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Stafford Dental Surgery

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 21 September 2023 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 advisor.

To get to the heart of patients' experiences of care and treatment, the following 2 questions were asked:

- Is it safe?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- Overall, the practice appeared to be visibly clean. However, improvements were needed to the levels of cleanliness in some areas and to the storage arrangements for cleaning equipment.
- The practice had infection control procedures which reflected published guidance; however, these were not consistently followed.
- Appropriate medicines and life-saving equipment were not available in accordance with current guidelines.
- The practice did not have effective systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place; improvements were needed to ensure accurate information was available to staff.
- The practice had staff recruitment procedures which reflected current legislation; however these did not operate effectively.
- Staff worked as a team and enjoyed working at the practice.

Background

Summary of findings

Stafford Dental Surgery is part of Riverdale, a dental group provider. The practice is in Stafford and provides NHS and private dental care and treatment for adults and children.

The practice is accessible for people who use wheelchairs and those with pushchairs. The practice is located close to local transport routes and car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 6 dentists, 5 dental nurses (1 of whom is the trainee), 1 dental hygienist, 1 practice manager and 2 receptionists. The practice has 6 treatment rooms.

During the inspection we spoke with 2 dentists, 4 dental nurses (1 of whom was a locum), 2 receptionists, the practice manager and a seconded group business manager. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Friday from 8:30am to 5:30pm

Saturday from 9am to 3pm

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

- 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 is not meeting are at the end of this report.

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

- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice**
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 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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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. Improvements were needed to the system to ensure information available to staff, relating to the management and escalation of safeguarding concerns was accurate and up to date. We saw the contact information available was not accurate and the policy detailed staff members who were no longer working at the practice.

The practice had infection control procedures which reflected published guidance. Improvements were needed to ensure staff adhered to guidance, including The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05). In particular.

- The temperature of the water used to manually clean dirty instruments was not monitored.
- We could not be assured brushes used to clean dirty instruments were replaced regularly and appeared visibly dirty.
- Staff did not wear the correct personal protective equipment (PPE) when decontaminating dental instruments.
- There were no lint-free cloths available to dry sterilised instruments.
- The practice cleaned instruments as soon as possible after use but when this was not possible, systems were not in place to store them in a moist or humid environment until subsequent decontamination.
- Local anaesthetic was not stored consistently in accordance with guidelines.
- Some sterilised instruments were found stored in a surgery in damaged pouches.
- A number of dental burs were found stored loose in a plastic bag in a surgery, with no way of knowing whether they had been sterilised.
- The sink in 1 of the surgeries was visibly dirty.

We were also shown an infection prevention and control audit completed by the practice, in December 2022. We were told a subsequent audit had been undertaken in June 2023 in accordance with HTM 01-05, however this was not available for review. We noted, the audit in December 2022 did not highlight the shortfalls we found on the day of the inspection, nor the corrective actions required. We discussed with the management team the importance of ensuring records were available to demonstrate the audit is undertaken bi-annually, completed accurately and have action plans to remedy any shortcomings, in accordance with the 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. However, we could not be assured these were effective. A Legionella risk assessment, undertaken in April 2023, made a number of recommendations that were all marked as completed. These included the descaling of taps. Taps seen on the day had a heavy build-up of limescale. The product used for the disinfection of the dental unit water lines was not consistently used in accordance with manufacturer's guidelines. Records available, showed temperature monitoring protocols were carried out monthly until July 2023, but had not been carried out since.

Improvements were needed to ensure clinical waste was segregated and stored appropriately in line with the Health Technical Memorandum 07-01: safe management of healthcare waste (HTM07-01) guidance. We saw some sharps bins

were not labelled correctly and the lids were not secure. Amalgam capsules ready for disposal, were not stored correctly, some were loose in a plastic container and unsecure sharps bin. In addition, the external clinical waste bin was not secured. Waste consignment notes relating to the handling of clinical waste could not be accessed and were not available for review.

On first impression the practice was visibly clean; however, improvements were needed to the level of cleanliness in some areas. We noted improvements could also be made to the storage arrangements of the cleaning equipment. A cleaning checklist was in use; however, it was unclear what areas were cleaned and at what interval. Records available showed this had been completed by staff until July 2023, but had not been completed since.

