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Wollaston Dental

Inspection report

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Overall summary

We carried out this announced focused inspection on 24 May 2022 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 adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

- 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:

- The dental clinic was visibly clean but not well-maintained.
- The practice did not practice infection control procedures which reflected published guidance.
- The provider could not provide evidence staff knew how to deal with medical emergencies. Not all appropriate medicines and life-saving equipment were available.
- The practice did not have systems to help them manage risk to patients and staff.
- Safeguarding processes were not in place and staff did not know their responsibilities for safeguarding vulnerable adults and children.
- The practice did not have staff recruitment procedures which reflected current legislation.
- The clinical staff did not provide patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.

Summary of findings

- Staff provided preventive care and supported patients to ensure better oral health.
- Patients were asked for feedback about the services provided.
- The appointment system did not take account of patients' needs.
- There was no effective leadership or culture of continuous improvement.
- The dental clinic did not have effective information governance arrangements.

Background

Wollaston Dental Practice is in Stourport and provides private dental care and treatment for adults.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to the physical environment to support patients with additional mobility needs.

The dental team includes one dentist and two dental nurses. The practice has one treatment room.

During the inspection we spoke with one dentist and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday to Friday from 9am to 3pm

We identified regulations the provider was not complying with.

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.

Full details of the regulations the provider was 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 effective?	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 (see full details of this action in the Enforcement Actions 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 practice did not have safeguarding processes and staff were unaware of their responsibilities for safeguarding vulnerable adults and children. Staff we spoke with did not demonstrate that they understood what processes were in place for safeguarding vulnerable patients. There was no policy in place for safeguarding children and three different policies for safeguarding adults.

The provider did not have a system to highlight vulnerable patients and patients who required other support such as with mobility or communication. This may expose people to the risk of receiving care that does not meet their needs.

We were not provided with evidence that staff had undertaken appropriate training in safeguarding vulnerable adults and children.

The practice did not have infection control procedures which reflected current published guidance. For example, single use items such as healing caps had been sterilised for reuse. Some implant instruments that had been sterilized were placed in unsealed pouches in drawers. Some implant instruments were not pouched at all, compromising their sterility. Some pouches containing instruments had not been dated. One dental treatment chair cover was ripped and covered with cello tape. We were told that steam penetration tests were carried out when sterilising implant instruments however the helix was not present and there were no logs or records that these had been completed.

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. For example, the dirty box used to transport instruments was not clearly labelled and there was no box to transport clean instruments. The decontamination room was cluttered with broken cabinetry and no ventilation. Water temperatures for solutions used to manual scrub instruments was not checked or recorded. The detergent used for manual scrubbing was not measured in accordance with manufacturer's instructions.

Staff did not provide us with evidence they had completed training in infection prevention and control as recommended.

Records were not available to demonstrate that the equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems. The legionella risk assessment completed in 2013 recommended a review in 2015 which had not been recorded. The risk assessment had identified areas of high risk which had not been addressed. We were told water temperatures were not monitored within the practice.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean.

Are services safe?

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including agency and locum staff. The provider was unable to provide any recruitment information for one staff member such as evidence of disclosure and barring service checks, proof of identification, right to work in the UK, references, qualifications or training. The staff record we saw contained evidence of hepatitis B status, general dental council registration and curriculum vitae.

We were not provided with evidence that the provider had an indemnity insurance certificate in place. They told us this was kept at their home.

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

The provider did not have effective fire safety management procedures. We were shown a fire risk assessment that required review in May 2017, however this had not been completed. We were told that regular fire safety checks were not completed including checks of smoke alarms, emergency lighting and the fire alarm. Fire drills had not been undertaken. We were not shown any evidence that the fire alarm and emergency lighting had been serviced.

The practice did not have arrangements to ensure the safety of the X-ray equipment.

The provider had not appointed a radiation protection advisor and there was no evidence that they reported, graded or justified X-rays.

Risks to patients

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety. For example, risks in relation to safeguarding, health and safety, fire and legionella bacteria management had not been identified and addressed.

The practice had not carried out a health and safety risk assessment to help them manage risks to staff and patients.

Not all emergency equipment and medicines were available and checked in accordance with national guidance. Items in the medical emergency kit were missing, including the medicine used to manage a seizure (midazolam), and low blood sugar (oral glucose), size one oropharyngeal airway and oxygen face mask with reservoir and tubing for adult and child. In addition, the self-inflating bag with reservoir (adult) was present but not clinically clean. The medicine used to treat low blood sugar (glucagon) was kept in a fridge, however the fridge temperatures were not monitored to ensure that it was kept at the recommended temperature and was effective. There were no logs or evidence to demonstrate checks were completed on the medical emergency equipment and medication.

