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Deepcar Dental Care

Inspection report

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Overall summary

We carried out this announced focussed inspection on 23 March 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 trigger for this inspection visit was a monitoring call held between the provider and the Care Quality Commission (CQC) in February 2021. The inspection was led by a 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 two questions:

• Is it safe?

• 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 providing safe 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.

Background

Deepcar Dental Care is in Deepcar, a village to the north west of Sheffield in South Yorkshire and provides private dental care and treatment for adults and children.

Summary of findings

There is level access to the practice for people who use wheelchairs and those with pushchairs. There is roadside car parking outside the practice.

The dental team includes one dentist, two dental nurses and one receptionist. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

During the inspection we spoke with one dentist, one dental nurse and one receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Thursday: 9am to 1pm and 2pm to 5:45pm and Friday: 7.30am to 2.30pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which mostly reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding children. However, the provider did not have a safeguarding policy for vulnerable adults.
- The provider's staff recruitment procedures did not reflect current legislation.
- Electrical safety checks at the practice were overdue.
- The provider did not have oversight of the risks relating to Legionella, and the process needed to be reviewed and improved.
- The provider did not have a Duty of Candour policy, and staff had not received training in the Duty of Candour.
- The provider did not have a consent policy, and staff had not received training in the Mental Capacity Act (2005).
- The provider did not have oversight of staff training.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

Full details of the regulation 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 practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'. In particular the completion of infection prevention and control audits on a six-monthly basis and reviewing the use of hand scrubbing instruments.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** ✓
Are services well-led?	**Requirements notice** ✗

Are services safe?

Our findings

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

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

Staff knew their responsibilities if they had concerns about the safety of children. The provider had a safeguarding policy and procedure to provide staff with information about identifying, reporting and dealing with suspected abuse for children. However, the provider did not have a policy or procedure relating to the safeguarding of vulnerable adults. We saw evidence that staff had received safeguarding training. All clinical staff had completed on-line training to level two in safeguarding in March 2021, non-clinical staff had completed level one safeguarding training at the same time. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

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 and procedures. They followed guidance 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. Staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. *The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.*

The provider carried out infection prevention and control audits annually with the last one completed in January 2021. We advised that national guidance (HTM 01-05) identifies these audits should be completed on a six-monthly basis. The latest audit showed the practice was meeting the required standards.

The practice had a protocol to guide staff involved in the manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument. The provider told us they were considering purchasing an ultrasonic cleaner to replace manual cleaning in the practice.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. An external company had completed the risk assessment in February 2013. We saw the actions identified in the assessment in 2013 had been addressed. There were records of water testing and dental unit water line management. These were in the form of tick charts and lacked detail or additional information which could be used for analysis. There were no records to demonstrate water temperatures had been checked to ensure they were below 20 degrees centigrade for the cold water or above 55 degrees centigrade for the hot water. These temperatures being the markers within which Legionella bacteria would possibly multiply and flourish.

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

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

Are services safe?

The provider had recently implemented a Speak-Up policy (a whistle blowing policy) as the result of a monitoring call with CQC. This was on display in the staff kitchen. The policy was not dated and did not include the full contact details for the external organisations who might be able to offer support. The provider told us this would be amended to include the missing information. Staff felt confident they could raise concerns without fear of recrimination.

The provider did not have a recruitment policy to help them employ suitable staff. We saw that all staff working at the practice had been in post for several years and no new staff had been recruited. We looked at the staff recruitment records for all four staff working at the practice. Recruitment records were not as specified in Schedule 3 of the Health and Social Care Act 2008 Regulations. Staff records did not include photographs, proof of identification, employment history or references. Clinical staff did have Disclosure and Barring Service checks (DBS checks). The practice had one non-clinical member of staff. They had not had a DBS check, and there was no risk assessment in place for this member of staff as an alternative to a DBS check.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover, this was provided through the provider's indemnity and umbrella cover for the dental nurses.

Staff ensured that equipment was maintained according to manufacturers' instructions. Both the autoclave and the compressor had been serviced in May 2020 by an external company as part of an agreed maintenance schedule. We saw the X-ray equipment had last been checked and serviced as part of the three-year agreement in July 2018. The provider told us they did not have a 5-year Fixed wire Electrical safety certificate, as they were unaware of the need for this. Records suggested the electrics had last been checked in February 2011. The provider was aware that the portable appliance tests for electrical items were overdue. Records showed this had last been completed in August 2015. The provider gave assurances these would be addressed

Risks to patients

The provider had a system in place 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 and recorded.

