey district of Lincolnshire. It provides private treatment to adults and children.

Treatments offered include general dentistry, orthodontics using the 'Fast Braces' orthodontist system and dental implants.

There is level access into the practice and the treatment rooms. There is no car parking available on site; there is public car parking within short distance of the practice.

The dental team includes the principal dentist, a visiting implantologist, a qualified dentist who also undertakes the role of a hygienist and two dental nurses. The practice has two treatment rooms.

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.

During the inspection we spoke with one dental nurse who had been working in the practice for several years; they were the only member of the team present when we visited the practice. We looked at practice policies and procedures and other records about how the service is managed.

Summary of findings

The practice is open: Monday to Thursday from 8.30am to 7pm, Friday from 8.30am to 5pm and on some Saturdays with appointment only, from 9am to 4pm.

Our key findings were:

- The practice appeared clean.
- The provider did not have all infection control procedures that reflected published guidance.
- There was no evidence to confirm that staff had completed training in basic life support within the previous 12 months. Not all appropriate medicines and life-saving equipment were available. We found some emergency medicines had expired up to one year ago; these had not been replaced. Monitoring logs for emergency medicines were not completed accurately, but were signed off by staff as requiring no further action.
- There was no evidence on the day of our visit that all staff had indemnity to carry out their clinical roles. Evidence for current indemnity was provided for all staff after our visit.
- Single use items had been re-processed. These included items used for orthodontics treatments.
- There was no evidence on the day that all facilities and equipment were maintained, serviced, tested and safe to use. Some evidence was provided to us after the day.
- The provider had safeguarding policies and processes. Most documentation was undated, so it was unclear when it was last reviewed.
- The provider had staff recruitment procedures; however, references were not held for one member of the team and a Disclosure and Barring Service check (DBS) check was missing on another staff member's file. The DBS certificate was sent to us afterwards.
- The practice had ineffective systems to manage risk to patients and staff.
- There were inadequate leadership arrangements.

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.

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

There were areas where the provider could make improvements. They should:

- Review the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff.

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 

We found that 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).

The practice did not have suitable systems and processes to provide safe care and treatment.

We saw evidence that most staff, except for one, had received training in safeguarding people within the last three years. The practice safeguarding policy was undated, so it was unclear when it had been subject to any review.

Staff were qualified for their roles. Indemnity certificates held on file for staff had expired. Following our inspection, we were sent evidence of current indemnity for all staff.

A member of the team had originally been recruited to work as a hygienist, although they were qualified as a dentist. The hygienist had also been undertaking work as a dentist. We did not see records on the day to show that they had suitable indemnity cover. Evidence of suitable cover was sent to us afterwards.

The practice completed essential recruitment checks, although references were not held on file for one member of the team.

We did not see evidence on the day of inspection that all facilities and equipment had been suitably maintained. For example, the ultrasonic bath and evidence of radiological testing for the intra-oral X-ray unit. Evidence of maintenance was sent after the day, and radiological testing was arranged and completed after our inspection.

We identified concerns in relation to items that had been identified by the manufacturer as solely for single use, that had been reprocessed for use or had not been disposed of following their use. This did not follow national guidance.

The practice did not have suitable arrangements for dealing with medical and other emergencies. Items of emergency medicines had expired and had not been replaced. Monitoring logs had not been accurately completed to reflect this.

Are services well-led?

Enforcement action 

We found that 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 found that the leader did not demonstrate they had the experience, capacity and skills to manage the service or effectively address risks to it. We found that staff training requirements, CPD, indemnity arrangements and staff GDC registration status required oversight and monitoring by the provider.

Summary of findings

The practice did not have arrangements to ensure the smooth running of the service. The provider did not have a structured system of clinical governance in place to include required policies, protocols and procedures. It was not evident that those that were available, were subject to regular review.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

The provider had not monitored clinical and non-clinical areas of their work to help them improve and learn.

Enforcement action

Are services safe?

Our findings

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

The practice did not have all suitable systems to keep patients safe.

The dental nurse we spoke with showed awareness of 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 safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Most policy and supporting procedural documents we looked in folders were undated except for one in May 2012. It was therefore not clear when documentation had been subject to any review.

The dental nurse told us that safeguarding was not subject to discussion in practice meetings and our review of meeting minutes showed that it was not recorded. External contact information for reporting concerns was posted on the wall behind the reception desk. We checked that the contact telephone numbers were accurate.