There were two defibrillators in the practice, however one was out of order but not labelled as not being fit for use.

We could not be assured staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Immediate Life Support training with airway management for staff providing treatment to patients under sedation had also not been completed.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health (COSHH). However, this did not include all COSHH substances being used in the practice and we did not see evidence that provider kept this file updated to ensure continued oversight of COSHH.

The dental care records we saw were not complete or legible. In particular, the provider was not maintaining accurate, complete and contemporaneous records for each service user. They failed to document discussion of treatment options and the benefits, risks and costs of treatment, consent and did not provide treatment plans or estimates for patients. The provider did not record all the necessary patient monitoring data when sedating patients.

Information to deliver safe care and treatment

Are services safe?

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. However, antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We found 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 Actions 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.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. However, we saw clinicians did not always assess patients' needs or deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Treatment plans lacked detail and diagnostic assessments were not always carried out.

The practice offered conscious sedation for patients. We found the practice did not have systems to do this safely. For example, patient's sedation needs were not assessed and recorded, contemporaneous patient notes were not taken, and the provider was not recording patient vital signs such as blood pressure, pulse rate and oxygen saturation. The provider did not record the amount of sedative given and how, post-operative instructions for the patient and details of the patient's escort. Written consent was not obtained prior to treatment. Patients were not given appropriate instructions with accompanying leaflets. Assessment was not performed prior to the day of treatment. Baseline observations were not obtained prior to the delivery of sedation agent. Patients were not given appropriate post-operative instructions and emergency contact information. The provider did not maintain a logbook of cases.

We saw the provision of dental implants was not consistently in accordance with national guidance. For example, patients were not offered a follow up appointment.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Clinical staff did not obtain patients' consent in line with Legislation and guidance. They were not routinely recording patient consent in clinical care records.

Although the principal dentist could demonstrate an understanding of informed patient consent, records were not available to demonstrate staff undertook training in patient consent and mental capacity.

Monitoring care and treatment

The practice did not keep detailed dental care records in line with recognised guidance. Contemporaneous patient notes were not taken. The dentist was not recording patient vital signs when providing sedation.

Staff were unable to demonstrate an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty. Staff we spoke with did not demonstrate that they understood what processes were in place for safeguarding vulnerable patients and there was no system for flagging vulnerable patients.

Evidence was not available to demonstrate the dentists justified, graded and reported on the radiographs they took.

The practice had not carried out radiography audits six-monthly following current guidance and legislation.

Effective staffing

Are services effective?

(for example, treatment is effective)

Evidence was not available to demonstrate staff had the skills, knowledge and experience to carry out their roles. Recruitment checks were not carried out prior to them being employed by the provider. We were not provided evidence of staff training.

The practice did not carry out a structured induction for newly appointed staff.

The practice did not have systems in place to ensure clinical staff had completed CPD as required for their registration with the General Dental Council. The provider did not have oversight of this area.

Co-ordinating care and treatment

Staff could not demonstrate they worked together with other health and social care professionals to deliver effective care and treatment. In particular, the provider did not have processes in place to inform the patient's routine dentist they had received treatment at Wollaston Dental Practice.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

The practice was a referral clinic for dental implants under sedation and we saw staff monitored and ensured the dentists were aware of all incoming referrals.

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 Enforcement Actions 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

Systems and processes that would provide a structure for governance and oversight of the practice were not embedded and lines of accountability and communication were not clear or well developed. Audits of infection prevention and control, radiography, disability access, antimicrobial prescribing and record keeping had not been completed.

Information we requested during the inspection was not available, difficult to access, out of date, inaccurate or lacked validity. During our inspection, the provider could not demonstrate how they would develop and sustain a high quality, continuously improving practice. However, they did promptly supply us with some evidence such as continued professional development showing a commitment to wanting to work towards compliance following our inspection.

The provider displayed a lack of awareness of the issues we identified at the practice and did not demonstrate that they understood the challenges or had plans to address them.

The provider was unable to demonstrate that they had developed a strategy for delivering the service which was in line with health and social priorities across the region and reflected the needs of the local population.

We were unable to confirm staff had completed all the required continuing professional development required for their registration with the General Dental Council, as records were not available and evidence was not submitted by the provider.

Systems and processes were not embedded among staff. For example, observations of the decontamination process identified that staff were not working in accordance with HTM 01 05.

Culture

The practice did not demonstrate a culture of high-quality sustainable care.

The practice did not have systems in place to adequately support staff. For example, the practice did not have a whistle blowing policy giving them internal or external contact details to raise any concerns they might have.

