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St George's Dental Practice

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 04 May 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 did not appear to be visibly clean and well-maintained.
- The practice had infection control procedures which did not reflect published guidance.
- Not all staff knew how to deal with medical emergencies. Not all the appropriate medicines and life-saving equipment was available.
- The practice did not have sufficient systems to help them manage risk to patients and staff.
- Safeguarding processes were not in place and not all the staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which did not reflect current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.

Summary of findings

- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- There was ineffective leadership and improvements were required regarding the clinical audit cycle.
- Staff felt involved and supported and worked as a team.
- Staff and patients were not currently asked for feedback about the services provided, although complaints were dealt with positively and efficiently.
- The dental clinic had information governance arrangements.

Background

The provider is an individual and this report is about St Georges Dental Practice.

St Georges Dental Practice is in Canterbury and provides NHS and 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, including dedicated parking for people with disabilities, are available near the practice. The ground floor treatment room was currently not in use.

The dental team includes four dentists, one registered dental nurse, who is the practice manager, and three trainee dental nurses who share reception duties. The practice has four treatment rooms, three on the first floor and one on the ground floor that is not in use.

During the inspection we spoke with a dentist, two trainee dental nurses, and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

9am to 5pm Monday, Tuesday and Friday

9am to 6pm Wednesday and Thursday

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

- Care and treatment must be provided in a safe way for service users.
- 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.
- Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons.

Full details of the regulations the provider was not meeting are at the end of this report.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**No action** 
Are services well-led?	**Enforcement action** 

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 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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

The practice did not have safeguarding processes and some staff were unaware of their responsibilities for safeguarding vulnerable adults and children.

The practice did not have information available to staff in relation to safeguarding vulnerable adults and children.

Staff had not undertaken appropriate training in safeguarding vulnerable adults and children.

The practice did not have infection control procedures which reflected current published guidance

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance.

Staff had not completed training in infection prevention and control as recommended.

Records were not available to demonstrate that the equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The practice had some procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. We found that the dental unit water lines were sufficiently maintained.

Recommendations made in the Legionella risk assessment had not been actioned since 2019.

Records were not available to demonstrate that water testing was carried out.

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

Systems were not in place to ensure the practice was kept clean.

We observed the practice was not visibly clean.

Some cleaning equipment was not available and other equipment was not stored appropriately.

The practice did not have a recruitment policy and procedure in accordance with relevant legislation.

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff. In particular:

- Records in relation to persons employed at the practice were either incomplete or not available.
- Four members of staff did not have a disclosure and barring service check conducted.
- References had not been sought for four members of staff.
- Employment history was not available for three members of staff and a gap in the employment history of one member of staff did not have an explanation.
- Seven members of staff did not have information regarding the hepatitis B vaccinations or status.
- Staff were not subject to a structured induction when they started to work at the practice.

Are services safe?

- Staff were not subject to supervision, one to one discussions and appraisal.

Clinical staff were qualified and registered with the General Dental Council. However, clinical staff did not have evidence of up to date professional indemnity cover.

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions.

The practice did not ensure the facilities were maintained in accordance with regulations, in particular.

- The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was partly available but had not been updated to the current legislation.

Local Rules and the Radiation Protection File. These required improvements as the controlled area was not indicated.

A Radiation Protection Supervisor (RPS) had not been appointed.

The X-ray equipment had been serviced and maintained according to manufacturer's requirements. However, we noted that rectangular collimation had been indicated for the X-ray unit in treatment room two and this had not been actioned.

Risks to patients

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety. In particular, relating to sharps safety and sepsis awareness, lone working and dental dam.

The practice had not carried out a sharps risk assessment to help them manage risks to staff and patients.

Risks associated with sharps were not appropriately managed. For example, new staff had not received training in what to do if they suffered an inoculation injury and two new members of staff were not vaccinated against Hepatitis B.

We found the practice did not have all the required medicines and equipment used to manage a medical emergency should one occur.

Emergency equipment and medicines were not checked in accordance with national guidance. In particular; there was no adrenaline available as the adrenaline in the medicines kit had expired and the oxygen was only 25% full. Masks and the adult self-inflating bag for resuscitation were damaged and not fit to use. A child size self-inflating bag was not available.

- Staff did not know how to respond to a medical emergency and had not completed training in basic life support and how to operate the Automated External Defibrillator (AED) every year.

The practice had not carried out risk assessments in relation to the safe storage and handling of substances hazardous to health.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, there was no risk assessments or data sheets available for staff to refer to.

The practice has insufficient precautions regarding fire safety in the practice, in particular:

- The fire risk assessment had not considered all risks associated with fire and had not been carried out by a person with the sills and qualifications to do so.
- The fire alarm system and the emergency lighting had not been checked regularly.
- No fire drills had been conducted and fire safety was not part of a structured induction process.
- Six of the seven members of staff had not completed fire safety training.
- There were no signs to alert the emergency services that compressed gas was stored on the premises.

