Adelphi Dental Care

Adelphi Dental Centre

Inspection report

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Overall summary

We carried out this announced focused inspection on 14 June 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

- The dental clinic was visibly clean and well-maintained.
- The practice had infection control procedures in place but did not follow all parts of recognised guidance.
- Staff knew how to deal with medical emergencies. However, all appropriate medicines and life-saving equipment were not available.
- Some systems were in place to help manage risk to patients and staff; we observed some systems in place were not always followed.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures in place did not reflect current legislation.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.

Summary of findings

- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership was absent in some areas; steps to support a culture of continuous improvement were not effective.
- The dental clinic had information governance arrangements. Record keeping in most areas was not sufficiently robust.

Background

Adelphi Dental Centre is in Preston, Lancashire and provides NHS and a small amount of 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 are available near the practice. The practice has made adjustments to support patients with additional needs. For example, through the provision of permanent ramp access to the practice and a hearing loop for those patients with hearing difficulties.

The dental team includes two dentists, five dental nurses, two of whom are trainees, a dental hygiene therapist, a receptionist and a practice manager. The practice has three treatment rooms.

During the inspection we spoke with one of the dentists, two dental nurses, a receptionist 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, Wednesday and Thursday from 8.30am to 5.30pm, Tuesday from 8.30am to 7pm, and on Friday from 8.30am to 5pm.

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 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?	**Requirements notice** ✖
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/ 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; some of these were not in line with published guidance. We observed that the cleansing system in place for the dental unit water lines, was not being used as described in manufacturer instructions. We highlighted this to the provider immediately. When we made checks, we found that the vacuum autoclave was not being tested, as required, for example, the test for steam penetration, to provide validation that this is sufficient when processing dental instruments. The required soil testing on the ultrasonic bath in the decontamination room was not being completed. Protein residue testing on instruments was not being completed on a regular basis.

The practice had introduced additional procedures in relation to COVID-19 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. When we made checks on the management and oversight of this, we saw that hot water temperatures, which should be above 55 degrees centigrade for thermic control of Legionella, were recorded as being 65 degrees centigrade. There were no signs placed at sinks to warn against the risk of scalding, or attempts made to reduce the temperature of the hot water slightly. There was no servicing arrangement in place for the air conditioning system in the practice; the provider was unsure as to whether the air conditioning system should be covered by the Legionella 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 a cleaning schedule to ensure areas of the practice were kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff. This was not routinely followed. Recruitment records held by the provider were not in line with regulatory requirements. The provider was unable to show us evidence of indemnity for the dentists and the dental hygiene therapist. We were told the practice nurses were covered by the partner dentists' indemnity but there were no documents available for us to verify this. There was evidence of immunity to Hepatitis B for two staff. The records held did not confirm this for six members of the dental team.

Clinical staff were qualified and registered with the General Dental Council.

The practice ensured equipment was safe to use; A fire risk assessment was carried out in line with the legal requirements and the management of fire safety was effective. We observed that a gas safety check had been carried out for the premises, but there was no valid electrical safety certificate in place for the practice. The last check was completed in 2016, which is more than the recommended interval of five years.

The practice had arrangements to ensure the safety of the X-ray equipment, through testing and maintenance of the equipment. However, the required radiation protection information was not available, as required. There was no scheme of delegation setting out the name and contact details of the Radiation Protection Advisor or the Radiation Protection Supervisor. There were no directions for operators of the equipment on where the safe area to stand was when taking X-ray images.

Are services safe?

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety; we observed that staff working in the decontamination room were dismantling sharps, contrary to a safer sharps policy being in place. There was no poster in the decontamination room giving details of emergency contacts in the event of a sharp's injury.

Staff had not completed sepsis awareness training.

Emergency equipment and medicines were not available in accordance with national guidance. There was no list of items that should be stored with the emergency medicines and equipment, for staff to check against. We found items that are not licensed for use in an emergency, and emergency drugs that were out of date. Key pieces of emergency equipment were missing from the kit, for example, a self-inflating oxygen bag with valve and mask for use on an adult; there were no clear face masks to attach to this. There was only one clear face mask in the kit which was in a size suitable for babies. The oxygen cylinder was below the recommended size and was not full.

Staff had completed training in emergency resuscitation and basic life support every year.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. However, there were no information sheets on products used in the practice, referred to as COSHH information, for staff to refer to.

