Mr. David Gilkeson

Dental Surgery - Stonegate

Inspection Report

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Overall summary

We carried out an announced follow-up inspection at Dental Surgery - Stonegate on 23 April 2018.

We had undertaken an announced comprehensive inspection of this service on the 23 November 2017 as part of our regulatory functions where breaches of legal requirements were found.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. This report only covers our findings in relation to those requirements. We checked whether they had followed their action plan to confirm that they now met the legal requirements.

We reviewed the practice against three of the five questions we ask about services: are the services safe, effective and well led? You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dental Surgery - Stonegate on our website at www.cqc.org.uk.

We revisited Dental Surgery - Stonegate as part of this review and checked whether they now met the legal requirements. We carried out this announced inspection on 23 April 2018 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 CQC inspector who was supported by a second CQC inspector and two specialist dental advisers.

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

Are services effective?

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

Are services well-led?

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

Background

Dental Surgery - Stonegate is in York and provides NHS and private treatment to adults and children.

Summary of findings

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, four dental nurses (two of whom are locums and one is a trainee) and a short-term practice manager.

The practice has one surgery, a decontamination room for sterilising dental instruments, a staff room/kitchen and a general office.

The practice is owned by an individual who is the principal dentist. 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 dentist, the practice manager and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday – Friday 9am to 12 pm & 2pm to 5pm

Our key findings were:

- Environmental cleaning of the practice was now carried out in line with recommended guidance.
- Infection control procedures were much improved and mostly reflected current guidance. Improvements could be made to ensure the practice was fully in line with guidance.
- Staff awareness of the process to identify, record and respond to a significant event remained limited.
- Staff were now confident they knew how to deal with medical emergencies. Emergency medicines and life-saving equipment reflected up to date guidance.
- Staff knowledge of systems to help them manage risk was limited.
- Fire safety management systems were improved. Further improvements could be made to ensure the process is fully embedded.
- The practice was now registered to receive medical device alerts from Medicines and Healthcare Products Regulatory Authority (MHRA).
- A process for the disposal of items identified under Control of Substances Hazardous to Health was in place.
- Clinical waste was not being prepared for disposal in line with recognised guidance.
- Staff awareness of safeguarding procedures had improved but knowledge of the processes to follow was not fully embedded at all levels.
- Awareness of the appropriate staff recruitment process to follow had improved but was not embedded.
- Clinical staff provided patients' care and treatment mostly in line with current guidelines but improvements could be made.
- Some areas of leadership had improved and staff felt supported although further action was necessary to ensure leadership was effective at all levels.
- Areas of concern relating to patients privacy and confidentiality had been addressed.

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 

We found that this practice was not providing safe care in accordance with the relevant regulations. The practice was still in breach of Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment.

Since the inspection on the 23 November 2017 improvements had been made to the environmental cleaning process and this was now carried out and monitored in line with guidance, for example, carpets had been removed and linoleum flooring fitted in several key areas.

Infection prevention and control and equipment validation processes had been reviewed and improved; these were now more in line with current guidance. Some areas of the infection prevention and control process could be further improved to ensure guidance was being fully adhered to.

The process to identify, report, record and analyse significant events or events that required reporting in accordance with the Reporting of Injuries, disease and Dangerous Occurrences Regulations 2013 was not embedded.

The practice was now registered to receive national patient safety and medicines alerts and a system for monitoring them was in place.

Rubber dam was not used routinely and no risk assessment procedure was in place to ensure patient safety.

Fire safety management procedures had been reviewed and appropriate action was taken to initiate a reduction of fire risks within the practice. We noted that in-house routine checks were not being carried out on the smoke detectors and firefighting equipment to ensure they were fit for purpose.

A process for the disposal of items identified under Control of Substances Hazardous to Health was now in place.

Awareness of the appropriate staff recruitment process to follow had improved but was not embedded.

We highlighted an area of concern in relation to clinical waste bags being prepared for disposal. The process was not being carried out in line with current guidance.

The practice's risk management processes were still not effective or embedded within the team.

The process to refer patients with suspected oral cancer was poorly understood.