We looked at safeguarding training records held in staff files. These showed most staff had completed training within the previous three years, except for the hygienist/dentist whose record was dated April 2016. The principal dentist did not have a record of this training held in his file. Following our inspection, we received a copy of a safeguarding certificate for the principal dentist that was dated 16 May 2019, three days after our visit.

There was no whistleblowing policy in the practice's policy folders. When asked, the dental nurse told us that they did not recall the practice having a policy. They told us that they would report any concerns to the CQC.

The dentist used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

There was no evidence of a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. When asked, the dental nurse did not know details of any business continuity arrangements. Following our inspection, we were sent a copy of the plan.

The practice had a recruitment policy; the version we located was undated. The policy did not include reference to legislative requirements. We looked at four staff recruitment records. These showed compliance with legislation, although we noted exceptions in relation to one member of the team who did not have references or other evidence of satisfactory conduct in previous employment recorded. Another member of the team did not have a DBS check held on their file; we were informed that this had been taken out of the file temporarily and off site, but would be brought back. Evidence of an appropriate DBS was sent to us following the inspection.

Records held for staff General Dental Council (GDC) registration were not all up to date. For example, three members of the teams' records showed that these expired in December 2017 and July 2018. We undertook independent checks on the register which confirmed that staff registration was up to date.

We found that records for staff professional indemnity cover were not within date. For example, all five members of the team had indemnity documentation that showed it had expired between February 2017 and September 2018. Following our inspection, we were sent evidence of current indemnity for the staff.

A qualified dentist had been recruited to work as a hygienist in the practice. A sample of patient dental records we looked at showed that they were undertaking examinations and cleans. We were told that if patients required further treatments, they would then be booked in with the principal dentist. Staff meeting minutes relating to a meeting that took place in January 2018 stated that the member of staff would update their indemnity insurance to reflect additional work being carried out. The latest indemnity certificate held on their file had expired; this stated they were insured to undertake hygienist/therapist work only. We received assurance following our visit that the hygienist/dentist was insured to undertake work as a dentist from 8 March 2019 to 8 September 2019.

We were not provided with all relevant documentation on the day to show that facilities and equipment were safe and maintained according to manufacturers' instructions. We were informed that the compressor was purchased in the last 12 months, but we did not see evidence to confirm this. Following our inspection, we were sent a copy of a receipt for the compressor purchased on 3 December 2018.

Enforcement action

Are services safe?

We saw that portable electrical testing (PAT) had taken place, but we did not see records to show that five yearly fixed wiring testing had been undertaken on the day of our visit. Following our visit, a certificate for the wiring testing was sent to us. This had been undertaken on 5 April 2016.

The practice was unable to locate an annual gas safety certificate. Following our visit we were sent a copy of a gas safety certificate which was dated 20 May 2019.

Records for fire alarm checks carried out by staff were held up until 21 November 2017, the same date as our previous comprehensive inspection. Records for fire extinguisher checks carried out by staff were held up until January 2018. We did note that servicing had taken place of the fire alarm system in May 2019, but servicing documentation for fire extinguishers was unavailable. Following our inspection, we were sent evidence of annual servicing for the fire extinguishers. This was dated 9 January 2019.

There was no evidence that the practice had suitable arrangements to ensure the safety of all the X-ray equipment. We noted that the last radiological testing for the intra-oral unit took place on 8 March 2016. A note on the record showed this was due in February 2019; no record was available to show this had taken place. Following our inspection, arrangements were made by the provider and testing was undertaken.

The practice had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. There was documentation available to show that a radiography audit was undertaken in 2017, but not after this time.

Records were not present on the day to show that clinical staff completed continuing professional development (CPD) in respect of dental radiography. For example, the principal dentist and implantologist did not have this evidence included on their files. The qualified dentist who had also been working as a hygienist had a certificate in their file dated November 2013, but no record after this date. Following our inspection, we were sent evidence of this CPD for the principal dentist. This was completed between 17 to 19 May 2019, after our inspection. We were also sent the hygienist/dentist's latest certificate which was dated 23 October 2018.

Risks to patients

We found that not all systems to assess, monitor and manage risks to patient safety were working effectively.

The practice had some health and safety policies and procedures; the documents we looked at were brief and undated; it was unclear when these had been looked at or when they were subject to review. We noted that the dental nurse was working alone in the premises; they did not know when asked, if a lone workers risk assessment had been carried out.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. We were unable to locate a sharps risk assessment on the day of our inspection. This was sent to us after the day. The assessment did not list all of the types of sharps used and the precautionary measures for each. It did not show whether all staff had viewed and understood the assessment.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

We were unable to locate staff training records to demonstrate they had undertaken emergency resuscitation and basic life support in the previous 12 months. The dental nurse was unable to find supporting documentation but recalled that training had taken place; they were unsure exactly when this was undertaken.

