Mr. David Gilkeson

Dental Surgery - Stonegate

Inspection report

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Date of inspection visit: 26/02/2020
Date of publication: 15/12/2021

Overall summary

We undertook a follow up focused inspection of Dental Surgery Stonegate on 26 February 2020. 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 second CQC inspector and a specialist dental adviser.

We undertook a comprehensive inspection of Dental Surgery Stonegate on 17 September 2019 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 effective care and was in breach of Regulation 9 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 Dental Surgery Stonegate on our website www.cqc.org.uk.

As part of this inspection we asked:

- Is it effective?

As part of our regulatory function we found additional areas of concern on the inspection day to ask:

• Is it safe?

• Is it well-led?

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Summary of findings

Are services effective?

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspection on 17 September 2019.

Are services well-led?

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

Background

Dental Surgery - Stonegate is in the centre of York and provides mainly private dental treatment to adults and children. The practice also holds a small NHS contract.

Due to the practice being located on the first floor, patients with mobility requirements are referred to a local practice that can help with access more easily.

The dental team includes the principal dentist and two administrators, (one of whom was formerly a dental nurse and one was formerly a trainee dental nurse). Locum dental nurses are employed to provide clinical assistance.

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 principal dentist and one of the administrators. We looked at practice policies and procedures and other records about how the service is managed.

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

Our key findings were:

- Some improvement was made to ensure preventative care was provided and support was maintained to ensure better oral health in the longer term.
- The practice's approach to quality assurance had improved but record keeping remained a concern.
- The provider was now aware of the need to comply with the General Dental Council (GDC) Position Statement on Tooth whitening.
- Systems in place to monitor staff training, in particular, safeguarding vulnerable adults and children and basic life support were not effective.
- The provider did not follow guidance on the use of dental dams from the British Endodontic Society during root canal treatment.
- The use and quality control of dental radiography was not in line Ionising Radiation (Medical Exposure) Regulation and guidance provided by the Faculty of General Dental Practice (FGDP) (UK).
- The completion of dental care records was not in line with nationally agreed guidelines issues by the FGDP and the General Dental Council professional standards.
- Systems in place to ensure locum staff working at the practice were effectively inducted, had the qualifications, competence, skills and experience to care for and treat patients safely were not effective.
- The provider did not ensure that leadership and governance systems were effective.
- Systems to help them manage risk to patients and staff were not fully effective.

Summary of findings

- Systems for reviewing and investigating when things went wrong were inadequate.
- We noted the inappropriate use of NHS prescriptions.
- Improvements made to ensure care and treatment provided was in line with current nationally agreed guidelines and regulations were not effective. In particular: The British Society of Periodontology, The Faculty of General Dental Practice (UK) and GDC standards.
- No improvements had been undertaken to address the issue of administrative staff working in areas where there was an infection prevention and control risk.

We identified regulations the provider was not meeting. They must:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was not providing safe 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 Enforcement Actions section at the end of this report.

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)

Staff did not have clear systems to keep patients safe.

We found the following areas of concern:

- One staff member had no safeguarding vulnerable adults and children certification in place. The provider was unable to demonstrate a safe system to ensure staff completed 'highly recommended training' (also known as continuing professional development (CPD)) in a timely manner, as per the General Dental Council professional standards and that they remained in date and possessed up to date evidence of capability as per the General Dental Council professional standards
- We reviewed systems to assess how staff remained up-to-date with 'highly recommended' CPD training. Records showed that two staff members' hands-on basic life support training certification was last completed 18 February 2019 and had now expired. There were no plans in place to renew the training when we asked. As a result, the provider could not demonstrate that there were always at least two trained people on the premises at any time to deal with any medical emergency as per the General Dental Council professional standards.
- The provider did not use dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. We were previously told that other methods were used to protect the airway, such as high-speed suction, cotton wool and a parachute chain. This process was not documented in the dental care record.
- Radiographs were not taken at appropriate times in line with FGDP guidelines, in particular; pre-operative radiographs prior to the commencement of root canal treatment. Evidence of this was found on three occasions in two dental care records we reviewed. The provider was unable to demonstrate any other examples of when pre-operative radiographs had been taken prior to the commencement of root canal treatment to assist with diagnosis and provide information about the root anatomy when we asked.

We reviewed the practice's fire safety management systems and found the process and oversight of the function of the fire alarm testing was not effective. In particular, evidence provided on the inspection day did not confirm that tests were being completed safely and in line with the legal requirements. The system in place to ensure the building fire alarm was functional, regularly tested and the outcome of the test recorded was not effective.