Are services effective?

No action

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

Summary of findings

We found there were elements of the effectiveness key question which had improved but some areas required further improvement. These are detailed in the main body of the report under consent to care and treatment, monitoring care and treatment, effective staffing and co-ordinating care and treatment.

The system in place to obtain consent to care and treatment was not in line with legislation and guidance.

Awareness of the Mental Capacity Act 2005 was still limited; no policy was in place to support staff.

We found the providers approach to patient recall intervals was not in line with current guidance.

Improvement was made to ensure staff completed training relevant to their role and staff told us they were fully supported to develop their skills. There was no system in place to monitor staff training or provide regular staff appraisals.

The practice had a process to identify patients who required a referral to other dental or health care professionals, but no log was in place to monitor or track the referral.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. The practice was still in breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Governance arrangements had improved but inconsistencies remained and staff lacked knowledge of the detail.

The process to manage sharps within the practice was inconsistent.

There was insufficient awareness of responsibilities concerning gaining appropriate consent and the Mental Capacity Act 2005.

Staff awareness of safeguarding and associated procedures had improved but there was limited understanding of the reporting processes to follow.

The process in place to recruit staff was improved but some elements still needed to be addressed.

Awareness of responsibilities in relation to Duty of Candour had improved, although a formal policy had not been produced.

Enforcement action

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays))

The practice had some improved systems to keep patients safe but further improvements could be made.

Staff had greater awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances but improvements could be made to embed the process fully and to include a reporting system. Staff training was carried out in 2017 and the provider had completed training in March 2018 and was also the safeguarding lead. Safeguarding policies had not been reviewed or updated since our last visit in November 2017 and the provider was unsure if the existing policies were still relevant. To determine a level of understanding we discussed safeguarding awareness with the team and the support staff were able to give us a detailed account of their individual responsibilities. The provider gave a less detailed account of their safeguarding responsibility and familiarity of the reporting processes to follow in the event of raised concerns was limited. We highlighted these areas of concern to the provider on the inspection day.

Staff were aware of their responsibilities with regards to whistleblowing although there was no policy to guide staff on the correct procedure to follow if required.

The provider did not use rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment. We were told that occasionally alternative methods would be used. There was no risk assessment procedure in place to mitigate the risks associated with the alternative methods and to ensure patient safety.

Some improvement had been made to address the recruitment concerns identified at the last inspection. We reviewed four staff files and found that Disclosure Barring and Service checks had been carried out for all staff.

The practice manager told us they were in the process of recruiting a dental nurse. We noted there was no policy or structure to the recruitment process to assure us relevant legislation was being followed during the recruitment of the dental nurse. The practice manager also told us they would be updating the recruitment procedures and a policy would be put in place to reflect relevant legislation.

We reviewed the provider's awareness of guidance from the Faculty of General Dental Practice (FGDP(UK) on X-ray frequency. Some improvement was evident but this process was not yet embedded. We saw evidence that the provider justified and graded on the radiographs they took. The practice had carried out a radiographic audit 21 April 2018, this followed current guidance. A rectangular collimator, designed to reduce the radiation dose to patients, was available but remained unused.

Risks to patients

The systems to assess, monitor and manage risks to patient safety was not embedded.

During our previous visit we identified that there was no formal process for logging or checking urgent referrals for suspected oral cancer. The provider told us they now had the relevant forms to refer patients with suspected oral cancer under the national two week wait arrangements but no referral tracker was in place. We asked the provider to give an example of when the referral process would be used. The provider's understanding of the process was unclear.

Although we noted that in-house routine checks were not being carried out on the smoke detectors and firefighting equipment to ensure they were fit for purpose, fire safety management procedures had been reviewed and positive action was taken to initiate a reduction of fire risk within the practice. For example, a fire risk assessment was carried out 6 February 2018, smoke detectors had been fitted, an evacuation drill had taken place and a fire alarm system and fire resistant doors were planned.