The practice did not have arrangements for staff to discuss their training needs during annual appraisals.

There were no formal opportunities for staff to discuss learning needs, general wellbeing and aims for future professional development.

Governance and management

The practice had an ineffective management structure and staff told us roles and responsibilities were unclear.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. We were not assured that the provider's system for clinical governance was effective.

The governance system did not include all the required policies, protocols and procedures and there was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis.

The practice did not have clear and effective processes for managing risks, issues and performance. For example, not all health and safety risk assessments had been completed.

Are services well-led?

Appropriate and accurate information

Staff did not act on appropriate and accurate information. The practice did not use quality and operational information, for example, audits to ensure and improve performance.

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

Engagement with patients, the public, staff and external partners

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

The practice did not have formal systems in place such as staff meetings or appraisals to gather feedback from staff. Staff were not therefore encouraged to offer suggestions for improvements to the service.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.

The practice had not undertaken audits of disability access, radiographs and infection prevention and control in accordance with current guidance and legislation.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	<p>Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose</p> <p>The registered person 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:</p> <ul style="list-style-type: none">• We found that the practice not have effective infection prevention and control processes in accordance with guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. Single items were reused, pouching processes of sterile instruments was not applied consistently, we did not see evidence that steam penetration tests were carried out.• Staff were observed completing the decontamination process and it was noted that this was not in accordance with HTM 01-05. For example, the dirty box used to transport instruments was not clearly labelled and there was no box to transport clean instruments. The decontamination room was cluttered with broken cabinetry and no ventilation. Water temperatures for solutions used to manual scrub instruments was not checked or recorded. The detergent used for manual scrubbing was not measured in accordance with manufacturer's instructions.• The legionella risk assessment completed in 2013 recommended a review in 2015 which had not been recorded. The risk assessment had identified areas of high risk which had not been addressed. We asked staff about monitoring of water temperatures for both the hot-water and the cold-water systems. We were told water temperatures were not monitored within the practice.

Enforcement actions

- The sharps box in the treatment room had not been dated when opened or labelled. The sharps box in the decontamination room had been dated as opened on 12 January 2022 and had therefore passed its three-month expiry date.
- We found the provider was failing to demonstrate effective and safe sedation, oversight and management.
- The practice did not have a mercury spillage kit.
- The provider had not appointed a radiation protection officer and there was no evidence that they reported, graded or justified X-rays.
- The provider had not ensured the availability of equipment and medicines or completion of training in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council. There were no logs or check sheets to demonstrate checks were completed on the medical emergency equipment. There were no logs or check sheets to demonstrate checks were completed on the medical emergency equipment. There was no evidence available of up to date ILS training for any staff on the premises.
- We were not shown a health and safety risk assessment or policy.
- We were shown a fire risk assessment that required review in May 2017, however this had not been completed. We were told that regular fire safety checks were not completed including checks of smoke alarms, emergency lighting and the fire alarm. Fire drills had not been undertaken. We were not shown any evidence that the fire alarm and emergency lighting had been serviced.

Regulated activity

Treatment of disease, disorder or injury

Surgical procedures

Diagnostic and screening procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Enforcement actions

- Staff we spoke with did not demonstrate that they understood what processes were in place for safeguarding vulnerable patients. There was no policy in place for safeguarding children or whistle blowing and three different policies for safeguarding adults. There was no system for flagging vulnerable patients.
- The practice did not have a functioning quality assurance system. Audits of infection prevention and control, radiography, disability access, antimicrobial prescribing and record keeping had not been completed. No completed audits were available or seen by the inspection team.
- There was no oversight of staff training. When requested we were not provided with any evidence of infection prevention and control, safeguarding, fire safety, mental capacity, radiography or immediate life support training for any staff.
- Staff recruitment processes were not in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was unable to provide evidence of disclosure and barring service checks, proof of identification, right to work in the UK, references, qualifications or training for one staff member.
- The provider did not provide induction for new starters. There were no documented induction records on the premises for any of the newly employed staff.
- The provider did not complete any staff appraisals and did not hold regular formal staff meetings.
- The provider was not maintaining accurate, complete and contemporaneous records for each service user. They failed to document discussion of treatment options and the benefits, risks and costs of treatment. They did not provide treatment plans for patients or estimates, did not record all the necessary patient monitoring data when sedating patients, such as oxygen saturation, blood pressure, amount of sedative given and how, or post-operative instructions for the patient and the escort details. They did not routinely record patient consent in clinical care records.

This section is primarily information for the provider

Enforcement actions

- The provider did not offer follow up or review appointments to patients following implant treatment. Patients were advised to return to their own dentist. The provider did not inform the patients routine dentist that they had provided any treatment to their patients.