- Fire alarm function tests were not recorded between 25 November 2019 to 6 January 2020 and 6 January 2020 to 24 February 2020. We were told the tests were being done, however, the test result had not been completed and that on some occasions due to staff shortages, it had been difficult to perform the test with only one person. This concern had not been raised as an area for improvement.

Risks to patients

Systems in place to ensure locum staff working at the practice had the qualifications, competence, skills and experience to care for and treat patients safely were not effective. For example;

- We saw no evidence to demonstrate that an effective process was in place to complete staff checks in ensuring identification was checked and documented, professional registration was in date, disclosure and barring service was role specific, at the enhanced level and that they were suitably indemnified.

Are services safe?

- The provider was unable to demonstrate that locum staff working at the practice had adequate immunity from the Hepatitis B virus. No records were available on the inspection day.
- Other than a General Dental Council registration number annotated on the induction sheet by a staff member, there was no other assurance demonstrated that any other checks were completed, including 'highly recommended' continuing professional development training certificates.
- Locum staff induction processes were not comprehensive. A tick sheet was used for induction purposes. The inductee did not sign the sheet to confirm understanding and were not given the opportunity to read and sign off policies, protocols and risk assessments to ensure they were fully informed of the practice procedures.

Staffing arrangements were unstable. There were two part-time staff employed as administrators who were familiar with the functioning of the practice. The provider relied on locum dental nurses to provide clinical assistance and these staff were not comprehensively inducted. The provider should have and implement up-to-date induction and training systems and are to ensure that persons providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely. The induction process shown to us for locum staff was not sufficiently robust to give us assurance that locum staff were inducted effectively.

Information to deliver safe care and treatment

We reviewed 15 dental care records to seek assurance the provider had recorded the relevant information to deliver safe care and treatment in line with the Faculty of General Dental Practice (UK) and General Dental Council standards.

We discussed 13 of the 15 dental care records with the provider, 12 of the 15 records reviewed confirmed that dental care records were not consistently written and managed in a way that kept patients safe. For example:

- Two hand written dental care records, when documented were illegible and impossible to decipher due to illegibility.
- A problematic tooth was documented in a dental care record on the wrong side of the mouth.
- We found incomplete dental care records of treatment carried out for two patients. No records of treatment plan, risks, benefits, costs or options discussed with patients, or radiographs reported on for eight dental care records reviewed.
- We identified on three dental care records, minimal details of the treatment planned and provided, and in some instances, no detail of the visit was recorded.

These areas of concern were reviewed and discussed thoroughly with the provider, who agreed with our findings.

Safe and appropriate use of medicines

We reviewed the provider's systems for safe and appropriate use of medicines, we noted that two NHS prescriptions had been issued to a patient who was privately funding their treatment for medicines which would not be considered appropriate for ongoing private treatment. The provider was not aware this was inappropriate practise.

Track record on safety, and lessons learned and improvements

We reviewed the practice's track record on safety, lessons learned and improvements. We identified two situations had occurred since January 2020 which had not been raised as a concern or incident to address for learning and improvement. In particular:

- The fire alarm system validation records were not being kept up-to-date in line with current regulations.
- A short-notice staffing situation which was hampered by the provider not being contactable out of working hours. This had led to other staff members having to address the situation in the early hours of the morning to ensure clinical assistance was in place for the following working day.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this practice was not providing effective 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 Enforcement Actions section at the end of this report).

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

To assess action taken by the provider to improve the quality of care and treatment delivered to patients we reviewed a random sample of 15 patients' dental care records and discussed 13 of them with the provider. In addition, we discussed how the provider had kept up-to-date with current nationally agreed evidence-based practice, in particular, guidance issued by The British Society of Periodontology (BSP) and the Faculty of General Dental Practice (UK). The findings of which were as follows:

- The provider told us they tried to follow BSP guidance but could not demonstrate they had access to this guidance or had completed appropriate training to aid their understanding and compliance with this.
- There was inconsistent action taken in respect to the outcome of a Basic Periodontal Examination (BPE) and follow up for patients with periodontal concerns. A BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need to assess and document levels of periodontal disease.
- We identified limited knowledge and awareness of detail pertaining to classification of disease stages and grades in respect to BSP treatment outcomes.
- We found inconsistent dental care records pertaining to a patient's periodontal concern where these did not contain sufficient assessment, periodontal management plans or treatment plans.
- We noted inconsistent provision of detailed self-care treatment plans which included dates for ongoing oral health reviews based upon a patient's individual periodontal needs in line with BSP guidance.
- There was no evidence in the dental care records that patients were made aware of their condition, management of the condition discussed, and appropriate self-care advice given.