Since our last visit the provider told us that sharps management was now being fully enforced and staff concurred. The provider told us they had not updated the policy to reflect this. We reviewed the sharps risk assessment and found it did not reflect current practice and contradicted a second risk assessment we came across; the risk assessments stated that a type of safer sharp was in use but this was not the case.

Staff also told us that they sometimes dismantled matrix bands. Matrix bands are considered a sharp item; staff were

not aware of this. One of the risk assessments did not include other sharp dental items such as matrix bands. The provider was not fully aware of the 2010 EU Directive on safer sharps usage. Sharps management was not fully compliant with the regulation.

Since our last visit, staff had completed training in emergency resuscitation and were confident they knew how to respond to a medical emergency.

Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. We noted the expiry date for medical emergency glucagon had not been adjusted to reflect that it was no longer being kept in the fridge.

Infection prevention and control (IPC) processes had been reviewed and improved; these were now more in line with current guidance. The practice was now working to the updated version of Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. Some areas of the IPC process could be further improved to ensure guidance was being fully adhered to. For example, validation of the ultrasonic bath was not being carried correctly. In addition, we noted the ultrasonic bath was not drained after the morning session as recommended in HTM 01-05.

Improvements were being made to update the IPC policy and the provider was now identified as the IPC lead. The provider told us they were not aware if there was an updated IPC policy.

The decontamination room was clutter free and new cabinetry had been installed. A double sink unit was now in place; this supported the correct hand washing and decontamination of instruments processes and a protocol was now in place for staff to follow. We observed throughout the inspection day that hand washing was not routinely taking place before or after decontaminating the instruments; this is contrary to the practice policy and recommended guidance. We also saw a staff member collected dental materials from the fridge whilst wearing clinical gloves; it was unclear if the gloves were clean. This practise was not in line with current guidance.

The provider had carried out IPC audits in line with current guidance but there was no resulting action plan or learning outcomes in place.

The environmental cleaning process was now carried out and monitored in line with current guidance. Alterations to the flooring in some areas had helped the cleaning process.

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 a sample of dental care records to confirm our findings. We noted that individual records were typically written and managed in a way that kept patients safe with the exception of risk assessment for caries, cancer and tooth wear. Dental care records we reviewed were legible and were kept securely and complied with data protection requirements.

Track record on safety

The provider told us that the IT system installed in January 2018 held all risk assessments for the practice.

The provider had installed an IT system which provided generic policies and risk assessments from a compliance company. These documents are generic until modified to become practice specific. The health and safety policy and risk assessments we reviewed were generic and had not been modified to reflect the risks within the practice. We identified a dental practice risk assessment which had not been adjusted to reflect the practice. We identified two risk assessments for sharps management and associated risk; these contradicted each other. The provider told us the IT system had provided policies and risk assessments but did not acknowledge that these required tailoring to the practice's specific circumstances. We asked staff of their awareness of the sharps risk assessment, staff told us they knew of it but were unsure of its location. Risk awareness and management of processes were not embedded within the practice at all levels.

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

During the last inspection we identified an area of concern relating to the clinical waste bagging process. We saw that improvements had been made and clinical waste was now being disposed of appropriately into a clinical waste bag in the decontamination room. We did identify a concern with clinical waste being deposited into a black bin liner (which

Are services safe?

was inside a yellow clinical waste bag) in the X-ray developing room. Upon further discussion it transpired that the black bin liner was used to prevent the yellow clinical waste bag from bursting open when the content of the bag was squashed down using the operator's foot. We highlighted to the provider that this is not recommended practise and the method explained to us is not in line with Health Technical Memorandum 07-01: Safe management of healthcare waste.

Lessons learned and improvements

Since our last visit no formal process had been put in place to identify, respond to and learn from significant events and incidents. The provider had limited understanding of what constituted a significant event. The provider was able to tell us they had an understanding of a near miss but was unable to give an account of what could constitute a significant incident other than something which affected a patient clinically. The provider had some awareness of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager told us they planned to carry out a training session on this topic to ensure it was more widely understood. We saw evidence the training was planned for 17 May 2018.

