Ishak Practices Ltd

Whitby Dental Care

Inspection report

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Overall summary

We undertook a follow up focused inspection of Whitby Dental Care on 29 April 2021. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser and the CQC senior national professional dental advisor.

We undertook a comprehensive inspection of Whitby Dental Care on 16 March 2021 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe and well led care and was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Whitby Dental Care on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is it safe?

• Is it well-led?

Our findings were:

Are services safe?

The provider had made improvements in relation to the conditions imposed to suspend regulated activities at the location on 19 March 2021.

Are services well-led?

Summary of findings

The provider had made improvements in relation to the conditions imposed to suspend regulated activities at the location on 19 March 2021.

Background

Whitby Dental Care is in Whitby, North Yorkshire and provides NHS and private dental care 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 at local car parks for a fee.

At the time of inspection, the dental team included two dentists (one of whom was not present during the inspection), one chairside support staff member, who was waiting to commence dental nurse training, and a receptionist. The team was supported on the inspection day by a practice manager and a lead dental nurse from a sister practice. The provider and registered manager were also present during the inspection.

The practice has four treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Whitby Dental Care is one of the company partners.

During the inspection we spoke with all staff present at the time of inspection. We reviewed systems, processes and procedures to assess where improvements to how the service is managed had been made.

The practice is open: Monday to Friday 9am – 5pm.

Our key findings were:

- The provider had taken into account guidance issued by Public Health England (PHE) in respect to Covid-19.
- The practice's Infection prevention and control systems and procedures were completed in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care.
- The legionella management system was improved but required further attention to ensure it was fully effective and embedded.
- The provider had reviewed recruitment, training and the monitoring of associated staff records; sharps risk and Hepatitis B risk mitigation required further attention to ensure they were fully effective and embedded.
- Systems to review and investigate when things went wrong had improved but required further attention to ensure they were fully effective and embedded.
- Staff felt involved and supported to work as a team. Staff were confident their concerns would be heard without fear of recrimination.
- Information governance arrangements were not in place in respect to the use of CCTV.
- Staff were not aware of the role and responsibility associated with being named as the Radiation Protection Supervisor.
- Systems were in place to provide effective staffing.
- The proposed systems to ensure effective leadership, governance and oversight of on-site management had improved and required monitoring and embedding.

Summary of findings

We identified regulations the provider was not meeting. 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 is not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. In particular: Review the location of isolation switch and the clinician’s knowledge and awareness of the role of Radiation Protection Supervisor (RPS).

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 that this practice was providing safe care and was complying with the relevant regulations.

At our previous inspection on 16 March 2021 we judged the practice was not providing safe care and was not complying with the relevant Regulations. We told the provider to take action as described in our conditions of registration. At the inspection on 29 April 2021 we found the practice had made the following improvements to comply with the regulation:

- Staff had received an induction and on-site dental nurse chair-side training since being recently recruited. The provider and staff confirmed the team from a sister practice would continue to provide weekly and monthly on-site training and oversight until staff were fully embedded at the practice. Staff were comfortable with these arrangements.
- The provider had reviewed recruitment, training and the monitoring of associated staff records and confirmed that more effective oversight would be maintained in future with the introduction of a practice manager and lead dental nurse monitoring progress weekly and monthly on site at the practice. The registered manager provided us with all staff recruitment and training documentation prior to the on-site follow up visit, except for comprehensive risk mitigation for safer sharps handling and Hepatitis B staff protection all documents were in order.
- We reviewed staff understanding of the delivery of safe care and treatment in line with Public Health England (PHE) COVID -19 statutory requirements when undertaking aerosol generating procedures (AGP). Staff demonstrated an acceptable level of awareness of protocols in place to ensure safe care and treatment was being provided under PHE COVID-19 requirements. The provider assured us, and we saw that the appointments allowed for appropriate cleaning down time in line with PHE COVID-19 requirements post AGP. The registered manager confirmed this would be actively monitored going forward and would take appropriate action taken if they noticed standards were falling.
- We identified a knowledge gap within the team in respect to how the fallow time had been calculated for each treatment room following an AGP ('Fallow' is the term used before allowing the next patient to enter the treatment room, the room should be left in solitude for a certain period of time. It is mandatory after any AGP for the microorganisms in the air to have dispersed / been extracted before occupying the room again). We brought this to the attention of the provider and registered manager, to ensure this was addressed.
- We discussed with staff what personal protective equipment (PPE) they had access to taking into account PHE COVID-19 requirements. Disposable gowns were available and appropriate face masks were in use. All staff were risk assessed and fit tested for face masks where appropriate.
- Staff demonstrated a good level of knowledge and awareness of infection prevention and control. The instrument decontamination process was demonstrated and found to be in line with national guidance. Staff were aware of the correct disposal process for clinical waste and described the correct procedure to undertake when removing an instrument from a sealed sterilisation bag containing multiple instruments.
- We discussed the safe sharps handling and disposal processes with all staff and found they had received appropriate training and understood that it was the clinician's responsibility to handle and dispose of sharps at point of use. The sharps policy and risk assessment did not reflect this for all sharps in use at the practice. The risk assessment in place was generic for all staff and both documents required risk mitigation to ensure handling and disposal of all sharps was effectively documented. This process required further review to ensure sharps handling was safe for staff and was in line with current Regulations.
- We discussed the current process to mitigate risk and protect staff while they are in the process of receiving their Hepatitis B vaccinations. The risk assessment in place was generic for all staff and did not take into account the additional safety measures required for vulnerable staff, particularly those undertaking a clinical role and handling contaminated instruments and sharps. The provider assured us this process would be reviewed.

