Elland Practice Limited

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Inspection report

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Overall summary

We carried out this unannounced inspection on 4 December 2020 with a further announced inspection visit on 16 December 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?

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 well-led?

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

Background

Elland Practice Limited is in Elland, West Yorkshire and provides NHS and private dental care and treatment for adults and children.

Summary of findings

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

The dental team includes one dentist, a practice manager, three dental nurses and a receptionist. The practice has two treatment rooms, a third treatment room is under development.

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

During the inspection we spoke with the principal dentist, two dental nurses and the receptionist. 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 12:30pm and 1:30pm to 5pm.

Our key findings were:

- Clinical areas appeared to be visibly clean and well-maintained. Instrument decontamination procedures reflected published guidance. Environmental cleaning and the monitoring of this needed to be improved.
- The provider had implemented standard operating procedures in line with national guidance on COVID-19.
- Staff knew how to deal with emergencies. Improvements were needed to the management and availability of life-saving equipment and medicines available.
- The provider did not have effective systems to help them identify and manage risk to patients and staff. In particular, fire and electrical safety, radiography, Legionella, hazardous substances and incident reporting.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures did not reflect current legislation.
- The provider had not established effective leadership and systems of governance.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had information governance arrangements. Arrangements for closed-circuit television (CCTV) were not in line with legislation.

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.

- 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

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

- Take action to ensure that clinicians take into account guidance provided by the Faculty of General Dental Practitioners when completing dental care records.
- Improve the security of NHS prescription pads in the practice.
- Improve the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 (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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

The systems to keep patients safe were not comprehensive. Staff had some processes to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. They followed guidance 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. Staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments 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.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

A Legionella risk assessment was not in place. Staff did not have clear procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. For example, a member of staff had implemented monthly water temperature checks but did not have the training and knowledge to interpret these. Hot water temperatures were noted to be around 65-68◦c but the risk of scalding had not been assessed and there was no record to show that all lesser used outlets were flushed appropriately to prevent water stagnating. Effective dental unit water line management was maintained.

Cleaning schedules were not in place to ensure the practice was kept clean. When we inspected, we saw clinical areas were visibly clean but environmental cleanliness was not thorough. Carpets had not been cleaned and cobwebs were visible on the walls. Window blinds in the ground floor surgery and toilet were visibly dirty. A cleaning schedule was in the process of being introduced in response to the inspection.

The provider had procedures in place to ensure clinical waste was segregated, stored and disposed of appropriately in line with guidance.

We reviewed the most recent infection prevention and control audit carried out in May 2020 and a second audit carried out on 14 December 2020 in response to our visit. The audit process had failed to highlight risks associated with a lack of Legionella risk assessment, manually cleaning instruments, the lack of information on staff immunity and non-intact

floors. There was no evidence the findings of the audit completed in May had been analysed or any action taken. The provider took action after the December audit to replace a clinical waste bin and plans were in place to install coved flooring in clinical areas and replace window blinds. We saw holes in clinical floors had been taped over as an interim measure.

Screening and triaging were undertaken prior to patients attending the premises and immediately upon arrival to assess individuals and identify those who may have been exposed to the COVID-19 virus. Premises adjustments had been made to ensure staff maintained social distancing. For example, a screen had been installed at reception. Hand hygiene facilities and face masks were available for use by staff, patients and visitors. Appropriate personal protective equipment and instructions for the correct donning and doffing of these was available for Aerosol Generating Procedures (AGPs) to be carried out. AGPs are procedures that create a higher risk of respiratory infection transmission and are defined as any dental or patient care procedure that can result in the release of airborne particles. We saw certificates to show that the protective face masks in use had been fit tested for the dental nurses. The dentist had a certificate to demonstrate they had received training to carry out fit testing of protective face masks but did not have a certificate to show the protective face mask currently in use had been appropriately fit tested. Verbal assurance was given that this had taken place but no evidence was sent to corroborate this.

The practice's whistleblowing policy could be improved by including 'Speak-Up' information about local sources of support and self-help resources. Staff felt confident they could raise concerns without fear of recrimination.

