Dr. Shala Imani

South Coast Dental Centre

Inspection report

274 South Coast Road
Peacehaven
Brighton
BN10 7PD
Tel: 01273583166

Date of inspection visit: 17 September 2020
Date of publication: 03/12/2020

Overall summary

We carried out this unannounced focussed inspection on 17 September 2020 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.

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.

Are services well-led?

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

Background

South Coast Dental Centre is in Peacehaven and provides NHS and private treatment for adults and children.

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

Summary of findings

The dental team includes three dentists, three dental nurses, one dental therapist one receptionist and a practice manager. Staff work between this site and the sister practice of Bright On Smiles. The practice has three treatment rooms.

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

The practice is open:

Monday to Friday from 9:00am to 5:30pm

Our key findings were:

- Infection control procedures did not reflect published guidance.
- The process for ensuring emergency medicines were disposed of once they passed their expiry date was not effective.
- The risks associated with fire, Legionella and COVID had not been appropriately managed.
- Staff recruitment procedures were not effective.
- Clinical governance arrangements were not effective.
- Systems and processes to identify and manage the risks associated with the carrying out of the regulated activities were not effective.

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

- Ensure care and treatment is provided in a safe way to patients
- Ensure all premises and equipment used by the service provider is fit for use
- 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 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?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

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. After the inspection we served a notice of decision to impose an urgent suspension on the providers registration. 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 and equipment and premises

Infection prevention and control procedures did not reflect guidance as laid out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. We observed a dental handpiece being wiped over with an alcohol disinfectant wipe before being returned to the treatment room for re-use and not being sterilised through the correct process. This poses a potential risk to patients of transition of blood borne viruses that can only be killed through sterilization. We reviewed the arrangements for the storage of sterilised instruments and found that instruments were not consistently pouched. Pouched instruments were not consistently marked with the date to identify the date they should be reprocessed.

We requested the service history documents for the two autoclaves. The last engineer service report was dated May 2019. Staff were not aware of any pressure vessel certificates for either autoclave. Staff were unsure if any engineer visits were booked to check the safety of the autoclaves.

We were shown a Legionella risk assessment dated June 2020. There were some recommendations including installing a new water tank and removing a redundant dead leg pipe. We asked staff if this had been done. Staff confirmed that these had not been addressed.

The risks associated with fire had not been appropriately managed. We were shown a fire risk assessment conducted by an external company on March 2015. There were 21 recommendations, nine recorded at medium risk. The report stated that the recommendations required action within one month. Staff were not able to provide evidence that these recommendations had been actioned. We asked to see evidence of portable appliance testing and a current gas safety certificate. Staff were unable to provide evidence of these. We asked to review records in relation to fire safety. Records produced showed smoke alarm tests conducted in 2014 and fire drills, with the last recorded fire drill dated May 2016.

The risks associated with COVID had not been appropriately managed. During the visit we noted two patients received, what appeared to be an aerosol generating procedure (AGP). We noted a reduced fallow time of 30 minutes was in place. This had not been risk assessed to determine why the fallow time had been reduced or what factors had been taken in to consideration to reduce

the fallow time. We were also not provided any evidence to show staff had the appropriate personal protective equipment available or if they had been fit tested and certificated.

We asked to see evidence of a current Health and Safety Executive (HSE) notification document which is required under the Ionising Radiation Regulations 2017 (IRR17). Staff were unable to show evidence of this document.

During the inspection we looked at eight staff recruitment records. There was no Disclosure and Barring Service (DBS) check for three members of staff, no photographic identification for two members of staff, no evidence of registration with the General Dental Council (GDC) or medical indemnity for one member of staff.

Risks to patients

The system for ensuring staff had adequate immunity to the Hepatitis B virus was not effective. We reviewed recruitment records and noted there was no evidence of vaccinations for three members of staff and for another member of staff there was no evidence of the effectiveness of the Hepatitis B vaccinations.

Are services safe?

During the inspection we checked the contents of the medical emergency kit.

- There were three medical oxygen cylinders, stored together. One had a sticker on the neck of the cylinder stating do not use after 2012, one was empty. This posed a risk of the expired cylinder being used in the event of a medical emergency occurring. The other cylinder was in date with an expiry date of December 2022 however had insufficient amounts of medical oxygen to respond to a medical emergency if one arose.
- There were two Glyceryl trinitrate (GTN) sprays, a medicine used to treat angina. These were kept together in the medical emergency kit. One was in date and one had expired on February 2020.
- There were two Salbutamol inhalers, a medicine used to treat asthma, one was in date and one had expired on June 2020. These issues posed a risk of an out of date medicine being used in an emergency and that it may have reduced efficacy.
- There was no buccal midazolam available, a medicine used to treat epilepsy.
- The self-inflating bag with reservoir had deteriorated, was not kept protected and clean and was visibly dirty. It was not fit for purpose as a good seal around the mask would not be possible due to the deterioration of the seal.
- There was no razor, scissors and gloves available with the automated external defibrillator (AED).