Emergency equipment and medicines were not all available as described in recognised guidance.

We found that glucogel, glucagon (HypoKit) and adrenaline had all expired between May 2018 to September 2018. These had already been removed from the kit and we found them on a table in the staff kitchen area. When discussed, we were told that the principal dentist would make the decision as to when they would purchase replacements. A purchase had not been made by the date of our inspection, one year after the glucagon had expired.

We looked at the staff check list completed for monitoring of the medicines. We noted expiry dates had not been recorded on the log sheet for these medicines. We were

Are services safe?

told that staff had been instructed not to record dates until the new products had been obtained. At the bottom of the log sheet dated in September 2018, we saw that the words 'Action Required No' had been written and signed.

We also noted that clear face masks sizes 0,1,2 were not present in the kit.

A dental nurse worked with the dentists and the dental hygienist when they treated patients in line with GDC Standards for the Dental Team.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

We could not locate the practice's infection prevention and control policy on the day of our inspection.

We identified concerns in relation to the practice not following guidance contained 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. We found that some items or devices identified by the manufacturer as single use only had been used but had not been disposed of.

The principal dentist fitted orthodontic braces using the 'Fast Braces' orthodontist system at the practice. They had been accredited as being a senior master provider as they had completed over 100 'Fast Braces' cases.

During our visit, we did not find any complete and sealed packs of 'Fast braces'. We found used brackets and wires in both the clean and dirty areas in the decontamination room, both pouched and un-pouched. Items that were pouched did not contain patient identifiable information on the packaging; if marked with this, it may indicate appropriate re-use for the same patient. We found a used brace that had been bagged for the sterilisation process; this also did not contain patient identifiable information.

We looked at the quality of some dental instruments and found that some were very worn, for example, tarnished mouth mirrors.

We noted covered but loose dental instruments in trays on the worktops in one of the surgeries.

We saw records to support that some staff completed infection prevention and control training. Two of the dentists did not have records relating to this on their files. The dentist who worked as a hygienist had a training record dated in December 2015. Following our inspection, we were sent evidence of infection prevention and control training for the hygienist/dentist dated 30 March 2019. One of the dental nurses had also updated their training on 14 May 2019 and this was sent to us.

Staff meeting minutes stated that infection prevention and control was discussed in those meetings.

We were not assured that all equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. We were not provided with, and did not locate servicing documents for the ultrasonic bath. We were informed that the autoclave and was purchased within the last 12 months, but we did not see evidence to confirm this. Following our visit, we were sent documentation to show that the autoclave had been purchased on 03 January 2019; this had been initially tested and certified safe and fit for use. We were also sent evidence to show that the ultrasonic bath had been subject to testing by staff, but had not been serviced. The principal dentist told us that they had not been advised that this was required by the engineer.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment dated March 2019.

Staff shared cleaning duties in the practice. The practice was visibly clean when we inspected.

The provider had procedures in place to ensure clinical waste was segregated. We found sharps bins were not stored in line with guidance contained in Health Technical Memorandum 07-01 Safe management of healthcare waste guidance. For example, one of the sharps bins was dated December 2018; guidance recommends that it should be collected after a maximum of three months. Waste collection records we viewed showed that clinical waste was collected every four weeks; sharps bins were collected six monthly.

The practice had carried out infection prevention and control audits, but not twice a year as recommended in guidance. The latest audit was undertaken in August 2018, and was due to be completed in February 2019. This had not yet been completed.

Information to deliver safe care and treatment

Enforcement action

Are services safe?

We looked at a small sample of dental care records to see how information to deliver safe care and treatment was handled and recorded.

We noted that individual records were written and managed in a way that kept patients safe.

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate referrals in line with current guidance. Patients were offered a copy of their referral, but the practice did not have a referral tracker in place to monitor these.

We were unable to locate and were not provided with a policy or protocol on sepsis management. Review of practice meeting minutes and discussion with the dental nurse did not show that sepsis had been discussed.

Safe and appropriate use of medicines

The provider did not demonstrate they had all reliable systems for appropriate and safe handling of medicines. Expired medicines for use in a patient emergency were stored on a table in the staff area at the time of our visit. In the fridge in one of the surgeries, we found some medication that had been opened. The nurse told us this belonged to a previous staff member who had left it. The fridge did not have a digital thermometer inside; when asked, the dental nurse told us that the batteries had run out.

