Perry House Dental Surgery Limited

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Inspection report

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Overall summary

We carried out this announced focused inspection on 8 April 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:

- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported by the provider.
- The provider asked staff and patients for feedback about the services they provided.
- The dental clinic was visibly clean and well-maintained.
- Staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect.
- Staff provided preventive care and supported patients to ensure better oral health.
- The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety.

Summary of findings

- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- The provider's information governance arrangements were not operated effectively.
- Appropriate medicines and life-saving equipment were not available.
- The provider did not have systems in place to ensure staff had completed training relevant to their roles.
- The provider's staff recruitment procedures were not operated effectively.
- The provider did not have effective leadership and a culture of continuous improvement.

Background

Perry House Dental Surgery is in Wendover near Aylesbury and provides private dental care and treatment for adults and children.

The practice is based on the first floor. We were told new patients are advised of this when they contacted the practice.

A hearing loop was available to support patients who wore hearing aids.

The dental team includes two dentists, two dental nurses, one dental hygienist and a receptionist. The practice has two treatment rooms.

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

The practice is open:

- Monday - 8.30am to 5.30pm
- Tuesday - 8.30am to 5.30pm
- Wednesday - 8.30am to 5.30pm
- Thursday - 8.30am to 4.00pm
- Friday - 8.30am to 12.00pm

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

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

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

- Implement protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.

The provider accepted the clinical and managerial issues raised and started to take action to address these.

They advised that in order to improve the governance management of the practice would include recruiting a dental compliance company to ensure improvements will be made.

Summary of findings

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

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

Are services safe?

Our findings

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

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

Records were not available to demonstrate that four staff had undertaken appropriate training in safeguarding vulnerable adults and children.

The practice had infection control procedures which reflected published guidance. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

Records were not available to demonstrate that three temporary clinical staff had completed training in infection prevention and control.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. Records were not available to demonstrate that actions highlighted in the risk assessment had been addressed.

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.

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff, including locum staff.

We looked at two permanent and three locum staff member's recruitment folders and found that:

- Three did not have evidence of eligibility to work in the UK.
- One did not have evidence of photographic identity.
- Three did not have evidence of a health assessment.
- Four did not have evidence of an employment history.
- Two did not have evidence of employment references.

Evidence available confirmed that of the eight permanent and locum staff one had immunity to the Hepatitis B infection.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The provider did not have effective fire safety management procedures. In particular:

- The fire risk assessment not carried out by a competent person or reviewed at appropriate intervals.
- A five yearly electrical installation check report was not available.
- The fire exit signage was incorrectly positioned in the reception.

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

- The notification to the Health and Safety Executive (HSE) was not available.
- The local rules did not reflect the current radiation protection advisor's details.
- The x-ray unit arm in surgery one was rusted.

Are services safe?

- Evidence was not available to confirm the X-ray equipment had received a three yearly equipment assessment by a suitable professional

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety and sepsis awareness.

Emergency equipment and medicines were not fully available and checked in accordance with national guidance. In particular:

- The practice did not have medicines to manage a seizure.
- The practice did not have equipment to open a patient's airway.
- Emergency medicines and equipment checks were not carried out at appropriate intervals of at least weekly.

Staff knew how to respond to a medical emergency. However, records were not available to demonstrate that three temporary clinical staff had completed training in emergency resuscitation and basic life support in the last 12 months.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health(COSHH): In particular:

- Safety data sheets were not available for COSHH identified products.
- The COSHH risk assessment was not comprehensive or dated to indicate when it was carried out.

Window blinds were present at practice windows. The operating cords/chains were not secured to the window frame in line with British Safety standards.

Information to deliver safe care and treatment

Dental care records we saw were complete and legible.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Records were not kept securely and did not comply with General Data Protection Regulation requirements. In particular:

- Patient records were stored on open shelving in the reception area.
- The practice accident book was not General Data Protection Regulation (GDPR) compliant.
- A confidentially agreement between the practice and the out of hours cleaning company was not available.

Safe and appropriate use of medicines

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

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 providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

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

Consent to care and treatment

Staff told us they obtained patients' consent to care and treatment in line with legislation and guidance. Signed treatment plans were not available on the day of inspection. We were told the electronic tool used for patients to sign was not working effectively and consent was not uploaded to patient records. The provider was addressing this.

Staff understood their responsibilities under the Mental Capacity Act 2005.

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

Monitoring care and treatment

The practice kept detailed dental care records in line with recognised guidance.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

We saw evidence the dentists justified, graded and reported on the radiographs they took.

The practice carried out radiography audits six-monthly but audits did not include findings or reflection.

Effective staffing

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.

In particular, records available confirmed that of the eight permanent and locum staff only:

- Four had carried out the appropriate level of safeguarding children and vulnerable adults training.
- One had carried out fire safety training in the previous 12 months.
- Five had carried out basic life support training in the previous 12 months.
- Five carried out infection prevention and control training.

Records were not available to confirm newly appointed and temporary staff had received a structured induction.

Co-ordinating care and treatment

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

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

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notice 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

There was a lack of oversight at the practice. In particular the principal dentist agreed they had not managed to attend to both clinical and managerial duties.

The inspection highlighted some issues which included, radiography, medicines, COSHH and fire safety management.

Culture

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

Staff discussed their training needs during annual appraisals. They also discussed learning needs, general wellbeing and aims for future professional development.

Governance and management

The provider did not have effective governance and management arrangements. In particular:

- Risk assessment management was not effective.
- Policies, protocols and procedures were not reviewed on a regular basis.

Appropriate and accurate information

The practice had ineffective information governance arrangements. In particular, secure storage of patient 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 gathered feedback from staff through meetings and informal discussions. Staff 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 in place for learning continuous improvement and innovation. For example:

- Antimicrobial audits were not available.
- A disability access audit was not available.
- Radiography audits did not include findings or reflection.
- A privacy impact assessment had not been carried out for the provision of CCTV.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **Regulation 17 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. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: **Radiography** • The notification to the Health and Safety Executive (HSE) was not available. • The local rules did not reflect the current radiation protection advisor's details. • The x-ray unit arm in surgery one was rusted. • Evidence was not available to confirm the X-ray equipment had received a three yearly equipment assessment by a suitable professional **Emergency Medicines and Equipment** • The practice did not have medicines to manage a seizure. • The practice did not have equipment to open a patient's airway. • Emergency medicines and equipment checks were not carried out at appropriate intervals of at least weekly. **Data Protection**

This section is primarily information for the provider

Requirement notices

- Patient records were stored on open shelving in the reception area.
- The practice accident book was not General Data Protection Regulation (GDPR) compliant.
- A confidentially agreement between the practice and the out of hours cleaning company was not available.

COSHH

- Safety data sheets were not available for COSHH identified products.
- The COSHH risk assessment was not comprehensive or dated to indicate when it was carried out.

Fire Safety

- The fire risk assessment not carried out by a competent person or reviewed at appropriate intervals.
- A five yearly electrical installation check report was not available.
- The fire exit signage was incorrectly positioned in the reception.

Legionella

- Records were not available to demonstrate that actions highlighted in the legionella risk assessment had been addressed.

Disability Access

- A disability access audit was not available.

Staff Training

- 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.

Recruitment

- Systems were not in place to ensure recruitment checks were carried out, in accordance with relevant legislation to help the practice employ suitable staff, including locum staff.