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Richardsons Dental Practice

Inspection report

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Overall summary

We carried out this announced focussed inspection on 10 May 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

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

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

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

Richardson's Dental Practice is located in Sutton-in-Ashfield town centre in north Nottinghamshire 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. There are town centre car parks available near the practice including spaces for blue badge holders.

The dental team includes two part-time dentists, two dental nurses, and the provider. The practice has two treatment rooms, both of which are on the ground floor. Currently, only one is in use as the second is being used as a personal protective equipment donning and doffing area.

The practice is owned by an individual. 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 one dentist, one dental nurse and the practice owner. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday: 9am to 5pm.

Our key findings were:

- The practice appeared to be visibly clean.
- A Legionella risk assessment had not been completed.
- There was no Landlords gas safety certificate or five-year fixed wire electrical safety certificate.
- The provider had implemented measures to reduce the risks of COVID-19 to staff and patients.
- The provider had effective? infection prevention and control procedures, although infection control audits were not being carried out.
- Staff knew how to deal with medical emergencies.
- The practice did not have all of the emergency equipment identified in national guidance.
- The provider's systems to help them identify and manage risk to patients and staff could be strengthened and improved.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's staff recruitment procedures did not follow the regulations.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- The quality assurance programme including audits could be improved.
- Staff felt involved and supported and worked as a team.
- The provider did not have systems to ensure staff completed their continuing professional development. Particularly in respect of safeguarding and infection prevention and control.

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

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

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

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of dental dam for root canal treatment.

- Take action to ensure clinical staff are aware of the recognition, diagnosis and early management of sepsis.

- Review the practice protocols regarding audits for prescribing of antibiotic medicinestaking into account the guidance provided by the Faculty of General Dental Practice.

- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

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 effective?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

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.

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

The provider did not have oversight of the infection prevention and control audits, as none had been undertaken.. The guidance HTM 01-05 identifies these audits should be completed on a six-monthly basis and when necessary an action plan produced to identify how improvements would be made.

The provider had introduced procedures to minimise the risks to patients and staff related to COVID-19. These included reduced patient numbers, social distancing, personal protective equipment for staff, and face coverings for patients and any chaperones. In line with the standard operating procedure produced by the Chief Dental Officer additional measures had been introduced when completing aerosol generating procedures (AGP's). These are procedures which will produce a splatter (for example drilling into a tooth) and therefore increase the risk of spreading the COVID-19 virus. Increased cleaning regimes had been introduced and the time between procedures had also increased to allow any air borne particles to settle and be cleaned.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments broadly in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

The risks relating to Legionella had not been adequately assessed by the provider. They had not had a Legionella risk assessment completed and was not aware if the landlord had completed one in the past. We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. Records of water temperature testing and dental unit water line management were maintained.

We saw effective cleaning schedules to ensure the practice was kept clean. During the inspection we saw the practice was visibly clean.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Measures were taken to ensure clinical waste was stored securely.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist told us they did not use a dental dam when completing root canal treatments,although dental dams were available. The dentist said root canal treatments were rare at the practice. This was not in line with guidance from the British Endodontic Society for providing root canal treatment. The dentist was not assessing the risks or taking measures to minimise them, the provider did not have an overview of those potential risks related to not using a dental dam or the use of alternative methods to protect the patients' airway.

The staff recruitment records did not have all of the information that Schedule 3 of the Health and Social Care Act 2008 Regulations say they should. We looked at five staff recruitment records. Out of the five records we saw that three staff members had Disclosure and Barring Service (DBS) checks that pre-dated their appointment. In one example the DBS

check was completed nine years before their appointment. The Care Quality Commission guidance on this matter identifies that: "Depending on their role and activities, new entrants to the workforce in services regulated by CQC are expected to obtain a new DBS check where eligible." In addition, none of the staff records had information relating to health status of the employee as identified in Schedule 3.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

We noted the annual landlord's gas safety certificate was dated 18 November 2017. The provider told us the landlord had been asked to arrange a new one, but this had not been actioned. We asked about a five-year fixed wire electrical safety check and the provider did not have an up-to-date certificate.

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider had registered with the Health and Safety Executive in line with changes to legislation relating to radiography. Local rules for the X-ray units were available in line with the current regulations. The provider used digital X-rays.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had not fully implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

A Covid-19 risk assessment had been completed. We observed staff were wearing personal protective equipment and a social distancing regime was in place.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

None of the clinical staff had completed training in the recognition, diagnosis and early management of sepsis. There was no posters or guidance for staff available in the practice. Staff had a general awareness of sepsis management and identification This could be strengthened through training.