The provider did not have recruitment procedures to ensure they employed suitable staff. We looked at all staff recruitment records. These showed the provider did not carry out essential checks in line with the relevant legislation. For example, Disclosure and Barring Service (DBS) checks were not carried out for any staff member. DBS checks or an adequate risk assessment should be undertaken at the point of employment to ensure the employee is suitable to work with children and vulnerable adults. Information about employment history, identification of any gaps and references were not sought for three staff members and photographic identification and evidence of immunity was not available for two staff members.

The provider confirmed that agency dental nurses are occasionally employed when the practice was short staffed. They did not seek any evidence of identification, appropriate immunity, professional indemnity or up to date basic life support training to ensure the dental nurses were suitable.

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

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

A fire risk assessment and inspection and testing of the mains electrical wiring had not been carried out in line with the legal requirements. We saw smoke detectors were located in the reception area, staff kitchen and on the first-floor landing but these were not tested to ensure they were in working order. On the second visit we saw these had been replaced. We saw there were fire extinguishers on two out of four floors of the building and fire exits were kept clear.

The arrangements for radiation protection were not in accordance with The Ionising Radiations Regulations 2017. The practice's use of dental X-ray equipment had not been registered with the Health and Safety Executive. A radiation protection file was available but had not been completed to provide written procedures including guidelines for medical exposures and radiation doses to operators and ensure these were complied with. The practice did not have arrangements to demonstrate that the safety of the X-ray equipment was assessed at the required intervals. For example, evidence of critical acceptance testing carried out in 2007 was available for one of two X-ray machines and there was no evidence to show that the required three yearly routine testing was carried out routinely. After the inspection the provider sent evidence that routine testing was carried out in 2019 and equipment was certified as satisfactory.

Are services safe?

We saw evidence the dentist justified, graded and reported on the radiographs they took. Radiography audits were not carried out every year in line with current guidance and legislation.

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

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were not reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The sharps management process and associated risks and responsibilities for all sharp items in use at the practice had not been effectively assessed in line with current Regulations. We discussed this with the principle dentist who gave assurance that this would be reviewed and risk assessed more thoroughly. Staff confirmed that only the dentists were permitted to assemble, re-sheath and dispose of needles where necessary to minimise the risk of inoculation injuries to staff. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were aware of the importance of reporting inoculation injuries.

The provider did not have a system in place to ensure all 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. There was no evidence of immunity to Hepatitis B for three clinical staff members. Evidence of immunity was later obtained and sent for two of these staff members.

Staff had completed sepsis awareness training. This helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were not available as described in recognised guidance. For example, insufficient emergency medical oxygen was available, the buccal midazolam available for use expired in June 2020, two oropharyngeal airways expired in 2011 and aspirin was not dispersible. We found staff did not carry out regular checks and keep records to make sure these were available, within their expiry date, and in working order. A checking system was in the process of being introduced and buccal midazolam was replaced in response to the inspection.

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

The provider did not have risk assessments to minimise the risk that can be caused from substances that are hazardous to health. In particular, cleaning substances and the efficacy and fire risks associated with alcohol-based hand sanitiser.

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 dentist 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 typed and managed in a way that kept patients safe. Dental care records we saw were generally complete, legible, were kept securely and complied with General Data Protection Regulation requirements. We saw a small minority of recent dental care records which were not up to the previous standards seen. For example, information relating to the findings of dental examinations and medical histories had not been documented contemporaneously. We discussed this with the provider who confirmed this would be addressed.

Are services safe?

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

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

In response to the inspection, we saw staff had introduced a logging system for NHS prescriptions as described in current guidance. The security of these should be reviewed, a prescription pad was found unsecured in the cupboard of a treatment room which was not currently in use.

The dentist was aware of current guidance with regards to prescribing medicines.

Track record on safety, and lessons learned and improvements

The provider did not have effective systems for reviewing and investigating when things went wrong. Staff understood the importance of reporting incidents, accidents and near misses.

In the previous 12 months there had been one incident that was investigated, documented and discussed with the rest of the dental practice team to share learning and prevent such occurrences happening again. The provider told us about other incidents relating to previous staff poor performance that had occurred in the practice that had not been appropriately documented.

There was inconsistent evidence that MHRA alerts were received and actioned if required.

We saw that some safety alerts were sent by the NHS England local area team. We highlighted more effective ways to ensure they received all relevant patient and medicine safety alerts. The principal dentist registered to receive these and confirmed they would review these routinely and act on any relevant alerts.

