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West Park, Leeds

Inspection Report

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Overall summary

We carried out an unannounced responsive inspection on 23 September 2015 to ask the practice the following key questions; Are services safe and effective?

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 not providing effective care in accordance with the relevant regulations.

Background

West Park-Leeds is situated in the West Park area of Leeds. It offers both NHS and private dental care services to patients of all ages. The services provided include preventative advice and treatment, routine restorative dental care, conscious sedation and cosmetic dental treatments.

The practice was a residential property which has been converted to provide primary dental care. There are three treatment rooms, two waiting areas and a reception area. The practice offers full disability access including a ground floor treatment room and disabled toilet facilities.

The practice has two dentists, an anaesthetist, two dental nurses, two receptionists and a practice manager.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons 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 practice is open Monday to Friday 9-00am to 5-00pm.

During the inspection we spoke with one dentist, one dental nurse, the practice manager and one receptionist.

Our key findings were:

- There was no evidence that persons involved in the provision of conscious sedation had the appropriate qualifications, training, competence, skills and experience to do so safely.
- There was no evidence that the anaesthetic machine had been maintained, serviced or calibrated to ensure its safe use.
- Medicines (including those used in conscious sedation) were not stored safely.

Summary of findings

- Sedative drugs which were used for conscious sedation appeared not to be titrated to effect. Available records suggested that all patients received the same dose of sedative drugs.
- There was little evidence of effective stock control of some controlled drugs.
- Doses of sedative medicines used for conscious sedation were not adjusted according to the patient's age or weight.
- There was little evidence that appropriate checks had been undertaken at an assessment appointment. There was no evidence of discussions with patients about other forms of anxiety control.
- There was little evidence of pre-operative checks being carried out prior to the sedation.
- There was limited documented evidence of checks on the patient's vital signs during the procedure.
- There was no evidence of documented post-operative checks prior to the patient leaving the premises.
- Treatment consent forms were not always completed prior to being signed by the patient.
- The sedation surgery was cluttered and equipment was visibly dusty.
- There were out of date dressings, intravenous cannulas and an intravenous fluid bag in the surgery.

We identified regulations that were not being met and the provider must**:**

- Ensure all staff who are involved in the provision of conscious sedation have the qualifications, competence, skills and experience to do so safely.
- Ensure that all equipment is maintained and cleaned to ensure its safe use.
- Ensure the proper and safe management of medicines.
- Review the practice's protocols for conscious sedation, giving due regard to guidelines published by the Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.

You can see full details of the regulations not being met at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that 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 Enforcement section at the end of this report).

There was no evidence that equipment had been maintained, serviced or calibrated to ensure its safe use.

There was no evidence that persons providing conscious sedation had the appropriate qualifications and training to deliver sedation safely.

There was limited evidence that controlled drugs were being safely managed.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

There was no evidence that other forms of anxiety management had been discussed with patients prior to the sedation appointment.

There was limited evidence that patients had been effectively assessed prior to conscious sedation. There was no evidence that patients' blood pressure or oxygen saturation were checked prior to the sedation procedure.

There was limited evidence that patients had been effectively monitored during the sedation procedure. There was a single reading of patients' oxygen saturation recorded for the whole procedure. There were no records of patients' blood pressure being taken during the procedure.

There was limited evidence that patients had been effectively monitored after the sedation procedure. There was no evidence that patients' blood pressure or oxygen saturation were checked prior to being discharged.

There was limited evidence that a robust consent process had been followed prior to treatment under sedation.

West Park, Leeds

Detailed findings

Background to this inspection

We inspected West Park-Leeds on the 23 September 2015. The inspection team consisted of a CQC inspector and a specialist dental advisor.

We carried out this inspection in response to concerns that one or more of the essential standards were not being met.

During the inspection we toured the premises, spoke with one dentist, one dental nurse, the practice manager and one receptionist. We also looked at records relating to the management of the service.

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

- Is it safe?
- Is it effective?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Medical emergencies

The emergency resuscitation kits, oxygen and emergency medicines were stored in the decontamination room adjacent to the surgery. Oxygen was also available through the anaesthetic machine which was in the surgery. We saw no evidence that this machine was regularly checked or serviced to ensure it was safe to be used. We saw that Guedel airways (appliances used in unconscious patients to maintain the airway) were stored in a drawer underneath the anaesthetic machine. These were un-bagged and appeared dusty.

All emergency drugs were in date and staff knew where they were kept.