The practice had access to a recruitment team to help them employ suitable staff and ensure appropriate pre-employment checks were undertaken. However, we found that recruitment procedures and continued oversight of documents were not established nor operating effectively. We were told a member of staff had recently started at the practice, however the practice manager did not have access to any of their recruitment checks. We also noted the system to ensure all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus was not effective as records were not available for all clinical staff. Where a risk assessment was carried out this should adequately consider and mitigate all the risks to the individual.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. An electrical installation condition assessment (EICR) had been undertaken in May 2023 that highlighted 15 areas where actions were required. We were told this work was scheduled to be undertaken in shortly after the inspection. In addition, we saw an electrical socket was hanging off the wall in the staff toilet. Unfinished wires were hanging out of the wall in the lean-to area of the practice, that on the day of the inspection was accessible to both staff and the general public. No steps had been taken to mitigate the risks.

A fire risk assessment, carried out in April 2023 made a number of recommendations that were all marked as complete. These included the removal of electrical extension cables. On the day of the inspection, we saw extension cables were in use in different areas including the lean-to area and office on the first floor. In addition, we could not be assured regular fire drills were carried out with all staff, as part of the overall management of fire safety. We noted the rear fire exits were fitted with key operated locks and we discussed with staff, the importance of considering the risks of this. We were sent confirmation immediately after the inspection that the locks had been changed.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available. We noted clinical staff were not consistently following guidelines in relation to the use of rectangular collimators when taking x-rays.

Risks to patients

The practice did not have effective systems to assess, monitor and manage risks to patient and staff safety. A risk assessment had not been undertaken to consider and mitigate the risks to patients and staff in relation the management of dental sharps and latex.

Recommendations were made in a health and safety risk assessment from April 2023; however, there was no evidence these had been actioned.

We saw a loose handrail on the stairs used by patients and staff and there was no evidence the risks of this had been considered and mitigated.

Emergency equipment and medicines were not available and checked in accordance with national guidance. We saw from the records available, that the monitoring of the medical emergency equipment and medicines was last carried out in July 2023 and had not been carried out since.

Are services safe?

On the day of the inspection, we noted the medicine used to treat epilepsy was beyond its use-by date. Needles and syringes available for use with the adrenaline (used to treat anaphylaxis) were not the correct sizes. Clear face masks for use with the self-inflating bag sizes 0, 2 and 3 and the oxygen face mask with reservoir and tubing for a child were missing.

We noted some items in the first aid kit were out of date. We could not be assured the bodily fluid and mercury spillage kits were in date.

The medicine used to treat hypoglycaemia (low blood sugar) was stored in a fridge in the first floor office. We discussed with staff the importance of considering the risks of storing medical emergency medicines behind a door with a key-code. We were told the fridge temperature was monitored to ensure that medicines and dental care products were being stored in line with the manufacturer's guidance, however no records were available to review to assure us of this.

Staff had completed training in emergency resuscitation and basic life support.

Staff told us the practice had information relating to the storage and handling of hazardous substances. On the day of the inspection, they were unable to access the online portal and we could not be assured they would be able to use this information in the event of an incident.

Information to deliver safe care and treatment

We noted the practice currently maintained digital patient care records. We saw historic paper dental care records were not stored securely. We found these were kept in unlocked filing cabinets in a storage area adjacent to the staffroom, on the day of the inspection, this was accessible to unauthorised persons.

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 had a system in place for monitoring prescription safety; however, this was not effective. We were shown prescription monitoring records and noted gaps and inconsistencies in the information recorded. For example, in one record for September 2023, we noted 2 consecutive prescriptions had no information recorded. Practice staff were unable to tell us whether these prescriptions had been issued or destroyed. In another log, it was apparent the numbering was not sequential and indicated information from different prescription pads was being recorded on the same log. Staff could not be assured all prescriptions would be accounted for.

Improvements were needed to the monitoring system to ensure materials were not beyond their expiry date. On the day of the inspection, we found a number of out of date materials in the surgeries.

Track record on safety, and lessons learned and improvements

There were ineffective systems in place to record and review significant events and accidents and use them as an opportunity to share any learning. We saw a number of sheets had been removed from the accident book but only 1 record was available for review. This had not been completed fully and there was no record of any action that had been taken following the incident.

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

There was a lack of leadership and oversight of processes in relation to peoples' safety.

Systems and processes were not effective or were not consistently followed by staff. On the day of the inspection the practice was open to feedback and took immediate action to address the concerns raised during the inspection. They have provided evidence to confirm that action was in progress. They demonstrated a commitment to continuing the work and engagement with staff and external organisations to make further improvements.

Accurate and up to date information and documentation was not organised or readily available.