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

During the inspection the registered manager and staff were open to discussion and feedback. We saw they took action to begin addressing the concerns raised during the inspection and showed evidence to confirm that action was being taken. The registered manager demonstrated a commitment to continuing the work with support from staff and engagement with external organisations to make further improvements.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population. The provider had implemented standard operating procedures to enable care to be provided to patients during COVID-19. Entry to the premises was controlled and signage at the entrance to the surgery clearly alerted patients not to attend if suffering from the symptoms of COVID-19. There was signposting to alternative courses of action if they had an urgent care need. Premises changes had been made to enable staff and patients to maintain social distancing. Appropriate personal protective equipment was provided and fit tested. Systems were in place to update staff on any changes to national guidance.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs informally and at one to one meetings. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

The staff focused on the needs of patients. For example, in the last year, priority had been given to implementing COVID-19 policies and procedures, and ensuring patients could access advice, care and treatment.

Openness and transparency were not demonstrated when responding to incidents. For example, we were told about incidents and previous staff poor performance that had occurred in the practice that had not been appropriately documented. The provider was aware of the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management, clinical leadership and day to day running of the practice. The practice manager was usually responsible for the day to day running of the service but at the time of the inspection they were on extended leave. Staff knew the management arrangements.

The clinical governance system which included policies, protocols and procedures were not reviewed on a regular basis. At the second visit we saw the provider was in the process of introducing a dental clinical governance compliance package for them to meet the required standards. This system was yet to be established. Staff were in the process of founding new roles and responsibilities. For example, schedules to ensure effective cleaning and processes to check the medical emergency kit.

Are services well-led?

The provider did not have systems to identify and manage risks, issues and performance. In particular, in relation to the oversight of medical emergency arrangements, Legionella, hazardous substances, radiographic safety, fire and electrical safety, infection prevention and control and recruitment processes. We saw evidence that the provider had engaged with external companies to carry out risk assessments for Legionella, fire safety, health & safety and disability access and an electrical installation inspection. The reports from these were yet to be received and acted on.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example NHS performance info and patient views were used to ensure and improve performance. Performance information was combined with the views of patients.

The provider did not have effective information governance arrangements in relation to the use of CCTV. CCTV governance arrangements were not in line with the General Data Protection Regulations. Recording took place without the explicit knowledge of the subjects and signage to inform people that recording took place was not clear and prominent. A privacy impact assessment had not been carried out to justify that the CCTV was necessary and proportionate. Staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved patients, the public, staff and external partners to support the service.

The provider used patient surveys, online reviews and encouraged verbal comments to obtain staff and patients' views about the service. Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used.

The provider gathered feedback from staff through meetings and informal discussions. Staff told us they were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The provider did not have systems and processes for learning, continuous improvement and innovation.

The provider did not have quality assurance processes to encourage learning and continuous improvement. Audits of radiographs were not carried out and audits of infection prevention and control were ineffective.

Staff completed 'highly recommended' training as per General Dental Council professional standards. We highlighted the importance of ensuring staff are provided with appropriate training and support to carry out their new responsibilities.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:** • The registered person did not ensure that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • Disclosure and Barring Service (DBS) checks or a suitable risk assessment were not carried out at the point of employment for any staff member. • Satisfactory evidence of employment history was not obtained for three staff members. • References were not obtained for two staff members. • Photographic identification was not obtained from two staff members. • Evidence of satisfactory immunity to Hepatitis B was not available for two clinical staff members. • The registered person confirmed a local dental nurse agency is used when the practice is short staffed. No assurance was sought from the agency or individuals to confirm their ID, immunity or whether they had appropriate professional indemnity or up to date basic life support training. **Regulation 19(3), Fit and proper persons employed**

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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:

- Environmental cleanliness of the premises was not maintained effectively in line with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care in 2013 and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'. Carpets were not clean, blinds were visibly dirty and cobwebs were visible on the walls. An effective schedule of cleaning was not in place.