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). We did not see that regular checks were undertaken on the AED to ensure that it was working. There was also a traditional defibrillator (commonly used in a hospital setting) in the surgery. We were told that this would be the one which the anaesthetist would most likely use. Again, we saw no evidence that this was regularly checked or serviced.

Staff told us that they had received basic life support training including the use of the AED. However, staff had not received any training specific to the provision of sedation.

Staff recruitment

The dentist told us that the anaesthetist he used for sedation clinics was excellent and that he provided safe treatment. However, when we asked to see records of training, experience, qualifications or Continuous Professional Development (CPD) for the anaesthetist these could not be provided. We have asked the registered provider to forward us details of the anaesthetist's training and up to date CPD. The Intercollegiate Advisory Committee on Sedation in Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that persons involved in the provision of conscious sedation must complete a minimum of 12 hours of continuing professional development every 5 years that are relevant to the techniques practised.

Equipment and medicines

During the inspection we looked at the room where the conscious sedation took place. The surgery was cluttered with lots of medical equipment associated with the provision of conscious sedation, some of it said to be redundant.

There were three blood pressure monitoring devices (a traditional sphygmomanometer, an arm cuff type monitor and a wrist cuff type monitor). We were told by a nurse that the wrist cuff was most recently used for taking blood pressure two weeks ago. However, when we attempted to test it the batteries were too weak to provide a reading.

We saw that there were two traditional pulse oximeters present but apparently not used because a simple finger device was used. We checked this finger device and confirmed that it was working.

There was an anaesthetic machine present which had the capability of providing relative analgesia (RA). RA is a form of conscious sedation induced by inhaling a combination of oxygen and nitrous oxide. The dentist told us that RA was not used. However we saw evidence in sedation records that it had been used both in isolation and also in combination with intravenous sedation. We also saw four full cylinders of nitrous oxide stored in a separate building behind the surgery. We did not see any evidence that the anaesthetic machine used in the provision of RA had been regularly maintained or serviced.

The surgery had a controlled drugs cabinet which was secured to the wall. We were told that the controlled drugs were locked in the cabinet when they were not being used. We found three pre-drawn up syringes of clear liquids in the cabinet. These syringes were not sealed and therefore were open to contamination. One of the syringes was unlabelled, one was labelled fentanyl and one was labelled hypnoval (midazolam). We were unsure how long these syringes had been there. There were also two bottles of tablets labelled dihydrocodeine 30 milligrams. The labels had been handwritten and there was no expiry date on the labels.

There were two trolleys which had drawers for storage of medicines and devices used in the provision of conscious

Are services safe?

sedation. We noted that these drawers were cluttered and dusty and Guedel airways were not sealed to prevent contamination. There were also several items which had passed their expiry date including dressings, an intravenous fluid bag and intravenous cannulas.

In the decontamination room we found a large supply of antibiotics stored. These included amoxicillin, metronidazole and erythromycin. The amoxicillin capsules had been decanted from a larger container into smaller tablet bottles. However, these smaller bottles did not have the expiry date or batch number recorded on the labels. We saw in the sedation records that patients were prescribed antibiotics. However, there was no documentation of the reason for the antibiotics being prescribed.

We saw a drug ordering book was kept in a cupboard in the decontamination room. This included details of drugs which had been ordered for the provision of conscious sedation. The majority of these drugs included midazolam and fentanyl. We saw evidence that propofol had also been ordered recently. Propofol is a drug used for conscious sedation of patients. However, we saw no evidence that propofol had been used on any patients whose records we looked at. We also saw evidence that thiopentone had been regularly ordered up until 2012. Thiopentone is an fast-acting drug used for the induction of general anaesthesia. We were told that thiopentone was not currently used in the practice but had been used as an adjunct to smooth sedation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the inspection we looked at 10 sets of sedation records. We did not see any evidence that other forms of anxiety control had been discussed prior to the sedation procedure or any attempt to counsel patients with regards to their anxieties. There was no evidence that a dental anxiety scale had been taken prior to the sedation procedure.

We saw that the patient's medical history was noted in patients' records. However, each patient had been deemed to be ASA classification 1 or 2. The American Society of Anesthesiologists (ASA) classification is a widely used system to determine the fitness of patients before undergoing a surgical procedure. We noted that there was no evidence as to why patients were allocated either ASA 1 or ASA 2. We saw evidence that patients who smoked were incorrectly classified as ASA 1 when according to the ASA these patients should be classed as ASA 2. We saw that patients' weights were recorded as part of the pre-sedation assessment; however these were not converted to a Body Mass Index (BMI) taking into consideration the patient's height.