We could not be assured the practice had effective processes to support and develop staff with additional roles and responsibilities.

Culture

Staff could not show how they ensured high-quality sustainable services and demonstrated improvements over time.

It was apparent staff worked well together and supported each other.

The practice did not have effective arrangements to ensure staff training was up-to-date and reviewed at the required intervals. On the day of the inspection, we noted there was no monitoring system in place and limited training records were available for staff members. For example, of the 4 staff training records we looked at, infection prevention and control training records were only available for 1 member of staff. No records were available in relation to consent, information governance, Mental Capacity Act, equality & diversity, legal and ethical issues and complaints handling.

Staff discussed their training needs and general wellbeing during annual appraisals, practice team meetings and ongoing informal discussions. We saw concerns had been shared with managers but we could not be assured action had been taken to address the issues raised.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

Staff described some challenges relating to recent staff shortages that they felt had impacted on some protocols not being adhered to. The wider management team were aware of the challenges and steps had been taken to address them.

The governance system included policies, protocols and procedures; however, on the day of the inspection we found these were not accessible to staff.

We saw there were ineffective processes for identifying and managing risks, issues and performance. For example, in relation to fire and electrical safety, risks from dental sharps, incidents and accidents, medicines management, legionella, recruitment procedures and medical emergency arrangements.

Appropriate and accurate information

Are services well-led?

Improvements were needed to ensure all information available to staff was accurate and up to date.

The practice had information governance arrangements and on the whole we noted staff were aware of the importance of protecting patients' personal information. Improvements were needed in relation to the storage of paper dental care records.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients and the public. We were told, where suggestions were made, these would be reviewed and acted on where appropriate.

Continuous improvement and innovation

The practice did not have effective systems and processes for learning, quality assurance and continuous improvement.

Audits of x-rays were not carried out in accordance with current guidance. We could not be assured audits of infection prevention and control were undertaken at the required intervals and did not highlight the areas of improvement noted on the day of inspection. Audits of patient care records were last carried out in October 2021 and a recommendation was made that a follow up audit would be undertaken six-monthly thereafter. There was no evidence this was carried out.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons 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: • Appropriate medical emergency equipment and medicines were not in place in accordance with current requirements. • The decontamination of used dental instruments was not in accordance with HTM01-05. • Protocols were not in place to manage the risks to patients and staff from dental sharps and latex. • Some electrical installations were not maintained safely in accordance with electrical safety regulations. • Out of date materials were found in some of the surgeries. • The risk of injury from loose handrail on the stairs had not been considered and mitigated. • Clinical waste was not segregated and stored in accordance with HTM07-01. • Records were not available to demonstrate all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. Regulation 12 (1)

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 17 HSCA (RA) Regulations 2014 Good governance
	
	Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	
	How the Regulation was not being met:
	
	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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:
	
	• Systems for the oversight and management of risks were not effective. For example in relation to:
	  ■ dental sharps
	  ■ latex
	  ■ unsafe electrical installations
	  ■ out of date materials
	  ■ a loose handrail on the stairs
	• Where risks assessments have identified specific risks these risks had not been assessed and mitigated. For example in relation to fire safety, legionella and health and safety.
	• The monitoring of the medical emergency medicines and equipment was not carried out as recommended and did not ensure all items were available and in date.
	• Required remedial work highlighted in the electrical installation condition report had not been carried out.
	• Systems to ensure clinical waste was not segregated and stored in accordance with the regulations were not effective. Information relating to the management of clinical waste was not available.
	• Systems to ensure materials were not available for use, beyond their expiry/use by dates were not effective.
	• Prescriptions were not stored securely and were not monitored appropriately.

This section is primarily information for the provider

Enforcement actions

- Cleaning equipment was not stored in accordance with guidelines, cleaning schedules were not being completed and areas of the practice did not appear clean.
- Incidents and accidents were not recorded correctly, reviewed and used as an opportunity for shared learning.
- Information relating to the storage and handling of hazardous substances was not accessible to staff.

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:

- Infection prevention and control and radiology (X-rays) audits are not completed in accordance with current guidelines.
- Staff cannot access important, accurate information and policies.
- The systems to enable and support leadership and staff oversight were not working effectively.
- The system for ensuring staff followed guidance was ineffective.
- Historic dental care records were not stored securely.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- Systems to monitor and share recruitment information were not effective.
- The system to ensure all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus was not effective.
- Systems to monitor staff training and ensure this is undertaken at the required interval were ineffective.

Regulation 17 (1)