Information to deliver safe care and treatment

Are services safe?

The dental care records we saw were legible but not always complete. In particular; two of the six records we reviewed did not have an up to date medical history. Two of the six notes we reviewed did not have information regarding the patient's extra oral or intra oral health. We noted that there were no risk assessments for caries, oral cancer, tooth wear, and periodontal health recorded in all the six records we reviewed. A basic periodontal exam (BPE) was not recorded in five of the records we reviewed.

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.

Antimicrobial prescribing audits were not carried out.

We saw prescriptions were not stored securely or monitored as described in current guidance.

The practice did not have an adequate stock control system of medicines which were held on site.

Track record on safety, and lessons learned and improvements

The practice had not implemented systems for reviewing and investigating when things went wrong. In particular, significant events that had occurred had not been recorded, risk assessed and learned from.

The practice did not have a system for receiving and acting on safety alerts. In particular, there was no process to receive Medicines and Healthcare Regulatory Agency alerts (MHRA)

Are services effective?

(for example, treatment is effective)

Our findings

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

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Effective needs assessment, care and treatment

The practice did not have systems that worked effectively to ensure dental professionals were up to date with current evidence-based practice. In particular, staff were not aware of the “Was not brought” initiative. This is to protect children and young people who are not brought to appointments; which could indicate medical neglect.

Helping patients to live healthier lives

The evidence does not sufficiently demonstrate that the practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

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

Some staff did not understand their responsibilities under the Mental Capacity Act 2005 (MCA).

Records were not available to demonstrate staff undertook training in patient consent and mental capacity. Dentists, when questioned, were able to demonstrate a good understanding of their responsibilities under the Mental Health Act.

Staff described how they involved patients’ relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The dental care records we saw were legible but not always complete. In particular; two of the six records we reviewed did not have an up to date medical history. Two of the six notes we reviewed did not have information regarding the patient’s extra oral or intra oral health. We noted that there were no risk assessments for caries, oral cancer, tooth wear, and periodontal health recorded in all the six records we reviewed. A basic periodontal exam (BPE) was not recorded in five of the records we reviewed.

There were inconsistencies in the information recorded within the dental care records we looked at. For example, staff told us that completed medical histories were scanned into the patient’s records, we saw that two records we reviewed did not have a medical history scanned in.

We saw evidence the dentists justified, graded and reported on the radiographs they took. However, tthe practice had not carried out radiography audits six-monthly following current guidance and legislation.

Effective staffing

Evidence was not available to demonstrate all staff had the skills, knowledge and experience to carry out their roles.

The practice did not carry out a structured induction for newly appointed staff.

The practice did not have systems in place to ensure clinical staff had completed CPD as required for their registration with the General Dental Council.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

Staff had not completed mandatory training. Risk assessments had not been conducted for sharps safety or general practice. Audits were not conducted to ensure systems and processes were working effectively.

There was a lack of leadership and oversight at the practice. In particular, due to a lack of nursing staff the practice manager often had to perform nursing duties, and this had led to leadership duties not being completed.

Systems and processes were not embedded among staff. For example, information for staff to refer to was either not available or was on a template that had not been made specific to the practice and did not contain all the required information. Systems and processes were not monitored, audited and checked to ensure they were operating effectively.

The inspection highlighted some issues or omissions. For example, some policies were still in a template form and had not been made relevant to the practice. Some processes were not available, such as safeguarding information.

The information and evidence presented during the inspection process was disorganised and poorly documented. For example, when requested some information could not be located, such as the prescription logbook.

Culture

The practice did not have systems in place to adequately support staff.

We saw no evidence of completed staff appraisals. The practice did not have arrangements for staff to discuss their training needs, learning opportunities, general wellbeing and aims for future professional development.

Governance and management

Staff had responsibilities roles and systems of accountability.

The practice did not have effective governance and management arrangements. In particular;

The practice had an ineffective clinical governance system in place.

The governance system included policies, protocols and procedures however, we were not assured these were accessible to all members of staff.

There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis.

The practice did not have clear and effective processes for managing risks,. for example, safety checks for gas had not been conducted since 2019. Sharps had not been risk assessed and new staff had not been trained or informed about the risk associated with sharps.

Appropriate and accurate information

The practice did not use quality and operational information, for example NHS BSA performance information, surveys, audits, external body reviews to ensure and improve performance.

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

There was no evidence staff gathered feedback from patients, the public and external partners.

There was no evidence the practice gathered feedback from staff through meetings, surveys, and informal discussions.

Staff stated they had not been asked to offer suggestions for improvements to the service.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.

