S A Harrison Laboratories Limited

Safe Dental

Inspection report

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Date of inspection visit: 18 December 2020
Date of publication: 15/02/2021

Overall summary

We undertook a follow up focused inspection of Safe Dental on 18 December 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 specialist dental adviser.

We undertook a follow up focused inspection of Safe Dental on 23 September 2020 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 safe or well led care and was in breach of regulations 12, 17 and 19 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 Safe Dental on our website www.cqc.org.uk.

As part of this inspection we asked:

• 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.

The provider had made improvements to comply with the conditions of registration which we imposed after the inspection on 23 September 2020, however, insufficient improvements had been made to ensure compliance with the Regulations.

Summary of findings

Are services well-led?

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

The provider had made improvements to comply with the conditions of registration which we imposed after the inspection on 23 September 2020, however, insufficient improvements had been made to ensure compliance with the Regulations.

Background

Safe Dental is in Morley and provides private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes four dentists, a dental hygienist and therapist, a dental nurse, a receptionist, a clinical dental technician and a marketing assistant. The practice has one treatment room.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Safe Dental is the clinical dental technician.

During the inspection we spoke with the clinical dental technician, the dental nurse, one dentist and the dental hygienist and therapist. We looked at practice policies and procedures and other records.

The practice is open:

Monday to Friday variable hours

Our key findings were:

- Improvements had been made to the systems for managing the risks associated with fire and Legionella. Further improvements could be made.
- Systems and processes to manage the risks associated with Covid-19 reflected nationally recognised guidance.
- Improvements had been made to the recruitment process. Further improvements could be made to the process for obtaining an up to date Disclosure and Barring Service check for new staff.
- Further improvements were required to governance processes to ensure compliance. In particular, the oversight of medical emergency arrangements and recruitment processes.

We identified regulations the provider was not meeting. 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.

Summary of findings

Full details of the regulations the provider is 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?	**Requirements notice** ✖
Are services well-led?	**Requirements notice** ✖

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 Requirement Notices section at the end of this report).

At our previous inspection on 23 September 2020 we judged the provider was not providing safe care and was not complying with the relevant regulations. We told the provider to take action. At the inspection on 18 December 2020 we found the practice had made some improvements. However, the improvements were not sufficient to fully comply with the regulations.

- We saw the actions identified in the fire alarm service and inspection report had been addressed. These included fitting additional fire detectors and internal sounders to the premises. We saw evidence of a sign off sheet for the work done. In addition, we saw evidence the actions identified in the emergency lighting inspection report had been addressed. These included installing additional emergency lighting. We also saw evidence of regular testing of the fire alarm and emergency lighting.
- During the inspection we noted the cellar was used as part of the dental laboratory. The cellar was visibly cluttered with flammable substances including paint, motor oil and dental laboratory substances. We shared our concerns with the local fire service.
- Improvements had been made to the system for managing the risks associated with Covid-19. We were told the practice had adopted protocols as laid out in nationally recognised guidance. We saw evidence of fit test certificates for enhanced personal protective equipment (PPE) for all staff involved in aerosol generating procedures (AGP). The practice had implemented an appropriate fallow time in line with nationally recognised guidance. AGPs are procedures that create a higher risk of respiratory infection transmission and are defined as any dental or patient care procedure that can result in the release of airborne particles.
- Improvements had been made to the process for ensuring staff had adequate indemnity cover. We saw evidence of adequate indemnity for all clinical members of staff. However, we noted the newest member of staff did not have an up to date DBS check. We saw evidence of a DBS check carried out by a previous employer for this member of staff which was four years old. There was no risk assessment in place to mitigate the risks associated with not having an up to date DBS check.
- Improvements had been made to the addressing the risks associated with Legionella. We saw the cold feed to the shower had been re-fitted therefore removing a previously identified dead leg. In addition, the tap in the decontamination room had been fixed and was now fully functional therefore not creating a dead leg. Dead legs are sections of potable water piping systems that have been altered, abandoned or capped such that water cannot flow through them. These lead to stagnation and increase the risk that the water inside the pipe becomes contaminated with potentially dangerous bacteria, including Legionella. We were told the responsibility of testing the water temperatures had been delegated to a member of staff who did not have the knowledge or training to interpret the results. We asked if they had completed Legionella awareness training and they confirmed they had not. The Legionella risk assessment states that all personnel involved in Legionella control should receive appropriate training. When we checked the records of the water temperatures, we noted the hot water temperatures did not reach 55◦C at one of the sentinel outlets. Hot water temperatures should reach 55'C in healthcare premises after running for one minute. We discussed this with the registered provider who told us that these temperatures were incorrect and said that it was due to staff not taking the reading correctly.
- The infection prevention and control audit which had been completed on 14 September 2020 had been reviewed on 6 November 2020. Improvements had been made to some aspects of the audit. We noted a question within the audit had been modified. This related to the replacement of heavy-duty gloves used for manually cleaning used instruments. The audit had previously asked if the gloves were changed "weekly". We noted this had been changed to "monthly". We were told this had been done by the registered provider. Nationally recognised guidance as laid out in

