

Mr. Graham Conlon

# G A Conlon Dental Surgery

## Inspection report

2 Front Street  
Concord  
Washington  
NE37 2BN  
Tel: 01914160429

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### Overall summary

We carried out this announced focused inspection on 12 April 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 was visibly clean and the provider was in discussions with the landlord regarding building repairs and maintenance.
- The practice had infection control procedures which reflected published guidance, apart from in two areas.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- The provider should review their assessment and management of risks to service users and staff in relation to fire, expired materials and medicines, prescriptions, referrals, sharps and endodontic treatment.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected 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.
- Effective leadership and a culture of continuous improvement was not apparent.
- Staff felt involved and supported and worked as a team.
- Patients were not asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The dental clinic had information governance arrangements.

## Background

G A Conlon Dental Surgery is in Washington and provides NHS and private dental care and treatment for adults and children.

The practice is on the first floor of a building with access via one flight of stairs. Patients are made aware of this prior to their appointment. Car parking spaces are available in two free council car parks a short distance from the practice.

The dental team includes the principal dentist, one dental nurse and one receptionist. The practice has two treatment rooms, with one room used only for storage and developing of X-rays.

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

The practice is open:

Monday 8.30am to 7.30pm

Tuesday and Wednesday 8.30am to 6pm

Thursday 8am to 4pm

Friday 8am to 2.30pm.

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

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

- Take action to ensure the clinician takes into account the guidance provided by the College of General Dentistry when completing dental care records.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

# 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 effective?	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)**

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. The safeguarding policy and flowchart did not contain necessary contact information for a safeguarding referral; this was added the following day.

After the inspection, the dentist explained they had information for a safeguarding referral on-site, but they also recognised this information was not easily accessible to staff.

The practice had infection control procedures which reflected published guidance. A washer disinfectant machine was used to clean instruments; the recommended weekly protein tests were not completed. We observed the use of wire brushes to clean instruments which is against national guidance. The dentist assured us they would implement the protein tests, and replace the wire brushes, as soon as possible.

We noticed cleaning mops were stored in the toilet cubicle; we advised the dentist to consider an alternative location for storage.

The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

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.

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean. We observed a lot of clutter within the practice, and cupboard doors in treatment rooms required repair, all of which could prevent efficient cleaning. We were assured by the dentist they would address these issues.

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire risk assessment was carried out in line with the legal requirements; this had five recommendations, of which we had assurance that three had been acted upon. The dentist was unsure as to whether the remaining recommendations were necessary; we advised them to seek advice regarding this from a competent person. Fire safety checks and maintenance was in line with guidance.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

### **Risks to patients**

The systems to assess, monitor and manage risks to patient and staff safety needed to be reviewed.

# Are services safe?

The practice risk assessment was very brief but the dentist was knowledgeable of sharps safety and sepsis awareness. We found an open sharps container sited on the floor in the dental surgery; this could pose a sharps injury or trip hazard. We also noted there was no contact information for employees to seek post-operative prophylaxis in the event of a sharps injury; this was addressed the following day.

The immune status to Hepatitis B could not be confirmed for clinical staff, however medical records confirming staff's vaccinations were available. The practice did not have risk assessments in relation to staff working in a clinical environment when the effectiveness of the vaccination was unknown.

Several expired medicines and dental materials were found on-site, including

- Ten boxes of Lignocaine anaesthetic
- Glucagon (used for diabetic emergencies – a replacement was on-site for use in a medical emergency)
- Disinfectant solution
- Glycogel (glucose)

The dentist told us they would dispose the expired items and implement a system to ensure stock was checked in a timely manner in future.

Endodontic treatment was carried out within the dental practice. Dental dam equipment, or an alternative method, was not in use to protect the airway and soft tissues. A risk assessment was not carried out to support this and there was no documentation in the patients' records. Following the inspection, we received confirmation that a dental dam kit had been purchased for use.

Emergency equipment and medicines were available and checked in accordance with national guidance apart from two sizes of airways. These were ordered the following day. The glucagon (used for diabetic emergencies) was kept in the fridge but the temperature was not monitored to ensure it was stored according to manufacturer's guidance. The dentist assured us they would start monitoring the fridge temperature.

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

The practice had arrangements to use a community-based defibrillator in the event of a cardiorespiratory arrest. They had not carried out a risk assessment to ensure it could be placed onto a collapsed individual, where appropriate, within three minutes, as recommended by the Resuscitation Council (UK). Following the inspection, the dentist had recognised this would not be possible and we received evidence of purchase of a defibrillator.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. We identified an unlabelled syringe containing clear fluid in one of the treatment rooms, which may pose a hazard if spilt or used incorrectly.

