Petrie Tucker and Partners Limited

Mydentist - Cavendish Road - Claughton

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 14 February 2024 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:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which reflected published guidance. Improvements were needed to ensure these protocols were consistently followed.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Improvements were needed to the systems for managing risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- The practice had staff recruitment procedures which reflected current legislation.

Background

Mydentist - Cavendish Road - Claughton is part of Mydentist, a dental group provider. The practice is in Wirral in Merseyside and provides NHS and private dental care and treatment for adults and children.

There is ramp access to the practice 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 3 dentists, 3 dental nurses (including 1 trainee), 1 dental hygienist, 1 dental therapist, 1 practice manager and 1 dental nurse/receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with 1 dentist, 1 dental nurse, 1 dental nurse/receptionist and the practice manager. The practice was supported by the group's Lead Regulatory Officer. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday, Tuesday and Thursday from 9am to 5.30pm

Wednesday from 9am to 6.30pm

Friday from 8.30am to 5pm

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation 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 protocols regarding auditing to ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

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 well-led?	**Requirements notice** ✗

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The 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:

- Staff did not wear the correct personal protective equipment (PPE) when decontaminating used dental instruments.
- Staff did not follow hand-washing protocols before and after decontaminating dental instruments.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment that was last reviewed January 2023. A number of recommendations had been made in January 2022, that included the removal of dead-legs. These were identified again at the review in January 2023 as outstanding. On the day of the inspection we could not be assured these actions had been completed. Prior to the inspection, a new risk assessment had been planned for 22 February 2024 and we received confirmation from the regulatory lead, that any previously outstanding recommendations would be completed prior to this being carried out.

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 2 of the 3 clinical waste bins were unlocked, they were not secured and were accessible to the public.

The practice appeared clean. Improvement could be made to ensure staff consistently completed the schedule in place to ensure it was kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These reflected the relevant legislation.

Clinical staff were qualified, registered with the General Dental Council. We discussed with the practice manager the importance of ensuring they obtained evidence of up-to-date indemnity cover for all clinical staff.

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

A fire safety risk assessment was carried out in line with the legal requirements. Overall, the management of fire safety was effective. The practice manager confirmed fire evacuation drills should be undertaken every six-months in accordance with practice protocols. We noted the last one was carried out in April 2023. They confirmed a fire drill would be carried out shortly after the inspection.

The practice had the required radiation protection information; however, improvements were needed in relation to the management of risks. A risk assessment, carried out by the practice manager identified a risk of unintentional radiation exposure in 1 surgery, and protocols had been introduced to mitigate the risk. These protocols differed from those detailed in the safety information available to staff. There was no evidence the practice leadership team had sought guidance from their Radiation Protection Supervisor (RPS) or other appropriately trained individual, when carrying out the risk assessment, in accordance with practice protocols.

Are services safe?

In addition, we noted a recommendation was made in a health and safety risk assessment, that keys should be removed from X-ray control panels to prevent unauthorised use/access. However, on the day of the inspection, we noted an X-ray unit control panel, located outside 1 surgery, was set to the 'on' position, and the keys were not present. The practice could not be assured the equipment would not be operated by unauthorised persons.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety; however we could not be assured these operated effectively. The practice manager had carried out a number of risk assessments in relation to the management of dental sharps, but these did not include the use of safety needles. On the day of the inspection, we noted staff were not consistently following practice protocols in relation to the disposal of used dental sharps. A risk assessment was in place for when staff worked alone; however, it did not reflect the current protocols in the practice.

Emergency equipment and medicines were available and checked in accordance with national guidance. The practice had a second oxygen cylinder for use in an emergency, located in the locked office. We discussed with the practice manager, the importance of ensuring this was easily accessible to all staff.

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

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. We noted the information was stored in the locked office. We discussed with the practice manager, the importance of ensuring this information was easily accessible to all staff.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out. NHS prescription pads were kept secure, and a log was in place to monitor and track their use.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice had a system for receiving and acting on safety alerts.

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 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 practice staff demonstrated a transparent and open culture in relation to people's safety. During the inspection, staff were open to discussion and feedback.

There was a lack of management oversight for some of the practice's systems and processes, and the inspection highlighted a number of issues and omissions.

Improvements should also be made to the oversight of the leadership team to ensure that the practice's systems and processes were followed and risks managed appropriately.

Culture

Staff stated they felt supported and enjoyed working at the practice.

Staff discussed their training needs during annual appraisals, during clinical discussions, practice team meetings and ongoing informal discussions. They also discussed learning needs, general wellbeing and aims for future professional development.

We saw staff carried out continuing professional development. We were shown a tracker for monitoring staff training, however this had last been updated in August 2022. Improvements were needed to the system to enable the practice manager to assure themselves that staff's training was up-to-date and undertaken at the required intervals, for example, in relation to safeguarding, and infection control.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. However, there were ineffective systems to monitor these and ensure that the practice team followed all practice procedures.

We saw there were processes for managing risks, issues and performance; however, these did not always work effectively.

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 were being taken to address them. They felt confident improvements would be implemented and maintained once the staffing situation stabilised.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Are services well-led?

Feedback from staff was obtained 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 where appropriate.

Continuous improvement and innovation

The practice had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, antimicrobial prescribing, and infection prevention and control. Audits did not consistently contain reflective outcomes and action plans to drive improvement.

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 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 managing Legionella were not effective. When recommendations were made, there was no evidence all actions had been completed. • Staff did not have access to accurate X-ray safety information for each surgery. • Systems to ensure staff consistently adhered to protocols and guidance in relation to X-ray safety, infection prevention and control and dental sharps, were not effective. • Systems relating to the management of dental sharps had not considered all the risks. • The risk assessment for when staff worked alone did not reflect the current protocols at the practice. • Systems to ensure clinical waste was segregated and stored in accordance with the regulations were not effective. 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:

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Requirement notices

- Systems to monitor staff training and ensure this is undertaken at the required interval were ineffective.

Regulation 17(1)