We discussed these dental care records at length with the provider and found limited action was taken to identify and provide effective treatment and outcomes for patients with gum disease, or to ensure patients understood their condition and treatment options. We saw some improvement in the completion of BPE scores and the taking of radiographs to monitor bone levels, however, there was limited evidence that the provider addressed periodontal issues in a planned and structured manner after the examination of the patient. This remained a concern.

In addition:

- We found deficiencies in the application of guidance from the Faculty of General Dental Practice (UK), General Dental Council standards and NHS contract obligations in respect of, the recording of patients' consent, treatment options, outcomes, risks and benefits.
- We saw that radiographs were not taken appropriate times in line with FGDP guidelines.
- We saw that some dental care records were illegible and did not include private patient costs information.
- We noted entries in the dental care records pertaining to the requirement of antibiotic cover, a partial denture, whitening trays and an upper orthodontic removable appliance lacked sufficient detail. Information documented was confusing and, in some cases, the dental care record did not reflect actual treatment undertaken or referred to teeth other than those charted.

Are services effective?

(for example, treatment is effective)

Guidance issued by the FGDP advises clinicians to maintain dental care records in such a state that any other clinician could seamlessly ensure continuity of care. Evidence reviewed and discussed with the provider in respect to this remained a concern.

There was some improvement in the documenting of consent, but this was inconsistent and remained a concern.

The provider had not completed a record keeping audit since August 2019. The areas of concern identified at our previous visit in September 2019 had not been reviewed or captured in an audit since.

The practice had made some improvements:

- The provider was now aware of the need to comply with the General Dental Council Position Statement on tooth whitening and the Cosmetic Products Enforcement Regulation 2013 with regard to tooth whitening used on a person of inappropriate age.
- We saw some improvement to ensure the patients' medical history was checked and documented at appropriate intervals.
- We saw improvement in the provision of preventive care and support to patients to ensure better oral health in the longer term. Evidence showed that oral health instruction and diet advice was being given to patients in line with the Delivering Better Oral Health toolkit.
- Some quality assurance systems had improved, we reviewed recent audits for infection prevention and control and the quality of X-rays. These had documented action plans for learning and improvement.

These improvements showed the provider had taken some action to comply with the regulation when we inspected on 26 February 2020. The provider had made insufficient improvements to put right the shortfalls we found at our inspection on 17 September 2019.

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 Enforcement Actions section at the end of this report).

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

We found the principal dentist did not have the capacity and skills to deliver high-quality, sustainable care.

The provider had made incremental changes and improvements to governance and clinical areas but by their own admission these had been driven by CQC and NHS England rather than a professional requirement incumbent on them as a clinician. We found 12 of the 15 dental care records reviewed contained errors and omissions, one we were able to give positive feedback and two were not discussed. The provider acknowledged the errors and omissions when these were discussed. The systems in place to ensure they remain up to date with and applied professional guidance were not effective.

Oversight and leadership to ensure responsibilities, roles and systems of accountability to support good governance and management were not effective; the practice staffing had reduced significantly since the comprehensive inspection in September 2019 and, the remaining staff team had limited overall governance experience.

Governance and management

The provider had previously demonstrated that they relied on a practice manager to ensure good governance; which included, risk management, identification of issues, performance management and to guide them on quality assurance systems. These areas cannot now be assured due to the lack of experience and knowledge remaining at the practice. In particular:

- The provider had devolved responsibility for the practice's governance arrangements to a staff member who had limited knowledge, was not fully prepared for the role and relied on the provider for guidance and support.
- There was no effective system to ensure governance would be maintained if the staff member with governance responsibility was absent.
- There was no system to ensure arrangements were in place to hold practice meetings or discuss day to day concerns.
- Oversight of fire safety systems with respect to testing and recording fire alarm function test results were not effective.
- Leadership and oversight of systems and processes with respect to reporting and recording and learning from incidents which are significant, were not in place.
- The provider did not have an effective system in place to ensure staff completed continuing professional development training as per General Dental Council professional standards.

We asked how the provider verified the locum dental nurses working at the practice had adequate immunity from the Hepatitis B virus specific to their role. The provider was unable to demonstrate that this was checked, in addition, no records were available on the inspection day. We did note that previous locum records for dental nurses no longer working at the practice had vaccination records in their files, these showed that an immunity was detected but the level of immunity was not annotated on the vaccination record. This demonstrated that the provider was not aware of the requirement to check the level of immunity for staff working to identify and mitigate any role specific risks. There was no effective system in place to support this process.