Information to deliver safe care and treatment

Dental care records we saw were of varying quality; these did not reflect the standard required by The General Dental Council. Records reviewed 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

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

The ordering and dispensing of medicines was not adequately recorded and monitored. For example, when medicines were ordered and received into the practice, these were not logged by batch numbers, quantity, and size of packet. As a result of this there was no way the practice could respond to any urgent medicines recall. Antimicrobial prescribing audits were carried out; however, these did not reflect current prescribing protocols, so areas requiring improvement could not be identified.

NHS prescription pads were not securely managed, in line with requirements. There were multiple prescription pads in use; when new prescription pads were delivered, these were not indexed, or allocated to specific staff members. The management of prescription pads at present meant that identifying when prescription sheets were missing, would not be possible.

Track record on safety, and lessons learned and improvements

The practice did not have a system for receiving and acting on safety alerts. The practice had not set up a shared email address that staff could access to see these alerts. The practice partner present on the day of inspection, confirmed they had not set up alerts for themselves to receive these important updates.

There were no records of any previous incidents and accidents for us to review, to see if systems in place supported lessons learned.

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

From a sample of patient dental treatment records reviewed and discussed with the dentist during our inspection, our finding was that patients were not given treatment plans that were sufficiently detailed. These did not adequately set out the different risks and benefits of treatments, the different treatment options available and the duration of courses of treatment.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health. From the detail contained in a sample of patient dental treatment records we reviewed, we were unable to confirm that full periodontal checks and scoring were effectively recorded, and where applicable, areas of concern and treatment options were discussed with patients.

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance.

Staff understood their responsibilities under the Mental Capacity Act 2005.

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.

When reviewing patient dental treatment records, we were unable to confirm the dentists justified, graded and reported on all radiographs they took. The provider was unaware that radiography audits should be carried out six-monthly following current guidance and legislation. Due to the lack of effective audit, this oversight had not been identified and acted on.

Effective staffing

Newly appointed staff had a structured induction and clinical staff completed continuing professional development. Systems in place to oversee this did not confirm that all clinicians and nurses were completing levels of training and development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver 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/ 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 at the practice was insufficient; although staff working at the practice demonstrated a commitment and levels of engagement to support performance, there was a lack of oversight, guidance and input from leaders. As a result of this, systems and processes were not embedded, and where they required review, this had not been identified and acted on.

The information and evidence presented during the inspection process was often incomplete. Processes we were told were in place, were not routinely followed.

The provider had recently taken on a new practice manager to oversee the day to day running of the practice. We observed that the new practice manager was experienced and had a good understanding of the requirements of The Health and Social Care Act 2008 and associated regulations, and of compliance within primary care settings.

Culture

The practice staff and leaders demonstrated that they were patient focussed and keen to deliver oral health services to the practice population. Staff stated they felt respected and valued by both colleagues and patients. Throughout the inspection, the provider and practice manager were responsive to our feedback and keen to address the areas of concern identified by this inspection.

Staff discussed their training needs during meetings. They also discussed general wellbeing. When we reviewed staff training and development, we saw some training was not up to date. Because systems and processes in place to support this had not been adhered to, it was difficult to identify when key subjects were due to be re-visited by staff. For example, infection control training, training on consent and radiation up-date training.

Governance and management

Staff had individual responsibilities and roles within the practice. Governance, management and oversight of this could be strengthened. For example, audits completed were not carried out rigorously, meaning learning points and areas for improvement were not identified; oversight of work in the decontamination room had not identified some validation testing on one of the autoclaves had been missed. The system of record keeping in respect of medicines and prescription pads was insufficient. Systems and processes to receive, share and act on alerts and updates were not in place. Oversight of radiation management had not been reviewed to ensure staff had access to the appropriate information in a timely manner. Details of key contacts in relation to radiation management, were not available in the practice.

The practice had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. Evidence from inspection confirmed that when these policies and procedures were not followed, oversights and errors occurred.

Processes for identifying and managing risks, issues and performance required greater oversight.

Appropriate and accurate information

Staff acted on information available to them. As outlined in this report, some information required, was absent and this had not been identified. For example, in relation to radiation protection, emergency medicines and equipment, and when critical safety checks were due for the practice premises.

Are services well-led?

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

Staff gathered feedback from patients and a demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service. The new practice manager demonstrated a commitment to listening to staff and acting on their feedback on how things could be improved at the practice.

Continuous improvement and innovation

The practice was unable to demonstrate they had systems and processes for learning, continuous improvement and innovation.

