Dr Christopher Whitehead

Dr Christopher Whitehead - St Peter's Place

Inspection report

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Overall summary

We carried out this announced inspection on 19 June 2023 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures in place, but these did not reflect published guidance.
- Appropriate medicines and life-saving equipment were available but staff training in the use and administering of emergency medicines was insufficient to support them in an emergency.
- The practice had systems to manage risks for patients, staff, equipment and the premises but some of these were not effective.

Summary of findings

- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment and training procedures in place, however these did not reflect current legislation.
- Clinical staff provided patients' care and treatment in line with current guidelines. Some prescribing we reviewed did not follow recognised guidance. Recording in patient records did not meet recognised guidance.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- Staff felt involved, supported and worked as a team.
- Patients were given the opportunity to provide feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

Dr Christopher Whitehead St Peters Place is a dental practice located in Fleetwood, Lancashire and provides private dental care and treatment for adults and children.

There is step free access to the practice, through use of a portable ramp, for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements for example, through provision of a handrail at the front door to help patients with reduced mobility when accessing the practice.

The dental team includes 1 dentist, 2 dental nurses and 1 receptionist. The practice has 2 treatment rooms.

During the inspection we spoke with the dentist and 2 dental nurses. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open Monday, Tuesday and Wednesday from 8.30am to 5pm; Thursday 8.30am to 4pm; and on Friday from 8.30am to 12 noon.

We identified regulations the provider is 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Requirements notice** ✖
Are services effective?	**Requirements notice** ✖
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**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.

The practice had infection control procedures in place, but these did not reflect recognised published guidance. The processing of dental instruments in the decontamination rooms did not follow the correct, documented pathway; the testing of equipment used for cleaning dental instruments did not follow recognised guidance, two out of three efficacy tests when using an ultrasonic bath for the processing of dental instruments, were not being completed. Staff knowledge of guidance applicable to this area of work was insufficient.

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

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

The practice appeared clean; we observed seating in the ground floor waiting area was not made of wipeable surfaces, which is contrary to recognised guidance. Cleaning schedules were not in place, to ensure that all areas of the practice were cleaned. Knowledge of recognised guidance to support staff in this area of work was insufficient. For example, staff did not undertake infection control audit, and documents we were shown which staff described as an audit, did not cover all areas of the practice. Staff were unaware of the required frequency of infection control audits.

The practice had a recruitment policy and procedure to help them employ suitable staff. When we made checks, we found that this was not always followed. We found background checks held for some staff were more than 10 years old at the time of recruitment; in one case there was no evidence of immunity to bloodborne viruses and no risk assessment had been put in place in respect of this staff member and the duties they carried out each day.

Clinical staff were qualified and registered with the General Dental Council. Copies of professional indemnity cover were not available for inspection; we asked the provider to send us this information following our inspection.

The practice ensured the facilities were maintained in accordance with regulations.A fire safety risk assessment was carried out in line with the legal requirements. The management of fire safety was effective.

The practice had arrangements to ensure the safety of the X-ray equipment. However, there was no nominated Radiation Protection Advisor for the equipment and local rules we saw were not sufficiently detailed. Of the three X-ray machines at the practice, one was overdue for testing; this was booked immediately by the provider when this became apparent.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety; staff we spoke to demonstrated some sepsis awareness, however, we observed there were no sepsis posters or prompts in the reception or waiting area to support staff when triaging patients.

Are services safe?

Emergency equipment and medicines were available; staff said they were checked in accordance with national guidance. When we checked emergency medicines and equipment we found the Glucagon (a medicine used to treat hypoglycemia) was out of date. The checks on emergency medicines and equipment carried out by staff had failed to identify the Glucagon was out of date and that it had not been date adjusted, in accordance with manufacturer guidance if the product is stored at ambient temperature rather than being refrigerated.

When we talked to staff, their knowledge on how to respond to a medical emergency, for example, in the administration of emergency medicines, was insufficient to support their response to a medical emergency. Staff said they had completed training in emergency resuscitation and basic life support every year. When we made checks, we saw that staff had been doing on-line training in medical emergencies since 2017, and some infrequent scenario training had been undertaken. Our finding on inspection was that this training was not sufficient.

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

We reviewed a sample of patient care records. We found these were not complete and did not meet the clinical record keeping standards as defined by the General Dental Council (GDC) or other recognised guidance.

There were no documented risk assessments in respect of mouth cancer, tooth wear and caries; there was no record of treatment options given and discussed with the patient, and no record of justification for X-rays taken or record of the quality of the X-ray. There was no record of verbal consent given by patients. Levels of detail in respect of diagnosis and prognosis did not align with recognised guidance.

The practice had systems for referring patients with suspected oral cancer under the national 2-week wait arrangements.

Safe and appropriate use of medicines

The practice had systems for appropriate stock control of medicines. Antimicrobial prescribing audits were not carried out; prescribing of antimicrobials did not follow current recognised guidance in terms of dose and length of course. Patient information leaflets, legally required to accompany dispensed medicines, were not being routinely issued to patients.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice could not demonstrate that the system for receiving and acting on safety alerts was effective. We found staff were not aware of three very recent safety alerts that were relevant to dental practices.

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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Effective needs assessment, care and treatment

The practice did not have effective systems to keep dental professionals up to date with current evidence-based practice. Specifically, this applied to receipt of alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) and up to date prescribing guidelines that reflect recognised guidance, for example from the Faculty of General Dental Surgeons and/or the Scottish Dental Clinical Effectiveness Programme.