Staff had completed training in medical emergencies and resuscitation in July 2020, and there were certificates available to evidence they had completed the training. A review of the emergency medicines in the practice showed they were not as identified in the 'British National Formulary': there was no dispersible aspirin and no buccal midazolam. We were told staff checked the emergency medicines regularly, but the checks had not identified the missing items. We saw the practice did not follow the recommended medical emergency equipment list as per the Resuscitation Council UK guidance. We saw there were items missing from this list at the practice. For example, the practice did not have portable suction or a self-inflating bag with reservoir for children or clear face masks for this. We also noted the size 1 oropharyngeal airway, oxygen masks for both adults and children and the self-inflating bag with reservoir for adults were past their use by dates. Staff checks had also failed to identify that equipment was missing or past its use by date.

Are services safe?

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. These included risk assessments and product data safety sheets.

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 dentists how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were hand-written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, and complied with General Data Protection Regulation requirements. We saw that some dental care records were stored in open shelving within the practice. This was not secure, and we advised the provider that hard copies of dental care records should be kept in lockable shelving to protect their security.

Medical histories were checked by the dentist at each visit, and they formed part of the patients' dental care record.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. We were told there was no log for private referrals, and therefore no way to track them or monitor their progress.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

Dentists were recording the antibiotics they prescribed in the patients' dental care records. However, antimicrobial prescribing audits were not being completed. The Faculty of General Dental Practice (FGDP) guidelines identify clinical audits of antibiotic prescribing have shown a reduction in the number of prescriptions and in the number of inappropriate prescriptions, as well as a dramatic improvement in the accuracy of dose, frequency and duration for antibiotic prescriptions. The FGDP recommend these audits are completed at least annually.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been one safety incident. The practice had systems and processes to record, investigate and analyse any safety incidents that occurred.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required. The practice reviewed regular Coronavirus (COVID-19) advisory information and alerts. Information was provided to staff and displayed for patients to enable staff to act on any suspected cases. Patients and visitors were requested to carry out hand hygiene and wear a mask on entering the premises.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

There were systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

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

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

Staff were aware of national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

A dentist described the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age. The team were aware of the Mental Capacity Act 2005 and understood their responsibilities under the act when treating adults who might not be able to make informed decisions.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories.

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a structured induction programme. We were informed clinical staff completed the continuing professional development required for their registration with the General Dental Council. We did not see training certificates related to training and were not assured the provider had oversight with regard to continuing professional development.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. We noted there was no referral log for private referrals and therefore no way of tracking those referrals to ensure they were responded to promptly.

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 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.

Leadership capacity and capability

The provider was visible and approachable. Staff told us they worked closely with them to make sure they prioritised compassionate and inclusive leadership.

There was limited evidence of a quality assurance programme in place. Record keeping did not provide evidence of a structured improvement programme, and certain aspects of clinical delivery such as the non-use of dental dam and record keeping showed a lack of oversight and leadership. We saw limited evidence of audits being completed, which would be an integral part of oversight of the practice. Systems and processes were not embedded, and examples of missing emergency medicines and emergency equipment that was out of date indicated a lack of awareness, oversight and leadership.

The COVID-19 pandemic had reduced numbers of patients seen at the practice. However, the provider had taken steps to ensure the maximum number of patients who could receive an appointment, received one. Provided this could be done safely and giving due consideration to the restrictions imposed by COVID-19.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice. The provider had a range of human resources policies and procedures, although we were not assured, they were being used effectively, as the recruitment details held in staff files did not fully reflect the procedures or legislation.

Staff discussed had received annual appraisals and we saw evidence of completed appraisals in the staff folders. Opportunities were missed to review staff training as part of this process.

There were records of staff meetings that had been completed at the practice. Due to COVID-19 staff meetings had been by zoom over the past year, however, there were no minutes from these minutes, or any identified actions.

The staff focused on the needs of patients, the ground floor treatment rooms and level access made accessing treatment for patients with mobility issues easy.

The provider was aware of and had a policy relating to the Duty of Candour.

Governance and management

Staff had clear roles within the practice. We were not assured, there were systems of accountability in place to support good governance and management.

The provider had overall responsibility for the management and day to day running of the practice. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. We saw limited evidence these policies, protocols and procedures were being used on a day to day basis.

Systems to identify and manage risks were not effective. We identified risks in relation to:

Are services well-led?