Are services safe?

- All X-ray isolation switches had been identified and labelled. Staff were aware of these and of their function. We discussed relocating one isolation switch to the treatment room doorway to prevent staff having to enter the room should an X-ray machine malfunction; the provider agreed to seek further advice on this. We also discussed clearly identifying the RPS on the Local Rules for using X-ray equipment and ensure the associated roles and responsibility of this are fully understood. Currently all clinicians are listed as the Radiation Protection Supervisor and the clinician we spoke with was not aware if they had any responsibility in respect to this. The provider agreed to address this.
- The practice had a CCTV camera in reception area. The provider had installed CCTV signage to inform patients and produced a policy to support its use. Upon review we found the policy was confusing and the signage did not identify the data controller or include a justification for its use. In line with General Data Protection Regulations (GDPR) providers are required to implement a 'data protection impact assessment', this had not been done. Further action is required to ensure the use of CCTV is in line with GDPR and the Information Commissioners Office code of practice.
- All recommendations in the fire risk assessment had been completed or were in the process of completion. Staff had undertaken fire training and a fire marshal appointed as the lead person to complete the required fire safety management checks.
- The landlord gas safety record was available and confirmed the boiler had been serviced and deemed fit for use on 22 March 2021.
- The stock room had been reorganised to assist staff with stock control. The provider had implemented a stock ordering system and identified a lead person to ensure stock remained at an acceptable level.
- The provider had reviewed the Legionella management systems and made some improvements, but further training was required. A lead person was appointed to ensure the required checks were taking place in line with the risk assessment. An interim legionella risk assessment was completed 13 April 2021 and legionella risk was assessed as low. The assessment recommended a thermostatic mixing valve for the disabled toilet to avoid the risk of scald for a wheelchair user, we were told this was ordered but no evidence was presented during the inspection. CQC staff ensured an appropriate warning notice was added on the day to reduce the risk of harm. We asked staff to demonstrate the water temperature testing process and found the wrong taps had been identified as the sentinel taps, hence, the wrong taps were being tested, indicating a knowledge gap. The provider and the registered manager assured us these areas would be reviewed.
- The provider assured us that day to day oversight and management of the practice was much improved, the practice had undergone a thorough review of systems and processes and new staff had received training and lead roles were appointed. Staff at a sister practice had provided training and mentoring and there was a proposed plan going forward to ensure the new staff remained on track with their induction and training. We were assured that the new team had received sufficient induction and training to work effectively and safety at the practice. The provider and registered manager were aware of the areas where improvement was needed and had implemented a structure to the practice for staff to follow in their absence.
- Newly recruited staff were happy to work at the practice had been treated with dignity and respect. Staff discussed the process they would follow if they felt they had concerns to raise. Staff confirmed that they had received training in what to do when things go wrong and were able to provide examples and explain the reporting process.
- The improvements we observed and discussed during the follow up inspection required monitoring and embedding to ensure safe care remains in the longer term.

These improvements showed the provider had taken action to comply with the regulation: when we inspected on 29 April 2021.

Are services well-led?

Our findings

We found that this practice was not providing well led care and was not complying 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).

At our previous inspection on 19 March 2021 we judged the provider was not providing well led and was not complying with the relevant regulations.

- Systems to ensure safe sharps processes were not in line with current regulations. The sharps policy and risk assessment did not address associated risks of handling and disposing of all sharps in use at the practice.
- An effective system was not in place to ensure risk mitigation was in place to protect staff from Hepatitis B whilst undertaking risk associated activities. The risk assessment did not take into account the additional safety measures required for vulnerable staff, particularly those undertaking a clinical role and handling contaminated instruments.
- Legionella management systems were not completed in line with the risk assessment and current guidance. The legionella risk assessment recommended a thermostatic mixing valve for the disabled toilet, we were told this was ordered but no evidence was presented during the inspection to confirm this. We asked staff to demonstrate the water temperature testing process and found that in some cases the wrong taps had been identified as sentinel taps, indicating a knowledge gap for further training.
- The providers ability to remotely monitor the practice required effective systems and processes to be in place. The improvements we observed and discussed during the follow up inspection required monitoring and embedding to ensure safe and well led care remains in the longer term.
- Systems in place to justify and support the use of CCTV were not in line General Data Protection Regulations (GDPR) and the Information Commissioners Office.

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** **There were no systems or processes that enabled 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 safe sharps procedures were not effective or in line with current (Sharp Instruments in Healthcare) Regulations 2013 - HSE • The system to ensure risk mitigation was in place to protect vulnerable staff from Hepatitis B whilst undertaking risk associated activities was not effective or in line with Green Book: Chapter 12. • Legionella management systems were not completed in line with the risk assessment and current guidance (HSE HSG 274 Part 2. 2014 and ACOP L8). • The providers ability to remotely monitor the practice required effective systems and processes to ensure they are fully embedded over time. **There was additional evidence of poor governance. In particular:** • Systems in place to support the use of CCTV were not in line General Data Protection Regulations and the Information Commissioners Office. **Regulation 17(1)**