Are services well-led?

At the previous inspection we noted the reception table, appointment book and the telephone were in the treatment room. In addition; the practice administration computer and work desk were in the decontamination room. We discussed how this could impact on the infection prevention and control measures in place, and put the people using these systems at risk of working in an area which would be difficult to keep clean due to the nature of work carried out in these rooms. No changes had taken place to risk assess or address these areas when we returned for the follow up inspection.

Continuous improvement and innovation

The quality assurance processes to encourage learning and continuous improvement were ineffective. Audits of dental care records had failed to identify that the clinician did not consistently assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance.

Systems were not in place to obtain evidence that employed, and locum staff completed continuous professional development training as per General Dental Council professional standards. For example, medical emergency and basic life support and safeguarding training to the appropriate level.

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. 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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not being designed with a view to achieving service user preferences or ensuring their needs were met. In particular: • The registered provider could not demonstrate they had remained up to date with nationally agreed guidance published by The British Society of Periodontology, The Faculty of General Dental Practice (UK) and GDC standards. • Radiographs were not consistently taken in line with guidance provided by the Faculty of General Dental Practice (UK). In particular: pre-and post-operative radiographs were not consistently taken during a root canal restoration or to monitor periodontal health. Service users were not being enabled or supported to understand their care and treatment choices. In particular: • The registered provider demonstrated Incomplete assessment processes, which resulted in patients not being made aware of their periodontal disease. • Patients were not provided with detailed self-care treatment plans which included dates for ongoing oral health reviews based upon their individual periodontal needs in line with recognised guidance. Relevant persons were not being provided with the information they would reasonably need for the purposes of making an informed decision in relation about care and treatment. In particular: • The registered provider demonstrated deficiencies in the application of guidance from the Faculty of General

This section is primarily information for the provider

Enforcement actions

Dental Practice (UK), General Dental Council standards and NHS contract obligations in respect of; the recording of patients' consent, and discussions of treatment options, outcomes, risks and benefits.

- Dental care records demonstrated illegible wording, no diagnosis, no treatment plan, no reference to options discussed and no private patient costs information.

Regulation 9 (1)

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 Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • The registered provider did not risk assess or use dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. • The registered provider was unable to demonstrate that a safe system was in place to ensure the building fire alarm was functional, regularly tested and the outcome of the test recorded. The registered provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The identification of, recording and subsequent learning for failed safety systems such as fire safety and staff training were not in place. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular: • The registered provider was unable to demonstrate that a safe system was in place to ensure staff completed

This section is primarily information for the provider

Enforcement actions

'highly recommended' continuous professional development training in a timely manner and that they remained up-to-date, as per the General Dental Council professional standards.

- The registered provider was unable to demonstrate that locum staff working at the practice were effectively inducted and had the qualifications, competence, skills and experience to care for and treat patients safely.

There was no proper and safe management of medicines. In particular:

- The registered provider demonstrated improper use of National Health Service prescriptions on two occasions.

There was additional evidence that safe care and treatment was not being provided. In particular:

- Dental care records were not consistently written and managed in a way that kept patients safe.

Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had systems or processes in place that operated ineffectively in that they failed to enable 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 • There was no system in place to verify that locum staff working at the practice had adequate immunity from the Hepatitis B virus specific to their role. • Improvements to address administrative staff having to working in areas where there was an infection prevention and control risk had not been achieved.

This section is primarily information for the provider

Enforcement actions

The registered provider 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:

- The registered provider did not ensure governance systems remained effective. The system did not include scrutiny and overall responsibility by the registered person with legal responsibility for the practice.
- Oversight and leadership to ensure responsibilities, roles and systems of accountability to support good governance and management were not effective.
- There were no systems in place to ensure governance would be maintained if staff were absent.
- There was no system to ensure arrangements were in place to hold practice meetings or regular discussions.
- Leadership and oversight of systems and processes in respect to reporting and recording of incidents which are significant, were not in place.
- Oversight of systems to ensure staff had completed 'highly recommended' training as per General Dental Council professional standards was not effective.
- The system to audit, monitor and improve the quality and safety of the service was ineffective. This failed to identify the deficiencies in the processes to assess patients' needs and deliver care and treatment in line with current legislation, standards and guidance.

Regulation 17 (1)