Dr. Karl Nightingale

Watch Dental Clinic - Benton

Inspection report

2 Manor Road
Benton
Newcastle Upon Tyne
NE7 7XS
Tel: 01912661487
www.watchdental.com

Date of inspection visit: 12 October 2021
Date of publication: 02/11/2021

Overall summary

We carried out this announced focused inspection on the 12 October 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 always ask the following three 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 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?

Summary of findings

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

Background

Watch Dental Clinic – Benton is in Newcastle Upon Tyne 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 in front of the practice.

The dental team includes a principal dentist, a practice manager, three associate dentists and four dental nurses, who also carry out reception work. The practice has two treatment rooms and is entirely on ground floor level.

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 practice manager, two dentists and three dental nurses. The principal dentist was not available. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday – Friday: 9am to 6pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- The provider had implemented standard operating procedures in line with national guidance on COVID-19.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The provider could improve their systems to manage risks to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's staff recruitment procedures did not reflect current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and 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.
- Leadership and management systems were not effective.
- 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.
- The provider had information governance arrangements.

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.

Summary of findings

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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:

- Improve 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, ensure the practice registers with the Health and Safety Executive for working with radiation devices.
- 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?	**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)

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. The practice manager was the lead in safeguarding; a recent safeguarding example was discussed and had been appropriately dealt with.

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 practice manager told us they had not recognised the autoclave validation and servicing was six months overdue. We saw evidence that validation and servicing was carried out following announcement of the inspection.

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 staff carried out 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 had implemented standard operating procedures in line with national guidance on COVID-19. Screening and triaging were undertaken prior to patients attending the premises and immediately upon arrival to identify COVID-19 positive individuals and those who may have been exposed to the virus.

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.

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. All recommendations in the assessment had been actioned and records of water testing and dental unit water line management were maintained. The practice manager told us the cold-water temperature was 16 degrees, but this was recorded as higher than 20 degrees by delegated staff. We checked the cold-water temperature on the inspection day – it reached 16 degrees. This had not been escalated by staff carrying out the checks nor recognised by the practice manager.

The practice was cleaned daily. 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?

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

The practice manager was the infection control lead and they carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

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

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy to help them employ suitable staff. We looked at three staff recruitment records. The provider had not followed their recruitment policy and had not undertaken appropriate recruitment checks (including a criminal record check, identification and employment history proof) for recently employed staff.

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

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. The electrical fixed wire inspection was carried out after we had announced our inspection as the practice manager was unsure when the previous electrical safety inspection had been completed.

The provider should review their fire risk safety measures to ensure they are in line with national guidance. A fire risk assessment was carried out by the practice manager however they could not confirm if they had any competency training to do this and knowledge on fire safety was insufficient. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The provider used digital X-rays. Arrangements to ensure the safety of the X-ray equipment were limited. Radiation protection documentation, apart from local rules, were not available in line with current regulations. The provider had not registered with the Health and Safety Executive in line with changes to legislation relating to radiography.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits however they did not know of, or follow, the current guidance and legislation.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

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. We saw that one member of staff was awaiting their blood test results to check the effectiveness of the vaccination; a risk assessment was not completed to mitigate the risk of working clinically in the meantime.

Are services safe?

Staff had completed sepsis awareness training. Sepsis prompts for staff and patient information posters were displayed throughout 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 found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

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 clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

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.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored NHS prescriptions securely. There were no records of prescriptions which would enable the practice to monitor if any were missing, as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines. A poster was present in the waiting area to inform patients that antibiotics were not a cure to tooth ache.

Antimicrobial prescribing audits were not carried out to ensure dentists were following current best practice guidance when prescribing antibiotics. The practice manager assured us they would start these.

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.

Where there had been safety incidents, we saw these were investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

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

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dentists described to 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.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

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 staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

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 detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements.

Effective staffing

Are services effective?

(for example, treatment is effective)

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

Dental nursing staff new to the practice had a documented induction programme, dentists were provided with a verbal induction. We confirmed clinical staff completed the 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.

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 principal dentist and practice manager shared equal responsibilities for the running of the practice. They were not knowledgeable about all issues and priorities relating to the quality and future of services.

The practice manager understood the issues identified on the inspection day and was very keen to learn and put right any shortcomings. They assured us they would review their management systems, and delegate roles to other staff where possible. We observed that more support was required for the practice manager to carry out their role adequately. The provider was not available during the inspection, however the practice manager emphasized they would take initiative together to address the weak leadership.

Culture

The practice had a culture of high-quality sustainable care.