The provider had registered the practice to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). A staff member was responsible for monitoring the alerts and the provider told us that they would be read and actioned if relevant to the practice. The provider told us that since registering in January 2018 they had received some alerts but none were relevant to the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The provider told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. The provider told us they used fluoride varnish for children based on an assessment of the risk of tooth decay.

The provider told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments.

The provider described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice.

Consent to care and treatment

We discussed with the provider if any improvements had taken place in respect to the recording of consent. The provider told us that verbal consent is most often obtained. A written treatment plan would be given to the patient and the nature and purpose of the treatment would be discussed. We saw that the patient's records were not always being completed to reflect the verbal discussion had with the patient. We identified that minimal improvements had been made since our last inspection. The provider did not routinely obtain consent to care and treatment in line with legislation and guidance, this process was not yet embedded.

We discussed with the provider what improvements had taken place to having a better understanding of their responsibility to and awareness of the Mental Capacity Act 2005. The provider gave a limited response to their responsibilities and awareness of the Mental Capacity Act 2005 and was unable to explain the key tests for testing capacity. The provider had undertaken Mental Capacity Act training in March 2018.

There was no consent or Mental Capacity Act 2005 policy in place to support staff.

Monitoring care and treatment

We discussed with the provider how patient recall intervals are assessed. The provider told us treatment needs were assessed but recall intervals were driven by patient preference rather than the risk based approach advised in National Institute of Clinical Excellence (NICE) guidance.

Effective staffing

The provider told us that they fully supported staff development and staff confirmed this.

We saw no evidence to support that an induction processes had been considered since our last inspection. We were told that locum dental nurses often worked at the practice; these were sourced from a local agency. A formal induction process was not in place to protect non-regular staff working at the practice.

We also reviewed the progress of staff development and appraisal. Staff told us that an appraisal process had not yet been implemented.

Co-ordinating care and treatment

The provider confirmed they routinely referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. The practice had a process to identify patients who required a referral, but no log was in place to monitor or track the referral.

Are services well-led?

Our findings

Culture

Staff told us they now worked more as a team and that there was an improved structure in their work.

The practice continued to maintain a patient focussed approach.

We reviewed the awareness of the Duty of Candour within the practice. Although there was no Duty of Candour policy in place the provider was aware of the requirements to be open, honest and to offer any apology if anything went wrong and was able to offer a scenario to support this.

Staff told us they were able to raise concerns and were encouraged to do so. They now had more confidence that these would be addressed. Staff told us they felt more empowered and the provider was becoming more amenable to change.

The practice manager was working temporarily at the practice addressing some of the administrative matters. We were told the provider was more engaged and willing to be involved.

Governance and management

Since February 2018 a practice manager had been working at the practice approximately six days per month to help with the governance and management arrangements.

The provider commissioned a company in January 2018 to install an IT system and software package. The package comes with a complete set of generic policies and risk assessments. Training on the IT system is due to take place May 2018.

The provider had commissioned the changes and improvements but was not driving them and as a result lacked critical awareness.

We discussed what improvements had taken place in respect of dental practice governance. The provider was unaware of the detail of the policies and risk assessments now available and could not confirm whether existing policies had been replaced or updated. Some risk assessments were contradictory and some policies were not in place, for example, whistleblowing, consent and duty of candour.

Risk management was not effective, rubber dam was still not in use and we saw evidence that the fast track referral system was unclear to the provider. Safeguarding processes and sharps management and awareness were still not fully embedded within the practice.

The provider had overall responsibility for the management and clinical leadership of the practice.

The practice manager gave assurance that they would encourage the provider to be more involved in the administrative element and to take ownership of the governance going forward.

The practice manager was working hard to bring order to the practice and staff confirmed they felt the practice manager had brought more of a structure to the work environment. We saw a planned training session for May 2018 and we saw that a practice meeting had taken place, where they had discussed some immediate concerns.

The provider was unable to give assurances on the inspection day that they were fully engaged with the governance element of compliance.

Continuous improvement and innovation

We reviewed if improvements had been made to the quality assurance processes. We found that radiographs and infection prevention and control processes were being audited. Improvements could be made to ensure records of the results of the audits and an action plan for learning and improvement was being recorded.