During the inspection, the dentist made us aware that the following day they would be working alone with no chairside assistance due to unforeseen circumstances. They had not risk assessed this and we referred the dentist to the General Dental Council's standards. They then took the decision to reschedule patients, having considered the risks that working alone may pose.

## Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

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

## Safe and appropriate use of medicines

# Are services safe?

The practice did not have systems for appropriate and safe handling of medicines. Prescriptions were not recorded or logged to help identify if one was missing. Antimicrobial prescribing audits were carried out; there was no analysis of the results or action plan in the audit.

## **Track record on safety, and lessons learned and improvements**

The practice had implemented systems for reviewing and investigating accidents. We discussed incidents with the dentist and a recent anaphylactic medical emergency that occurred to a person had not been discussed, documented or investigated.

The practice had a system for receiving and acting on safety alerts.

# 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.

### **Helping patients to live healthier lives**

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.

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.

### **Monitoring care and treatment**

The practice kept dental care records however these were not detailed in line with recognised guidance. We viewed five dental records, out of which none had entries of treatment options including risks and benefits, patient's risk category for oral conditions, consent, recall intervals for examinations, and oral health advice. Three out of five records had entries of diagnoses and radiographs taken in line with national recommendations.

We told the dentist we would share our findings in relation to record keeping with NHS England.

The dentist assured us they would revisit national record keeping guidance, and we were sent evidence of training following the inspection.

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

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance and legislation. Audits did not have analysis, learning points or action plans.

### **Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

### **Co-ordinating care and treatment**

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. There was no system in place to track and monitor routine referrals to ensure prompt clinical care was received.

# 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**

Practice leadership needed improvement to address the issues identified during our inspection. In particular, the dentist undertook several roles and delegation of duties to other staff was minimal. A large work-load capacity resulted in a lack of oversight of many areas. It was apparent on the inspection day that systems and processes were not embedded among staff.

The dentist was open to discussion and feedback during the inspection. They understood the challenges and demonstrated that they were keen to address them. We received confirmation that many areas of improvement had already been addressed, including updating policies, moving the sharps container, requesting a competent person to review the fire safety measures, purchasing a defibrillator, clearing out the expired materials and creating colour-coded logbooks for referrals and prescriptions.

### **Culture**

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

Staff discussed their training needs during appraisals and during clinical supervision. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had arrangements to ensure staff training was up-to-date and reviewed at the required intervals.

### **Governance and management**

Systems to support good governance and management were not apparent. Delegation of roles and responsibilities could enable better management.

The practice had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

There were ineffective systems for managing risks, issues and performance. We found:

- Some actions from the fire risk assessment report had not been completed
- Risk assessments were not completed for
- staff whose immunity to hepatitis B could not be confirmed
- lone working
- not using rubber dam or a suitable alternative method to protect the airway
- No systems were in place to record and monitor NHS prescriptions or patient referrals
- Several expired medicines and materials had not been identified or adequately disposed of.
- A syringe containing a clear liquid used for dental procedures had not been labelled and adequately stored.
- Significant events were not recorded.

### **Appropriate and accurate information**

Staff acted on appropriate and accurate information.

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



# Are services well-led?

## **Engagement with patients, the public, staff and external partners**

During the COVID-19 pandemic the practice had not been able to gather patient feedback due to the restrictions in place. The dentist assured us they would start obtaining patient feedback again, through the use of the National Health Services' Friends and Family test.

The practice gathered feedback from staff through meetings 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 practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access, radiographs and infection prevention and control. Audits did not contain results analysis, learning points or action plans.

## 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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"><li>• The registered person had ineffective systems to ensure the risks in relation to sharps injury and working without evidence of immunity to Hepatitis B were assessed and managed appropriately.</li><li>• The registered person did not have adequate systems in place to ensure adequate disposal of expired medicines.</li><li>• The registered person did not have effective systems in place to ensure the recommendations in the fire risk assessment had been actioned.</li><li>• The registered person did not have effective systems in place to ensure the risks of working without chairside support were assessed and managed appropriately.</li><li>• The registered person did not have adequate systems in place to assess and manage the risks associated with carrying out endodontic treatment without using dental dam, or an equivalent method, to protect patients airway.</li><li>• The registered person did not have effective systems in place to recognise and record significant events within the practice. In particular, a medical emergency that occurred on-site was not recognised as being 'significant'.</li></ul>

## Requirement notices

There was additional evidence of poor governance. In particular:

- The registered person did not have adequate systems in place to ensure audits of radiography and infection prevention and control had documented learning points and action plans.
- There was no system in place, such as a prescription log, to identify a missing NHS prescription.
- The practice's infection control procedures and protocols did not take into account all the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

**Regulation 17 (1).**