We noted that there was an inventory of antibiotics held by the practice.

Track record on safety and Lessons learned and improvements

The provider did not demonstrate that they had all suitable safety arrangements. We also found that not all appropriate safety risk assessments were undertaken, for example, lone working.

There was an accident book held in the practice. There were no completed accident reports. The dental nurse told us that they did not recall that there had been any accidents.

There was a document on significant events and analysis, which was undated. We looked at adverse event log sheets. We saw that two incidents in June 2017 and April 2018 were linked to the same issue regarding a computer crash. The provider had improved their computer system because of the incident. There were no other incidents recorded. Our review of staff meeting minutes did not include reference to any incidents or incident reporting. The dental nurse showed awareness of the type of incident they would report.

We were unable to identify if there was a system for receiving and acting on patient and medicine safety alerts. The dental nurse was unaware of any safety alerts received or how they may be received. They did not recall that alerts were subject to any discussion amongst staff in the practice.

Enforcement action

Are services well-led?

Our findings

Leadership capacity and capability

We found that the leader did not demonstrate they had the experience, capacity and skills to manage the service or effectively address risks to it. The provider did however, send us evidence of some compliance after our inspection had taken place.

The principal dentist was not present on the day of our unannounced inspection and there were no patients booked to be seen on the day. We were informed that the dentist travelled abroad on a regular basis to undertake dentistry. We were told that the principal dentist was abroad at the time of our visit and was due to return the following day.

The dental nurse told us that when the dentist was in the practice, they were approachable.

Following our inspection, the provider told us that a staff meeting was held to discuss how the practice would aim to ensure compliance with the regulations. We were provided with detailed actions as to how the practice were addressing the concerns we identified.

Vision and strategy

We did not see evidence to show that there was a clear vision or set of values.

The practice planned its services to meet the needs of the practice population. Private dental care included general dentistry, orthodontics and dental implants. The provider had recruited a mixed staff skill-set to deliver dental care.

Culture

We spoke with one member of staff on the day of our inspection as they were the only member present. Information we obtained did not support a positive cultural working environment.

Whilst there was undated policy and procedural documentation in relation to significant events, we noted that two linked incidents had been identified historically and nothing reported since April 2018.

It was not evident that the provider had systems to ensure compliance with the requirements of the Duty of Candour. Policy provision was not found in relation to this.

Staff could raise issues or concerns. We saw that when issues were raised, they were not always addressed. For example, expired emergency medicines had been left on a table in the staff kitchen by one of the dental nurses to bring this to the attention to the provider; these were waiting to be replaced. One had expired 12 months ago.

Governance and management

The systems and processes in operation were ineffective in supporting governance and management. We found that staff training requirements, CPD, indemnity arrangements and staff GDC registration status required monitoring. We were not provided with evidence to show how this was being overseen.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The principal dentist was also responsible for the day to day running of the service.

The provider did not have a structured system of clinical governance in place to include required policies, protocols and procedures. It was not evident that those that were available, were subject to regular review.

There were no clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

The practice did not show it always acted on appropriate and accurate information. For example, radiological testing for the intra-oral X-ray unit was overdue; this had not been addressed by the time of our inspection.

Continuous improvement

There were not suitable systems and processes for learning and continuous improvement.

The practice did not have quality assurance processes to encourage learning and continuous improvement. For example, audits of recent dental care records, radiographs and infection prevention and control.

We did not view any staff annual appraisals completed within the previous 12 months. We saw that one of the dental nurses had last received an appraisal in October 2017.

There was not any documentation on staff files to show that they discussed learning needs, general wellbeing or aims for future professional development.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** The registered person was not assessing the risks to the health and safety of service users of receiving the care or treatment. In particular: • Emergency medicines had expired and monitoring logs for this had not been completed accurately to reflect this. • Single use items such as those used in the practice orthodontics system had been re-processed. This did not comply with the manufacturers instruction.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Policies were undated or those required were not available. • An effective policy and procedure framework was not in operation to enable staff to report, investigate and learn from untoward incidents. • Ineffective monitoring for staff training requirements and CPD.

This section is primarily information for the provider

Enforcement actions

- Staff had not received appraisal of their work.
- There were limited systems for monitoring and improving quality. For example, audit activity had been limited such as radiography and infection and prevention control.
- The registered person had not ensured that monitoring of safety issues such as fire checks had been completed by staff.

There were limited systems or processes established to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The registered person had not implemented a system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and shared these with staff.
- The registered person had not implemented or made available a lone worker risk assessment.