- Precautionary measures to reduce the risk of Legionella were not in line with the Approved Code of Practice and Guidance L8, Health and Safety Executive (ALCOP L8), and HTM 04-01: The control of Legionella, hygiene, 'safe' hot water, cold water and drinking systems. A member of staff had implemented monthly water temperature testing but temperatures above 60◦c had not been assessed to minimise the risk of scalding. There was no evidence that lesser used taps and toilets were flushed regularly to reduce the risks associated with Legionella.

- The life-saving equipment was not in line with Resuscitation Council UK guidelines and General Dental Council standards. The emergency medical oxygen cylinder was an insufficient size. The buccal midazolam available for use expired 06/2020, two oropharyngeal airways expired in 2011 and aspirin was not dispersible. There were no quality assurance processes of the medical emergency arrangements in place to review expiry dates for emergency medicines and the availability of oxygen.

- Staff were not provided with information to ensure hazardous substances were stored, used and disposed

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that operated ineffectively in that they** **failed to enable the registered person to assess, monitor and improve the quality and safety of the** **services being provided. In particular:** • The registered person did not operate effective systems and processes to assess and monitor the service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). They did not ensure that governance systems remained effective. The system did not include sufficient scrutiny and overall responsibility the provider and registered manager. • The registered person had systems or processes in place that operated ineffectively in that they failed to enable the assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular, processes were not in place to effectively

of in line with The Control of Substances Hazardous to Health Regulations 2002. In particular, the efficacy of and fire risks relating to alcohol-based hand sanitiser. Substances staff used for cleaning were also not risk assessed.

- The inspector observed a lack of smoke and fire detection systems or consideration of emergency lighting appropriate to the size and layout of the premises. No testing was carried out on three smoke detectors to ensure they were working correctly and inspection and testing of the mains electrical wiring was not carried out in line with The Regulatory Reform (Fire Safety) Order 2005.

Regulation 12(1) -Safe care and treatment.

This section is primarily information for the provider

Enforcement actions

assess the risks relating to fire and electrical safety, Legionella, hazardous substances, infection prevention and control, radiation protection and systems to respond to medical emergencies.

- The registered person did not maintain oversight of environmental cleanliness of the premises was maintained and audited effectively in line with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care in 2013.

- The registered person did not ensure a Legionella risk assessment was undertaken in line with the Approved Code of Practice and Guidance L8, Health and Safety Executive (ALCOP L8), and HTM 04-01: The control of Legionella, hygiene, 'safe' hot water, cold water and drinking systems which states "A suitable and sufficient assessment must be carried out to identify and assess the risk of exposure to Legionella bacteria from work activities and water systems on the premises and any precautionary measures needed". They did not ensure staff carrying out Legionella checks had the appropriate training and knowledge for the role.

- The registered person did not ensure that appropriate life-saving equipment was provided to enable staff to respond to a medical emergency in line with Resuscitation Council UK guidelines and General Dental Council standards. They did not ensure there were appropriate quality assurance processes of the medical emergency arrangements in place to review expiry dates for emergency medicines and the availability of oxygen.

- The registered person did not have systems to ensure that all hazardous substances were effectively risk assessed, stored, used and disposed of in line with The Control of Substances Hazardous to Health Regulations 2002.

- The registered person did not ensure fire risks were assessed and a fire precautions log book including up

This section is primarily information for the provider

Enforcement actions

to date testing and maintenance of all fire safety systems and mains electrical wiring was completed in line with The Regulatory Reform (Fire Safety) Order 2005.

- The arrangements for radiation protection was not in accordance with The Ionising Radiations Regulations 2017. The practice's use of dental x-ray equipment was not registered with the Health and Safety Executive. Written procedures including guidelines for medical exposures and radiation doses were not in place, available to and complied with by referrers, practitioners and operators. Quality assurance audits for dental radiology were not established and maintained.

- Incidents were not appropriately documented to demonstrate they were reviewed and thoroughly investigated by competent staff, monitored to make sure that action was taken to remedy the situation, prevent further occurrences and make sure that improvements were made as a result, and consideration given to appropriate information sharing with other relevant individuals or bodies.

- Closed-circuit television (CCTV) governance arrangements were not in line with the General Data Protection Regulation 2016/679. Recording took place without the explicit knowledge of the subjects. Signage to inform people that recording took place was not clear and prominent. A privacy impact assessment had not been carried out to justify that the CCTV is necessary and proportionate.

Regulation 17 (1) (2) Good governance.