We saw that the practice had introduced measures to reduce the risk to staff and patients from Covid-19. These included Covid screening of all patients before they attended the practice, staff wearing personal protective equipment, a protective screen at reception, socially distanced appointments, temperature checks, and hand sanitizer. Any patients who identified as shielding or vulnerable were offered an appointment at the beginning of the day. All patients attending the practice were asked to wear a face mask. When completing aerosol generating procedures (such as using a dental drill) the practice was following national guidance from the Chief Dental Officer in relation to fallow time (the time between procedures to allow particles to settle and the environment to be cleaned).

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support. Records showed the last training was delivered in 2018. We saw evidence that basic life support training with an external trainer had been booked for 4 April 2021.

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

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

The provider told us they had provided a domiciliary care service in the past. However, on reviewing the guidance, the provider had decided to no longer offer a domiciliary service to patients.

Information to deliver safe care and treatment

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

Are services safe?

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of the emergency medicines available at the practice.

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. The last recorded accident had been in April 2018, this being an injury to a member of staff. The provider had reviewed their system for managing significant events, and two staff members had completed training in significant event analysis during March 2021. There had been one significant event recorded in the previous 12 months.

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 visible and approachable. Staff told us they worked closely with them to make sure they prioritised compassionate and inclusive leadership.

We saw the provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population.

Culture

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

The staff focused on the needs of patients. Staff were following the guidance published by the Chief Dental Officer in relation to dealing with the Covid-19 virus.

The provider was aware of the Duty of Candour. However, there was no policy to give staff guidance, and no training records to evidence staff had completed training in or awareness of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed. There was a speak up policy (a whistleblowing policy) on display in a staff area of the practice. The policy directed staff to external sources of support such as the General Dental Council and the Public Concerns at Work website.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management, clinical leadership and was responsible for the day to day running of the service. of the practice. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. We noted there were policies which were not dated, and which therefore did not identify when they had last been reviewed.

Systems to identify and manage risks were not effective. We identified risks in relation to:

- There was no safeguarding policy specifically relating to vulnerable adults.
- Records identified that staff training in Medical Emergencies and basic life support had not been completed since 2018. This is an annual requirement. We did note that training had been booked for 4 April 2021.
- The provider did not have a Duty of Candour policy and staff had not completed training related to the Duty of Candour to give them awareness and understanding of the issue.
- The provider did not have a consent policy, and there was no information relating to the Mental Capacity Act (2005) to guide staff when necessary.
- Staff records did not comply with Schedule 3 of the Health and Social Care Act 2008 Regulations. For example: not every member of staff had a Disclosure and Barring Service check (DBS check) or a risk assessment.
- There was no system for the provider to have oversight of staff training.

Are services well-led?

- The provider did not have oversight of the risks associated with Legionella as records did not identify that water temperatures were being checked. Therefore, the provider could not be assured that hot water was above 55 degrees centigrade and cold water below 20 degrees centigrade, which would reduce the risk of Legionella.
- The provider did not have a five-year fixed wire electrical safety certificate. Records indicated the electrics were last checked in February 2011. Records also indicated that the last Portable Electric Appliance check (PAT test) was in August 2015. Guidance suggests these should be completed at least once every three years.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider 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 involved patients, the public, staff and external partners to support the service. For example: through feedback questionnaires and surveys.

The provider 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 provider had quality assurance processes to encourage learning and continuous improvement. These included audits of infection prevention and control, although these could be improved to ensure they follow national guidance. Staff kept records of the results of these audits and the resulting action plans.

Staff had completed most of the 'highly recommended' training as per General Dental Council professional standards. The provider supported staff to complete continuing professional development.

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17** **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. 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 had failed to ensure policies and procedures were kept under review and reflected the most up to date guidance. In particular • Safeguarding vulnerable adults • Duty of candour • Consent • recruitment • The provider did not have an effective recruitment procedure in place to ensure DBS checks were undertaken at the point of recruitment or risk assessed as required. Proof of identification, employment history or references were not available. • There was ineffective oversight of staff training in place. • There was no system or process to effectively monitor health and safety at the practice. As a result, the risks relating to Legionella and electrical safety had not been taken into account.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1)