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Dental Surgery

Inspection report

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Overall summary

We carried out this announced focussed inspection on 4 February 2021 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 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 asked the following questions:

• 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:

Are services safe?

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

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

Dental Surgery is in Poynton and provides NHS and private dental care and treatment for adults and children.

There is a small step to access the practice. The practice has a dedicated car park.

The dental team includes one dentist, two trainee dental nurses and one receptionist. 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 the dentist and receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday from 8:30am to 5:15pm

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- Infection prevention and control and waste segregation procedures did not reflect published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- Systems and processes to help them identify and manage risk to patients and staff could be improved. Including in relation to fire and Legionella.
- Improvements could be made to the practice's safeguarding processes. There was no evidence staff had completed safeguarding training.
- The provider did not have effective staff recruitment procedures in place.
- The clinical staff provided patients' care and treatment in line with current guidelines. Improvements could be made to the standard of clinical record keeping and auditing of these.
- Systems and processes were not working effectively to support good governance procedures.

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.

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)

Staff had an awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. Staff knew about the signs and symptoms of abuse and neglect. The provider had safeguarding policies and procedures to provide staff with information about identifying suspected abuse. There was no evidence of safeguarding training for any members of staff.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy. However, this policy referred to out of date guidance. Infection prevention and control procedures did not reflect nationally recognised guidance as laid out 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 in 2013. There was only evidence the dentist had completed infection prevention and control training. Systems were in place for the safe transport of used and clean instruments to and from the decontamination area. We noted the required tests were not carried out on the ultrasonic bath and washer disinfector. These were the weekly protein residue test on both the ultrasonic bath and washer disinfector, the quarterly soil test on the washer disinfector and the quarterly ultrasonic activity test. We were later sent evidence that these tests had been implemented.

The service had implemented a Covid-19 standard operating procedure which was in line with nationally recognised guidance. A fallow period had been adopted following any aerosol generating procedure (AGP) which was appropriate for the set-up of the room and the ventilation. Adequate Personal Protective Equipment (PPE) was available for all staff and had been fit tested. We noted the surgeries were visibly cluttered which would make cleaning after a patient and specifically an AGP difficult. We discussed this with the registered provider who told us that this would be addressed and the surgery worksurfaces decluttered.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

A Legionella risk assessment had been carried out in 2017. The report included some high-risk recommendations. It was not clear from the risk assessment if these had been actioned. The risk assessment had recommended a new boiler to be fitted. This had been done. However, a new risk assessment had not been completed after this. The named nominated individual no longer worked at the practice. We looked at water temperature log sheets and saw that only hot water temperatures were recorded from one outlet. There were no records of cold-water temperatures being recorded from the sentinel outlets. Sentinel outlets are specified in the risk assessment report as water outlets with the risks most closely associated with the presence of Legionella bacteria.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean.

Are services safe?

During the inspection we noted that clinical waste was not always segregated correctly. We noted gypsum waste and part of a dental amalgam capsule were in a clinical waste bin. These should be segregated into separate clinical waste receptacles as specified in Health Technical Memorandum 07-01: safe management of healthcare waste. We were later sent evidence that this had been addressed.

An infection prevention and control audit had been carried out in January 2021. This audit had not identified the issues which we found during the inspection.

The provider had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist did not routinely use dental dam when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, then other methods to attach endodontic instruments were not used. We discussed the importance of securing endodontic instruments when carrying out root canal treatment to protect the patient's airway. We were later informed that endodontic instruments would be securely attached when carrying out root canal treatment.

The provider did not have a recruitment policy or procedure to help support an effective recruitment process. A policy and procedure was developed on the day of inspection. We looked at three staff recruitment records. We noted that there were no Disclosure and Barring Service (DBS) checks for two members of staff. This issue had been identified during our Transitional Regulatory Approach call prior to the inspection and we saw evidence that these had been applied for.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

During the inspection we asked if the fire alarm and gas boiler had been serviced. We noted the fire alarm was last serviced in September 2019 and the boiler was installed in September 2018. There was no evidence these had been serviced within the last year. We were later sent evidence that engineers had been arranged to get these items serviced.

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and the fire exit was kept clear. We noted there was no emergency lighting within the premises. The provider told us they would place torches around the practice to use as emergency lighting. In addition, the signage for the fire exit was not clear. We were told this would be addressed.

The practice had some arrangements to ensure the safety of the X-ray equipment. We saw evidence of current servicing and maintenance of the X-ray equipment. When we reviewed the radiation protection folder there was no evidence of registration with the Health and Safety Executive (HSE), no risk assessment for the use of radiation and no employers' procedures. We discussed this with the provider who told us they would contact their Radiation Protection Advisor (RPA) for assistance with this.

The dentist did not record a justification, grade or report on the findings of the radiographs they took. A radiography audit had been carried out which showed the X-rays taken were of an adequate quality. We were later told that the dentist had started recording a justification, grade and report on the findings of the radiographs they took.

Risks to patients

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. A sharps risk assessment had been undertaken. This stated that needle re-sheathing devices were used. However, we were told that these devices were not used.

Are services safe?

The process to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked was not effective. We noted one member of staff had been advised from occupational health to have a booster Hepatitis B injection. We asked if this had been done and the provider was unsure.

