Dental Partners (DISA) Limited

Holt House Dental Practice

Inspection report

Holt Lane
Matlock
DE4 3LY
Tel: 01629339610

Date of inspection visit: 7 July 2022
Date of publication: 01/08/2022

Overall summary

We carried out this unannounced focused inspection on 7 July 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.
- Improvements were needed to infection control procedures to ensure they reflected published guidance.
- Staff training for medical emergencies was overdue. Checks of emergency equipment could be improved.
- The practice's systems to help them manage risk to patients and staff were ineffective.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures did not reflect current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.

Summary of findings

- Staff and patients were asked for feedback about the services provided.
- The dental clinic had information governance arrangements.

Background

The provider has four practices and this report is about Holt House Dental Practice.

Holt House Dental Practice is in Matlock in Derbyshire 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 disabled people, are available near the practice.

The dental team includes three dentists, five dental nurses including two trainee dental nurses, a receptionist and a practice manager. The practice has four treatment rooms.

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

The practice is open:

Monday to Friday from 8:15am to 4:45pm

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.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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:

- Improve the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
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 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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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. However, training certificates to demonstrate staff were up to date with safeguarding training were not available for all staff.

The practice did not have infection control procedures which reflected current published guidance. We noted there were no records to show gloves and long-handled brushes used in manual cleaning were replaced. We observed staff were not following the procedure for manual cleaning of dental instruments as identified in national guidelines. The guidance was not displayed for staff to guide them through the process, and staff were not following the procedures identified 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 further noted that dental instruments were not kept moist, after use and before being processed in the decontamination room.

Records to demonstrate the autoclaves and the ultrasonic cleaner were working correctly were not kept up to date. Specifically, there were no records to demonstrate quarterly foil or soil tests had been completed on the ultrasonic cleaner. The practice had three autoclaves in the decontamination room, but only had service records for two machines.

Audits for infection prevention and control were not available for inspection. National guidance (HTM 01-05) states these audits should be completed on a six-monthly basis.

The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems. Recommendations made in the Legionella risk assessment had not been actioned. Records were not available to demonstrate that hot and cold-water testing had been carried out. We were given assurances that this was under review, and new forms for recording hot and cold-water temperatures had been introduced. A member of staff had been identified to oversee this process and all staff would undertake refresher training in the management of the risks associated with Legionella.

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.

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including agency and locum staff. We saw five staff recruitment files, and none contained all the information required by the Schedule 3 of the Health and Social Care Act. Not all of the staff files contained a recent photograph, or proof of identification, information relating to their conduct in previous employment, full employment history or information relating to their physical or mental health which might affect their capability to perform their roles. When asked staff were unsure whether this information was held at a location other than the practice. There had been a recent change of management and leadership at the practice. We saw that an action plan had been put in place to ensure every staff member had all of the required information within their recruitment file held at the practice.

Are services safe?

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

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire risk assessment was carried out in line with the legal requirements and the management of fire safety was effective.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. We noted that radiography audits were not available for all necessary clinical staff. The audits that were available were incomplete as they did not include a summary or action plan.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working.

Emergency equipment and medicines were available, however, on the day of inspection, we noted the paediatric self-inflating bag was out of date. This was ordered immediately, and evidence sent after the inspection. Checks to the emergency equipment had failed to identify this issue.

Staff training records showed all staff were overdue for their annual medical emergency and basic life support training.

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 we saw were complete, legible, were kept 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.

Safe and appropriate use of medicines

We saw no evidence that antimicrobial prescribing audits were carried out.

The security of NHS prescription pads should be improved to ensure systems would account for any missing prescriptions.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA). However, the practice policy did not clearly define best interest decisions and information relating to Power of Attorney was brief. Staff gave assurances the policy would be reviewed to address these issues.

Monitoring care and treatment

The practice kept detailed dental care records in line with recognised guidance.

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 evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance and legislation.

Effective staffing

Evidence was not available to demonstrate staff had the skills, knowledge and experience to carry out their roles. In particular we saw there had been no monitoring or overview of staff training, and no evidence to show staff were completing necessary training. We saw that the new management team had begun a review of staff training, to ensure all necessary training was up to date.