The practice had not undertaken audits of disability access, radiographs and infection prevention and control in accordance with current guidance and legislation.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: • Records in relation to persons employed at the practice were either incomplete or not available. • Four members of staff did not have a disclosure and barring service check conducted. • References had not been sought for four members of staff. • Employment history was not available for three members of staff and a gap in the employment history of one member of staff did not have an explanation. • Seven members of staff did not have information regarding the hepatitis B vaccinations or status. • Staff were not subject to a structured induction when they started to work at the practice. • Staff were not subject to supervision, one to one discussions and appraisal.

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 person had not done that which was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular • You did not have precautions in place regarding gas safety. • No gas safety certificate. • No portable appliance testing had been conducted. • You had not completed water temperature checks to ensure that legionella could not develop in the practice as indicated by the legionella risk assessment.

This section is primarily information for the provider

Enforcement actions

- You had insufficient precautions regarding fire safety in the practice.
- The fire risk assessment had not considered all risks associated with fire and had not been carried out by a person with the sills and qualifications to do so.
- The fire alarm system and the emergency lighting had not been checked regularly.
- No fire drills had been conducted and fire safety was not part of a structured induction process.
- Six of the seven members of staff had not completed fire safety training.
- There were no signs to alert the emergency services that compressed gas was stored on the premises.

- You are not prepared should a medical emergency occur at the practice.
- A number of items of equipment were not fit to use.
- You did not have enough emergency medicines as required.
- Checks of the equipment and medicines had failed to identify the items that were not fit to use, and the amount of medicines and oxygen required.
- Staff had not completed training in basic life support and how to operate the Automated External Defibrillator (AED).

- Infection prevention and control was not conducted in line with current guidance.
- We witnessed dirty instruments left out on the worktop awaiting decontamination.
- There was no consistency in the storage of reprocessable instruments. We found a number of pouches that did not have an expiry date indicted and other pouched instruments had expired.
- We witnessed staff performing decontamination duties without the correct personal protective equipment such as heavy-duty puncture resistant gloves.
- Staff had not been trained in what to do should they experience an inoculation injury.
- Staff had not conducted the daily and weekly checks of the autoclaves to ensure they were working effectively.
- We did not see any servicing information for the autoclaves.
- Seven members of the clinical team did not have information regarding their Hepatitis B vaccination status.

This section is primarily information for the provider

Enforcement actions

- Staff had not completed the recommended training for infection control.
- Environmental cleaning was not conducted in line with national guidance for healthcare cleanliness.
- The practice was visibly dirty in a number of areas, such as the stock room and the accessible toilet.
- Boxes of personal protective equipment were stored in the accessible toilet which posed a risk of contamination of these items.

- Medicines and materials were not managed sufficiently. In particular, there were a number of expired items in both the stock room and the treatment rooms.

- We saw that local anaesthetic cartridges had been decanted from their blister packs; this poses a risk of contamination.

- NHS prescriptions were not logged in and out of the practice and were not kept securely when the practice was closed.

- You did not have sufficient information, systems or processes regarding the safeguarding of adults at risk and children.
- There was no information for staff to refer to if abuse was suspected.
- You did not have the contact details of the local authority; including out of hours information or who to contact if staff suspected abuse.
- Staff had not completed safeguarding training for adults at risk and children to the correct level.
- You were not aware of the “was not brought” initiative and there were no systems or processes for staff to follow.
- You had not recruited staff safely as four members of staff had not been subject to a disclosure and barring check to ensure they are safe to work with adults at risk and children.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Surgical procedures	

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

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 improve the quality and safety of the services being provided. In particular:

- You had not assessed the risks associated with dental sharps.
- Substances that are hazardous to health had not been risk assessed.

The registered person had systems or processes in place that were operating ineffectively, in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

- No audits were conducted for infection prevention and control, radiographic quality, dental care records, antimicrobial prescribing and disability access.
- Staff had not completed core training in, infection control, safeguarding both adults at risk and children, sepsis, mental capacity act, medical emergencies, information governance, radiography and fire safety.
- There was a process to capture and learn from significant events, but nothing had been recorded. We were told of a number of events that had occurred.
- You did not receive safety alerts from the medicines and healthcare regulations authority (MHRA.)
- You did not have all the required information for the safe use of radiography equipment. Information that available referred to the old legislation and had not been updated.
- You did not have a radiation protection supervisor appointed.
- The public liability certificate on display had expired in August 2020 and no other was available.
- Policies were generic and had not been made bespoke to the practice.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

This section is primarily information for the provider

Enforcement actions

- Two of the six records we reviewed did not have an up to date medical history recorded.
- Two of the six records were reviewed did not have information regarding, soft tissue, intra oral, extra oral status or temporomandibular joint function recorded.
- In all the six records we reviewed there was no information recorded regarding risk assessments for caries, oral cancer, tooth wear and periodontal health.
- Five of the six records we reviewed did not have a basic periodontal score recorded (BPE).