Are services safe?

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05) states that these gloves should be changed on a weekly basis. We discussed this with the registered provider who told us they had changed the audit as they did not agree with the guidance and had therefore changed the audit question. There was no risk assessment in place and the registered provider told us that they were a part time surgery. Staff told us that they were working four or five days a week. In addition, we noted a question relating to the use of clinical waste bags had been answered incorrectly. This had not been identified by effective governance oversight.

The provider had made improvements to comply with the conditions of registration which we imposed after the inspection on 23 September 2020, however, insufficient improvements had been made to ensure compliance with the regulations.

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 Requirement Notices section at the end of this report).

At our previous inspection on 23 September 2020 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action. At the inspection on 18 December 2020 we found the practice had made some improvements. However, the improvements were not sufficient to fully comply with the regulations.

Systems and processes were not working effectively to ensure the risks associated with the carrying out of the regulated activities were appropriately managed:

- The system in place to ensure newly recruited members of staff had an up to date DBS check was not effective. This was highlighted by the fact that the registered provider could not show that a new member of clinical staff had a DBS check carried out within the previous three months. In addition, there was no risk assessment in place to mitigate the risks associated with this.
- The system in place to ensure the infection prevention and control audit process reflected nationally recognised guidance was not working effectively. This was highlighted by the fact the infection prevention and control audit had been modified and the reasoning behind the modification had not been risk assessed or the reasoning documented.
- Some improvements had been made to the system for checking emergency medicines and equipment. We checked the contents of the emergency medicine and equipment kit. These reflected nationally recognised guidance. We saw evidence that an item had been replaced since the previous inspection as a result of the checking process. However, we noted one item (the spacer for the inhaler) had passed its expiry date. This item was not kept with the rest of the medical emergency kit and therefore had been missed when it was checked. We saw evidence a replacement was ordered on the day of inspection. We were told this would be included in the medical emergency kit and would be included in the checking process.
- The system in place to ensure the risks associated with Legionella were appropriately managed was not effective. This was highlighted by the fact that water temperatures had not exceeded 55◦C from the sentinel outlets. In addition, not all members of staff involved in the control of Legionella had not completed Legionella awareness training.

The provider had made improvements to comply with the conditions of registration which we imposed after the inspection on 23 September 2020, however, insufficient improvements had been made to ensure compliance with the regulations.

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 **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:** • The system in place to ensure new members of staff have a current Disclosure and Barring Service check or risk assessment was not effective. • The system for ensuring emergency medical equipment did not pass its use by date was not effective. • The system in place to ensure the risks associated with Legionella were actioned and responsible staff provided with the necessary training was not effective. • The updated infection prevention and control audit did not reflect nationally recognised guidance. **Regulation 17 (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 **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:** • There was not a valid DBS check for a newly recruited member of clinical staff and no risk assessment in place to mitigate the risks associated with this. • Legionella water temperatures for the sentinel outlets had not reached the required temperatures. • The cellar was visibly cluttered and was used by staff.

This section is primarily information for the provider

Requirement notices

- The infection prevention and control audit had been modified by the registered provider. No risk assessment had been done and no reasoning documented to support the change.

Regulation 12 (1)