- Clinical staff had not completed training in the recognition, diagnosis and early management of sepsis. There was no information or guidance about sepsis for staff available in the practice.
- The provider did not have a Legionella risk assessment completed by a competent professional assessor. They were also unaware if the landlord had a Legionella risk assessment.
- The dentist was not using dental dam when completing root canal treatments, which was contrary to guidance issued by the British Endodontic Society. This had not been identified by the provider, and therefore steps to ensure dentists were following national guidance had not been taken.
- Staff working at the practice had not received a new Disclosure and Barring Service (DBS) check. National guidance identifies that DBS checks are not transferrable between employers. In one example the DBS check on file was completed nine years before the individual's employment at the practice had started. Staff recruitment records were not as identified in Schedule 3 of the Health and Social Care Act 2008 Regulations.
- The provider did not have an up-to-date Landlord's gas safety certificate, and could not be assured the premises were safe, as this aspect had not been assessed in over three years. In addition, the provider did not have an up-to-date five-year fixed wire electrical safety certificate and told us the landlord had not completed this work. This was contrary to the Electricity at Work Regulations 1989 and the Institute of Engineering and Technology Wiring Regulations BS 7671:2008.
- Emergency medicines were not as identified in 'British National Formulary.' Emergency equipment was not as identified in the Resuscitation Council UK guidelines. Checks on both the medicines and equipment had failed to identify items that were missing and that some items in the emergency equipment had passed their use by date.
- Dental care records were not secure, as they were stored in open shelving.
- Dental care records relating to the use of antibiotics were not complete. This had not been identified by the provider or action taken to address this issue as antimicrobial prescribing audits were not being completed. This was not in line with Faculty of General Dental Practice (FGDP) guidelines.
- Systems and processes to track and monitor private referrals were not effective therefore it was not possible to ensure those referrals had been responded to promptly.
- The provider did not have an effective quality assurance programme to monitor and assess processes within the practice. Routine audits were not being completed, and risks and concerns identified in this inspection had not been addressed as the systems and processes were not in place to identify and rectify them. For example, Infection prevention and control audits were not being completed.

Appropriate and accurate information

We saw limited evidence that staff acted on appropriate and accurate information. There were examples where national guidance was not being followed and information and training related to sepsis had not been shared with the staff.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. Computers were password protected, however, the storage of hard copies of records within the practice was in need of review.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public and staff in the delivery of the service.

The Covid-19 pandemic had restricted the measures the practice used to gather feedback from patients, they were however, encouraged to complete feedback on-line.

Continuous improvement and innovation

Are services well-led?

Systems and processes for learning, continuous improvement and innovation were limited at the practice. We saw there was no oversight of staff training, and the quality assurance processes to encourage learning and continuous improvement were ineffective.

We identified that a radiography audit had been completed in January 2020, but audits for areas including infection prevention and control, dental care records, hand hygiene, patient feedback and antimicrobial prescribing had not been completed. As a result, there were no action plans or improvements identified.

There was no system in place to monitor and support staff in training and meeting the requirements of their continuing professional development. Staff records did not identify they had completed 'highly recommended' training as per General Dental Council professional standards.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person's recruitment procedures did not ensure that only persons of good character were employed.** **The registered person's recruitment procedures did not establish whether staff were able, by reasons of their health and after reasonable adjustments, to properly perform tasks intrinsic to the work for which they would be employed. In particular:** • The registered person did not have all of the staff recruitment records identified in Schedule 3 of the Health and Social Care Act 2008 Regulations. • The registered person had not taken steps to adequately mitigate the risks involved in staff recruitment. • The registered person did not have oversight of staff training, and therefore could not be assured, staff had the skills to safely meet patients' needs and carry out the regulated activities. **Regulation 19(1)&(2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

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.

The registered person had systems or processes in place that were operating 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 person did not have oversight of the risks to patients and staff or improvements needed at the practice. There was no effective quality assurance system in place. There was no schedule of audits to review, monitor and improve the quality of the service.
- The registered person had failed to ensure that Infection prevention and control audits were being completed. The guidance HTM 01-05 identifies these audits should be completed on a six-monthly basis and when necessary an action plan produced to identify how improvements would be made.
- The registered person did not have oversight of checks on the emergency medicines and had therefore failed to identify and act on the fact some emergency medicines were missing from the list identified in the 'British National Formulary'.
- The registered person did not have oversight of checks on the emergency equipment and had therefore failed to identify and act on the fact some emergency equipment was missing and some was passed its use by date. This as identified in guidance produced by the Resuscitation Council UK.
- The registered person had not protected patients' information as dental care records were not stored securely.

Regulation 17(1)

This section is primarily information for the provider

Requirement notices

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:** • The registered person did not have a Legionella risk assessment in line with guidance from the Health and Safety Executive. They had failed to identify all of the risks related to Legionella in the practice and had also failed to address this issue with the landlord. • The registered person was not assured that the gas and electric services supplied to the practice were safe. • The registered person did not have all of the emergency medicines as identified in 'The British National Formulary' or all of the equipment for dealing with medical emergencies as identified in the Resuscitation Council UK guidelines. • The registered person had not ensured safe care and treatment for patients as dentists were not protecting the patients airway when completing root canal treatments. **Regulation 12(1)**