Quality assurance processes in place were insufficient and did not promote or drive improvement. These included audits of dental care records, radiographs and antibiotic prescribing audit.

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 Care and treatment must be provided in a safe way for service users How the regulation was not being met: • There was no risk assessment in place for those staff whose immunity to Hepatitis B had not been confirmed; some of these staff were carrying out decontamination work and handling sharps. • Staff were not managing the dental unit water lines in accordance with manufacturers instructions. Staff were not familiar with the operating processes of a 'closed' system. • There were no Local Rules available for any of the X-ray equipment at the practice. Information sheets with the names of the Radiation Protection Advisor and Radiation Protection Supervisor were not available. • The temperature of hot water from outlets in the practice was 65 degrees centigrade; there was no signage in place to warn of the risk of scalding. • There was no risk assessment in place in relation to the six air conditioning units at the practice; these had not been serviced from 2019 onwards. • There is no signage in the practice indicating that medical gases are stored on site (for the benefit of emergency services entering the building). • All items of medical emergency equipment and medicines were not available, as detailed in recognised guidance. There were no clear face masks for adults, no adult ambu-bag, only one size of clear face mask for a child ambu-bag. The adrenaline held was out of date, the aspirin was out of date. The Midazolam held in the kit was in phials used for intravenous sedation; this is not licenced for use in emergencies. The oxygen cylinder was below the recommended 460L size; the cylinder available was not full.

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Requirement notices

- There was no information sheet held in the emergency medicine kit setting out the correct dose to administer for a child and for an adult.
- The required soil testing on the ultrasonic bath in the decontamination room is not being completed. Protein residue testing on instruments is not being completed on a regular basis. Steam penetration tests on the vacuum cycle autoclave are not being completed regularly.
- There is no valid electrical safety certificate in place for the building. The last certificate was issued in May 2014.
- COSHH information was not available for staff using cleaning products in the practice.
- NHS prescription pads were not kept, managed and overseen as required. Security systems to support safe management of prescriptions was inadequate.
- Medicines management systems were insufficient; there was no logging of batch numbers of medicines received into the practice, and batch numbers issued to patients. Logs to support this were lacking in required detail.
- There was no system in place to receive medicines and health care products alerts from MHRA or other updates into the practice, or for these to be discussed and shared with staff.

Regulation 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

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:

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Requirement notices

- Systems and processes to support checks when recruiting staff and to support record keeping in relation to recruitment were insufficient. We found:
- No records available, digital or otherwise, of sufficient professional indemnity cover for all staff at the practice.
- No evidence of checks in respect of six staff on their immunity to bloodborne diseases, for example Hepatitis B. Processes in place had failed to prompt the carrying out of a risk assessment in respect of those staff and the duties they performed.

- Systems and processes in place to ensure documented procedures were followed, were insufficient; contrary to practice policy, we found nurses dismantling sharps in the decontamination room. Audit had failed to identify this.

- Systems to support oversight of infection control and related areas within the practice, were not embedded or sufficiently supported. For example, in managing and maintaining the dental unit water lines, for required soil tests on the ultrasonic cleaner, for protein residue tests on instruments, for steam penetration tests in respect of instruments sterilised in the vacuum autoclave.

- Systems and processes to support safe working were insufficient. For example, Local Rules were not available for the X-ray equipment; information for staff using X-ray equipment was missing, for example details of the radiation protection advisor and radiation protection supervisor.

- Systems to trigger radiography audit were insufficient; the only audits you could show us were from 2017 and June 2021. The audit did not include the justification for taking an X-ray, which is a recommended field for audit.

- Systems and processes to highlight when key safety checks and maintenance is due were insufficient. For example, for electrical safety for the building and for the air conditioning units.
- The system for checking emergency medicines and equipment was ineffective; there was no list of recommended items for staff to check against; we found medicines out of date. The oxygen available was

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Requirement notices

below the recommended amount of 460L, and the oxygen tank was not full. The Midazolam available for use was for intravenous administration. This is not licenced for use in an emergency.

- Systems for the correct management of NHS prescriptions, did not reflect the requirements of NHS Business Services Authority.

- Audit processes were ineffective; prescribing audits were not in place, for example, for antibiotic prescribing. Medicines management audit was not in place. Patient record card audit had failed to identify that patient treatment records in their current form did not meet the required standard of The General Dental Council.

Regulation 17(1)