We saw the provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

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

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 told us they obtained patients' consent to care and treatment in line with legislation and guidance. However, recording of this, for example, in patient records was insufficient. We found staff understood their responsibilities under the Mental Capacity Act 2005.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly, however we found this was not sufficiently recorded in patient care and treatment records.

Monitoring care and treatment

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

The dentist told us how they justified and graded radiographs they took, but this could not be evidenced, for example, in patient dental records. The practice staff showed us radiography audits they had conducted but these had no findings, conclusions or areas identified for improvement.

Effective staffing

We found staff worked hard to meet the needs of patients and knew their patients well. Our findings from inspection were that training facilities and programmes staff had access to, did not fully support them to build skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction. Clinical staff completed continuing professional development in line with their registration requirements with the General Dental Council. However, materials and training programmes accessed by staff were not meeting their needs.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

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 caring?

Our findings

We found this practice was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

On the day of inspection, we reviewed feedback from. Patients had commented that staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and told us they gave patients information to help them make informed choices about their treatment.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentist explained the methods they used to help patients understand their treatment options. These included for example photographs, study models, and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments, including installation of a handrail for patients with access requirements.

Timely access to services

The practice displayed its opening hours and provided information on their website.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. The frequency of appointments was agreed between the dentist and the patient, and patients had enough time during their appointment and did not feel rushed.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to any concerns or complaints appropriately. Staff discussed outcomes to share learning and improve the service.

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.

Leadership capacity and capability

The provider was not able to demonstrate that systems and processes within the practice were up to date and embedded, and the inspection highlighted some issues or omissions. When we provided feedback the provider was open to this and keen to work to address the issues we raised.

The information and evidence presented during the inspection process was not sufficiently detailed and in some instances outdated, meaning staff were not aware of or working to current recognised guidance in a number of areas. For example, in infection control, radiation protection, prescribing protocols, creation and maintenance of dental care records and for clinical audit.

The practice did not have processes to support and develop staff with additional roles and responsibilities. We found training relied on by staff, did not meet their needs; appraisal of staff had not identified this.

Culture

Staff worked hard to ensure sustainable services which were accessible and responsive to patient needs. The small practice team worked well together and knew their patients well. We found that interaction or contact with other dental organisations was not something the practice were involved in; as a result, peer support was lacking.

Staff discussed their training needs during annual appraisals and informal meetings. They also discussed learning needs, general wellbeing and aims for future professional development. Knowledge of high quality training sources from was limited, which meant staff were not fully updated on all areas of dental practice, including highly recommended training, in line with GDC requirements.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff. Our findings on inspection were that systems and processes in place were not informed by current recognised guidance, or not supplied from trusted sources, which impacted on several areas across the practice. For example:

- The practice was not signed up to receive important safety alerts and product recalls, for example, from MHRA.
- Clinicians were not signed up to receive updates to prescribing guidance and protocols, for example, updated NICE guidelines and information from The College of General Dentistry; and
- on management of key areas such as infection prevention and control, and the required clinical audits a practice should complete and the frequency of these.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

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

Are services well-led?

Feedback from staff was obtained through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service.

Continuous improvement and innovation

The range of required clinical audit was not being completed by the practice. This included audits of patient care records, antimicrobial prescribing, and infection prevention and control. As a result, opportunities for learning and improvement were not part of daily routine. During inspection the whole practice team expressed their desire to update their knowledge and to improve the service were possible, through the use of some of the tools we signposted on the day.

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: Local rules for X-ray equipment were insufficiently detailed. There was no appointed Radiation Protection Advisor. The decontamination of dental instruments was not being carried out in accordance with recognised guidance Health Technical Memorandum 01-05: Decontamination in primary care dental practices. Staff knowledge of medical emergencies and administration of emergency medicines was insufficient. Staff could not say what doses of adrenaline should be used in the case of child or adult anaphylaxis and there was no guide available within or close to the emergency medicines to refer to if needed. Glucagon in the emergency medicines had passed its expiry date. Prescribing of medicines was not in line with recognised guidance, particularly the prescribing of antimicrobials. The required patient information leaflet accompanying medicines was not always being issued to patients. Staff were not accessing safety alerts and clinical updates and product recalls, for example, from MHRA. Staff were unaware of three very recent alerts applicable to general dental practice, the two relevant ones being a recall of a batch of buccal Midazolam and an instruction to check on oxygen cylinders which were not full and / or faulty. Regulation 12(1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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:

Systems and processes to support and maintain clinical audits were ineffective. The lack of effective audit meant it had not been identified that dental care records did not meet recognised standards; that staff were not processing dental instruments in accordance with recognised guidance, and that prescribing of medicines, particularly antimicrobials, did not follow recognised guidance.

Systems and process to assess the effectiveness of staff training were not in place. Training in medical emergencies and administration of emergency medicines was ineffective.

Systems and processes in place to ensure all emergency medicines were available and ready for use, were ineffective.

Systems and processes to ensure staff training was delivered at the correct and appropriate intervals, were ineffective. Staff were unaware of the recommended intervals for training in infection prevention and control.

Systems and processes for clinical oversight and supervision of staff had failed to identify the various gaps in the knowledge of staff.

Systems and processes to ensure all required recruitment documents are taken up and held by the provider, were ineffective.

Systems and processes in respect of radiation protection and management of this were ineffective.

Systems and processes to ensure all required servicing and testing for radiation equipment was not effective.

Systems and processes to ensure all efficacy testing required when using an ultrasonic bath for the processing of dental instruments, were ineffective.

Regulation 17(1)