Sepsis prompts for staff and patient information posters were displayed in the practice. This helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were available as described in recognised guidance. We asked staff about what checks were carried out on medical emergency equipment and medicines. Logs of the checks on medical emergency equipment and medicines were held. However, these were not checked at intervals specified in nationally recognised.

A dental nurse worked with the dentist when they treated patients in line with General Dental Council Standards for the Dental Team.

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

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with the dentist to confirm our findings and observed that individual records were written and stored securely. Dental care records we saw lacked detail in relation to consent and special investigations such as radiographs. For example, we asked the dentist if any periodontal assessment was carried prior to placing a dental implant. We were told it was. There was no record of this in the dental care records we looked at of this assessment. In addition, here was no evidence of a justification, report of quality assurance grade of the x-rays which had been taken or evidence of the consent process.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentist was aware of current guidance with regards to prescribing medicines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been no safety incidents. Staff told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

Are services safe?

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

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. The dentist told us they assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. However, clinical record keeping was limited. These lacked detail in relation to consent and special investigations such as radiographs. We asked the dentist if any periodontal assessment was carried prior to placing a dental implant. We were told it was. There was no record of this in the dental care records we looked at of this assessment. In addition, here was no evidence of a justification, report of quality assurance grade of the x-rays which had been taken or evidence of the consent process.

The practice offered dental implants. These were placed by the principal dentist who had undergone appropriate post-graduate training in the provision of dental implants. We saw the provision of dental implants was in accordance with national guidance. However, record keeping was not detailed.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist told us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. There was no evidence of these tests recorded in the dental care records.

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. The dental care records which we looked at lacked evidence of the consent process.

Monitoring care and treatment

The practice kept dental care records containing some information about the patients' current dental needs, past treatment and medical histories. The dentist told us they assessed patients' treatment needs in line with recognised guidance.

An audit of dental care records had been carried out by the provider. This audit had not been effective, it had not identified the issues we found with regards to the dental care records which we looked at.

Effective staffing

We were told that staff new to the practice had a structured induction programme. However, we did not see evidence of this being formally recorded within their staff folders.

We saw evidence of continuing professional development certificates for the provider. There was no evidence of any other continuing professional development for any other members of staff.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

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

The dentist 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.

Governance and management

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

Policies, protocols and procedures were accessible to all members of staff. However, these had not been reviewed or updated recently. We were later sent evidence that the provider had enlisted the help of a compliance organisation to help with the policies and procedures.

Systems and processes were not working effectively to ensure the risks associated with the carrying out of the regulated activities were identified and appropriately managed:

- The system in place to ensure infection prevention and control procedures reflected nationally recognised guidance was not effective. This was highlighted by the fact that regular tests were not carried out on the decontamination and sterilisation equipment.
- The system in place to ensure the risks associated with Legionella were appropriately managed was not effective. There was no documented evidence high risk recommendations had been actioned. Hot water temperatures were recorded from only one tap within the premises and cold-water temperatures were not recorded.
- An effective system had not identified that the fire alarm and boiler had not been serviced.
- The system to ensure recruitment procedures were in line with regulation was not effective. DBS checks were not sought at the point of employment. There was no evidence that advice from occupational health had been followed with regards to a booster required for Hepatitis B.
- The system for checking medical emergency equipment and medicines did not reflect nationally recognised guidance.
- The system for ensuring clinical waste was segregated in line with nationally recognised guidance was not effective. This was highlighted by the fact that we identified gypsum and part of an amalgam capsule were in the incorrect waste stream.

Continuous improvement and innovation

We saw evidence of some quality assurance processes in place. These included audits of dental care records, radiographs and infection prevention and control. However, these audits had not identified the issues we found during the inspection. These included issues with regards to testing of decontamination and sterilisation equipment, dental care records and documentation with regards to radiography.

There was no evidence that all staff had completed training relevant to their roles. The system to ensure staff were up to date with training requirements was not working effectively. These included safeguarding and infection prevention and control.

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 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 operated ineffectively in that they failed 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 system in place to ensure recruitment procedures were in line with legislation was not effective. In particular, with regards to DBS checks, immunity to Hepatitis B and ensuring staff were given an appropriate induction. • The system in place for checking medical emergency equipment and medicines did not reflect nationally recognised guidance. • The system in place to ensure the risks associated with Legionella were effectively managed was not effective. • The system in place to ensure staff were up to date with required training was not effective. • The system in place to ensure equipment was serviced at the required intervals was not effective. • The system in place to ensure clinical waste was segregated correctly was not effective. **The registered person had systems or processes in place that operating ineffectively in that they failed to enable**

This section is primarily information for the provider

Requirement notices

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:** **The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Infection prevention and control procedures did not reflect nationally recognised guidance. In particular, with regards to the regular testing of decontamination and sterilisation equipment. • Water temperature checks were not taken in line with the Legionella risk assessment. • Clinical waste was not segregated according to nationally recognised guidance.

the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

- The auditing process did not identify the issues which we found on the day of inspection. In particular, with regards to infection prevention and control and dental care records.

There was additional evidence of poor governance. In particular:

- The radiation protection folder did not contain all required documentation.
- Dental care records were not detailed an did not include evidence of periodontal examinations or evidence of the consent process.

Regulation 17 (1)

This section is primarily information for the provider

Requirement notices

- Patient's airways were not protected when carrying out root canal treatment.
- The fire alarm and gas boiler had passed their required service intervals.
- The surgeries were visibly cluttered which would make cleaning difficult.

Regulation 12 (1)