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

Staff discussed their training needs at an annual appraisals and during clinical supervision. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

The staff focused on the needs of patients.

We saw the provider had systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The providerwas aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

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

The provider 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.

We found the governance processes for managing risks, issues and performance were not effective.

For example, the provider and practice manager:

- Had not completed essential recruitment checks for all staff prior to employment as detailed in their recruitment policy. Disclosure and Barring Service (DBS) checks had not been carried out to ensure a recent employee was suitable to work with children and vulnerable adults. The provider used a previous employers DBS check and a risk assessment was not in place to mitigate the risk of not carrying out their own check. In addition, proof of employment history and identification were not sought.

Are services well-led?

We saw the practice manager had applied for DBS checks for several members of staff following our inspection being announced. We discussed the guidance in relation to DBS checks and gave the practice manager information on recruitment legislation.

- Did not complete a risk assessment for a clinical staff member whose immune status to Hepatitis B was unknown.
- Had not recognised the autoclave servicing was six months overdue.
- Had not identified the need to train staff involved in Legionella temperature checks and did not have a system in place to monitor temperatures recorded. Records from the previous six months showed cold water temperatures were over 20 degrees. The practice manager was not clear why they were recorded as above 20 degrees as the temperatures were below this. The cold-water temperature was measured during the inspection, and we saw the temperature was below 20 degrees. We discussed the need for training staff who carry out the checks and to have an oversight of records to ensure they are accurate.
- Did not have sufficient radiation protection information or radiation safety measures in place. There was no 'employer's procedures' documentation, written examination protocols or in-house performance testing in place. We saw evidence of 'performance and radiation protection survey' reports from July 2021. The report recommended full electrical and mechanical checks should be carried out by the practice's X-ray engineer. We were told the practice manager did not realise this and therefore this had not been arranged.
- Fire safety measures were not in line with legislation. The practice manager was the lead in fire safety, however had not undergone any fire safety training. Periodic visual fire safety checks were not completed by the provider for the fire extinguishers, emergency lighting or fire exits. A fire drill was carried out once a month, where the fire alarm system was set off. Fire alarm safety checks were not completed weekly by the provider, as recommended by legislation. Fire extinguishers were serviced annually, however the wired fire alarm system was not serviced.
- Did not have a system in place, such as a record or logbook, to identify a missing prescription.
- Did not recognise or take action where there were five recommendations from the electrical fixed wire safety inspection report.
- Could not locate the written scheme of examination for the compressor, though it had recently undergone servicing and we were told this included an inspection of the pressure vessel equipment.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example NHS BSA performance information, surveys and audits, were used to ensure and improve performance. Performance information was combined with the views of patients.

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.

The provider encouraged verbal comments to obtain staff and patients' views about the service. The practice manager explained prior to the pandemic, they were collecting patient views through practice surveys and the NHS Friends and Family Test. They are planning to start this again soon.

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.

Are services well-led?

Continuous improvement and innovation

The provider needed to review their quality assurance systems and processes. Audits of dental care records, radiographs and infection prevention and control were carried out. Staff kept records of the results of these audits and the resulting action plans and improvements. Recent radiograph audits were not in line with the Guidance Notes for Dental Practitioners on the Safe Use of X-ray equipment, 2020. We discussed these points with the practice manager and they assured us they would amend their quality assurance processes.

The provider showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. They subscribed to a learning package for all dental nurses to aid their continuous development, however they did not have a system in place to monitor whether training was carried out. The practice manager was not familiar with the General Dental Council professional requirements and we signposted them to this information.

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 Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **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: • The provider had ineffective systems to ensure sufficient radiation protection information, and radiation safety measures, were in place. • Oversight and escalation of Legionella temperature checks were ineffective. Staff lacked the knowledge and understanding to undertake the testing role. • Recommendations from the electrical fixed wire inspection had not been recognised or acted upon. There was additional evidence of poor governance. In particular: • The provider did not complete a risk assessment for clinical staff whose immune status to Hepatitis B was unknown. • There was no system in place, such as a prescription log, to idenitify a missing prescription.

This section is primarily information for the provider

Requirement notices

- The provider did not have an effective system in place to ensure servicing of pressure vessel equipment was completed.
- The provider did not have a system to monitor staff training, in line with General Dental Council recommendations.
- The provider did not follow their recruitment policy to complete recruitment checks.

Regulation 17 (1)

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 potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular: • The registered person had not completed a Disclosure and Barring Service (DBS) check, sought proof of employment history or identification for a recent employee. **Regulation 19 (1).**