The practice public liability insurance certificate on display in the waiting area had expired in 2015. We asked staff if there was a current certificate. They were unable to show us evidence of this.

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. After the inspection we served a notice of decision to impose an urgent suspension on the providers registration. We will be following up on our concerns to ensure they have been put right by the provider.

Governance and management

We asked to see evidence of policies for staff to refer to. The polices which were produced had not been updated or reviewed since 2013. In addition, there was no whistleblowing policy for staff or information on what to do or who to contact external organisations if they had concerns.

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

- The system to ensure premises were maintained appropriately was not effective. There was no evidence of a gas safety certificate and PAT certificate being carried out.
- The system to manage the risks associated with fire were not effective. There was no evidence recommendations made in the fire risk assessment dated March 2015 had been acted upon. In addition, there was no evidence that the smoke alarms or fire extinguishers were regularly checked.
- The system in place to ensure recruitment procedures reflect Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was not effective. We identified gaps in recruitment records of members of staff including lack of evidence of a DBS check, photographic identification, current indemnity, immunity to the Hepatitis B virus and registration with the GDC.
- The system to manage the risks associated with Legionella we not effective. There had been no action to address the recommendations made in the Legionella risk assessment dated June 2020.
- The stock control system for ensuring materials do not pass their expiry date was not effective. We found out of date medicines during the inspection in one of the treatment rooms.
- The systems and processes to ensure the risks associated with the transmission of COVID was not effective. We observed instances where staff did not follow nationally recognised guidance when carrying out AGP.
- The system for ensuring medical emergency medicines which have passed their expiry date was not effective. We found several emergency medicines within the medical emergency kit which had passed their expiry date and had not been disposed of.
- The system to ensure infection prevention and control procedures reflected nationally recognised guidance was not effective. We asked to see an infection prevention and control audit. The latest one which was available had been completed in 2019. This had not identified the issues we found on the day of inspection.

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 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:** • There were ineffective systems in place to ensure the emergency drugs and equipment, were checked weekly, had the recommended drugs and equipment and these were all in date or disposed of effectively, as required by the Resuscitation Council UK guidance. • The last infection prevention and control audit provided was completed in 2019. This had not addressed issues identified on the day of inspection, such as the re-use of single use items and the dating of pouched, processed instruments. • There were ineffective recruitment procedures in place. Not all staff had a valid DBS check, evidence of immunity to the Hepatitis B virus, evidence of registration with the GDC or evidence of valid medical indemnity cover. **There was additional evidence of poor governance. In particular:** • There was not a current Health and Safety Executive (HSE) notification document as required under the Ionising Radiation Regulations 2017 (IRR17).

This section is primarily information for the provider

Enforcement actions

- We reviewed the practice public liability insurance certificate which had expired in 2015. We asked if there were any other up to date certificates. Staff could only produce a copy of the same certificate.
- Operational policies available for staff to refer to were not updated, did not contain up to date information and had last been reviewed in 2013. There was no whistleblowing policy for staff or information on what to do or who to contact external organisations if they had concerns.

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 **Care and treatment must be provided in a safe way for service users.** **How the regulation was not being met:** **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:** • We reviewed the availability of the medical emergency drugs and equipment. We found several expired medicines which were available for use alongside medicines that were within their expiry date. In addition, there was insufficient amounts of oxygen to manage a medical emergency. • Infection prevention and control procedures were not in line with The Health Technical Memorandum 01-05: decontamination in primary dental care practices (HTM 01-05) published by the Department of Health and Social Care. • Systems in place to reduce the risk of the transmission of Covid-19 did not reflect current guidance.

This section is primarily information for the provider

Enforcement actions

- We reviewed the latest legionella risk assessment which was conducted by an external company on 9 June 2020. This contained some recommendations relating to the cold-water tank and a dead leg pipe. Staff stated these had not been addressed,

Regulation 12 (1)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Ensure all premises and equipment used by the service provider is fit for use

How the regulation was not being met:

The registered person had failed to ensure that all premises used by the service were properly maintained. In particular:

- We were shown a fire risk assessment conducted by an external company on 18 March 2015. There were 21 recommendations, nine recorded at medium risk. The report stated that the recommendations required action within one month. Staff were not able to provide evidence that these recommendations had been actioned.
- We asked to review records in relation to fire safety. Records produced showed smoke alarm tests conducted in 2014 and fire drills, with the last recorded fire drill dated May 2016. The fire safety log book produced, had no entries. There was no evidence that fire extinguisher had been serviced.
- No documents could be produced when requested regarding portable appliance testing or equivalent of electrical items and there were no visible stickers on equipment to show they had been tested.
- The last gas safety check certificate was dated 21 February 2017, staff could not show that any further safety checks had been undertaken.

This section is primarily information for the provider

Enforcement actions

- We requested the service history documents for the two autoclaves. The last engineer service report was dated May 2019. Staff were not aware of any pressure vessel certificates for either autoclave. No engineer visits were booked to check the safety of the autoclaves.

Regulation 15 (1)