The practice did not have systems in place to ensure clinical staff had completed their continuous professional development as required for their registration with the General Dental Council. In particular we noted all staff were overdue for their annual medical emergencies training, and not all staff had evidence they had completed safeguarding training within the last two years. We were given assurances this had been identified and were shown evidence that medical emergencies and safeguarding training would be completed for all staff in the coming weeks.

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 Requirement Notices 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered. We were informed following the inspection that an application for a registered manager was pending.

Leadership capacity and capability

The practice had recently had a change of manager, with the current manager taking up their post two weeks before this inspection. We identified they had reviewed many of the systems and processes and were working on an improvement plan for the whole practice.

Systems and processes were not embedded among staff. For example, infection prevention and control procedures did not follow national HTM 01-05 guidance HTM 01-05 and the system for monitoring the emergency equipment had failed to highlight a piece of equipment that was past its use by date.

The inspection highlighted some issues or omissions. For example, water temperature checks on the hot and cold-water systems were not being completed as detailed in the Legionella risk management protocols.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs during annual appraisals. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice's arrangements to ensure staff training was up-to-date and reviewed at the required intervals was not effective.

Governance and management

We saw the staff structure and responsibilities was under review.

The practice had an ineffective clinical governance system in place. For example, there was a lack of oversight of the infection prevention and control procedures. Procedures for managing the risks associated with Legionella were not effective.

The practice did not have clear and effective processes for managing risks, issues and performance. For example, records in the practice showed recruitment checks and staff training were insufficient to manage risks. Annual staff training for medical emergencies and the risks associated with sepsis were overdue.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Are services well-led?

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement. Staff training records were incomplete, monitoring and oversight of processes needed to be improved to ensure risks were mitigated and record keeping needed to be improved to demonstrate compliance with the regulations.

Records to indicate the practice had undertaken audits of record keeping, antimicrobial prescribing and infection prevention and control were not available for inspection.

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

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 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 registered person had failed to ensure that Infection prevention and control processes followed national guidance HTM 01-05. Manual cleaning processes were not as described in the guidance and records to demonstrate the autoclaves and the ultrasonic cleaner were working correctly were not kept up to date. Specifically, there were no records to demonstrate quarterly foil or soil tests had been completed on the ultrasonic cleaner. • The registered person had failed to ensure that the risks associated with Legionella had been mitigated. Records were not available to demonstrate that water testing was carried out. • The provider had not ensured the safety of staff and patients as training records showed all staff were overdue for their annual medical emergency and basic life support training. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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:

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Requirement notices

- The registered person did not have an effective quality assurance system. Audits to review, monitor and improve the quality of the service were ineffective. In particular, there were no infection, prevention and control audits or record keeping audits available for inspection. Radiography audits were incomplete.
- The registered person did not have oversight of checks on the emergency equipment and had therefore failed to identify and act on the fact some emergency equipment was passed its use by date. This as identified in guidance produced by the Resuscitation Council UK.
- The registered person did not have oversight of the checks on the equipment used in the infection prevention and control procedures. Records to demonstrate the autoclaves and the ultrasonic cleaner were working correctly were not kept up to date.
- The registered person had failed to mitigate the risks associated with Legionella due to an absence of testing of the hot and cold-water systems.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person's recruitment procedures did not ensure that only persons of good character were employed. The registered person's recruitment procedures did not establish whether staff were able, by reasons of their health and after reasonable adjustments, to properly perform tasks intrinsic to the work for which they would be employed. In particular: • The registered person did not have all of the staff recruitment records identified in Schedule 3 of the Health and Social Care Act 2008 Regulations available

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Requirement notices

for inspection at the practice. Specifically, none of the staff files seen contained all of the information required by Schedule 3. Staff were unaware if the necessary information was held anywhere other than at the practice.

- The registered person did not have oversight of staff training, and therefore could not be assured, staff had the skills to safely meet patients' needs and carry out the regulated activities. Specifically, staff training was overdue for annual medical emergency and basic life support training. Some staff members were overdue updates on their safeguarding training.

Regulation 19(1)(2)