We were told that pre-operative checks of the patient's vital signs were undertaken however documentation of this was limited. There was no documentation of the patient's blood pressure prior to the procedure. Sedation records stated that an electrocardiogram (ECG) was taken prior to the procedure. These were all marked as normal. The patient's pulse rate was recorded as part of the pre-operative assessment. There was no evidence that the patient's oxygen saturation or blood pressure were checked prior to the sedation procedure. The Intercollegiate Advisory Committee on Sedation in Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that patients receiving sedation with midazolam and fentanyl should have their oxygen saturation and blood pressure taken and recorded pre-operatively as a baseline reading.

We noted that all patients received the same dose of sedative drugs. All sedation records showed that every patient received 10milligrams of midazolam and 50micrograms of fentanyl. We saw no evidence that the patient's weight was taken into account when selecting the dose of sedative drugs. We saw no documented evidence that doses of sedative drugs were titrated to achieve the desired effect. We saw no evidence that batch numbers of drugs administered were recorded.

We were told that patients' vital signs were checked throughout the sedation procedure. These included the patient's oxygen saturation and an ECG. However in all of the records which we looked at there was only one reading for the oxygen saturation for the whole procedure. For all of the records which we looked at the patient's oxygen saturation was 99%. All of the records stated that the patient's ECG readings were normal. There was no documented evidence that intra-operative checks of the patient's blood pressure were undertaken. The Intercollegiate Advisory Committee on Sedation in Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that patients receiving sedation with midazolam and fentanyl should have their oxygen saturation and blood pressure taken and recorded intra-operatively.

Once patients were able to walk unaided they were moved to the recovery room which was also the decontamination room. Here they sat with the receptionist to check they were comfortable and not feeling faint. The chair used for the patient did not have the facilities to be placed to a head tilt down position in case of a medical emergency. A post-operative record and discharge questionnaire was completed by the receptionist. This was a tick box form and included statements about the patient's blood pressure and pulse being stable. We saw that there was no documentation of the results of these checks. The Intercollegiate Advisory Committee on Sedation in Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that patients receiving sedation with midazolam and fentanyl should have their oxygen saturation and blood pressure taken and recorded post-operatively (both when they are unable to walk to recovery and when the patient is ambulant with an escort).

Before that patient was discharged the receptionist checked that the patient had satisfactory transport home with an escort. The post-operative record and discharge form was signed by the receptionist. The receptionist told us that even though they had a background in dental nursing they had received no specific training with regards to sedation. They had received basic life support training. The Intercollegiate Advisory Committee on Sedation in

Are services effective?

(for example, treatment is effective)

Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that all persons involved in the provision of conscious sedation (including the recovery from conscious sedation) must complete a minimum of 12 hours of continuing professional development every five years that are relevant to the techniques practised and also training in intermediate life support.

We asked if the practice had ever conducted an audit of the sedation services which were provided and were told that none had been undertaken. The Intercollegiate Advisory Committee on Sedation in Dentistry document 'Standards for Conscious Sedation in the Provision of Dental Care' states that persons providing conscious sedation should initiate and complete audit processes in order to improve as a result of the audit results.

Consent to care and treatment

Patients were asked to sign a "consent for operation under sedation form". This form was signed at the reception desk by the patient prior to the sedation appointment. The form states that the patient agrees to the treatment which has been proposed and which has been explained by the dentist. However, in several records we saw that these forms had been signed by the patient but the proposed treatment had not been completed by the dentist. We also saw no documented evidence in the patient's dental care records that a robust consent process has been followed.

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. 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 **Regulation 12 HSCA (RA) Regulations: Safe care and treatment.** **How the regulation was not being met:** **The registered provider did not:** • Ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. • Follow policies and procedures about the proper and safe management of medicines. **Regulation 12 (1)(2)(c)(g)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations: Premises and equipment.** **How the regulation was not being met:** **The registered provider did not:** • Ensure that equipment was clean. • Ensure that there were suitable arrangements for the maintenance of equipment. **Regulation 15 (1)(a)(e)**

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

This section is primarily information for the provider

Enforcement actions

Regulation 19 HSCA (RA) Regulations: Fit and proper persons employed

How the regulation was not being met:

The registered provider did not:

- Ensure that persons employed for the purposes of carrying on a regulated activity had the qualifications, competence, skills and experience which are necessary for the work to be performed by them.
- Ensure that the information specified in Schedule 3, and such other information as is required under any enactment was kept by the registered person in relation to such persons employed.

Regulation 19 (1)(b) (3)(a)(b)