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Bearcross Dental Practice

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 17 January 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 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 two specialist dental advisers.

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

- 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 practice appeared to be visibly clean.
- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were available.
- Improvements were needed to ensure systems to help them manage risk to patients and staff were effective.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment. Improvements were needed to ensure patient care records were completed effectively.
- Staff treated patients with dignity and respect and took care to protect their privacy.

Summary of findings

- The appointment system took account of patients' needs.
- 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 dealt with complaints positively and efficiently.
- The provider had information governance arrangements.

Background

Bearcross Dental Practice is in Bournemouth and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice (via a ramp) for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

The dental team includes four dentists, two dental nurses, two trainee dental nurses, two dental hygienists, two receptionists and a practice manager. The practice has three treatment rooms.

During the inspection we spoke with two dentists, one dental nurse, two receptionists and the practice manager. We also obtained the views of two other staff working during our visit.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday 8am to 5.30pm
- Tuesday 8am to 5.30pm
- Wednesday 8am to 5.30pm
- Thursday 8am to 5.30pm
- Friday 8am to 1.00pm

The practice closes for lunch each day.

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.

Full details of the regulation the provider was not meeting is at the end of this report.

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

- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray ensuring the practice is in compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review staff awareness of Gillick competence and ensure all staff are aware of their responsibilities.

Summary of findings

The provider accepted the clinical and managerial issues that we raised and took immediate action the day of our inspection to begin to address these. We were sent an action plan within 48 hours of our visit, which included evidence to demonstrate that many of the shortfalls have since been addressed.

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.

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

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

The provider had procedures to reduce the possibility of Legionella or other bacteria developing in water systems, in line with a risk assessment.

The provider 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.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation.

Agency staff were employed on occasion. Records of their induction were not kept. The manager told us the agency staff had a written induction, but the agency retained this and would keep a copy on file in future. Since our inspection we have been sent photographic evidence which confirms this shortfall has been addressed.

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

The provider did not ensure decontamination room facilities were maintained effectively. In particular:

- A clinical waste bin was broken and could not be operated by foot.
- The worktop to wall seal had perished in places.

Since our inspection we have been sent evidence which confirms these shortfalls have been addressed.

Equipment was maintained according to manufacturers' instructions including electrical and gas appliances.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

Improvement was needed to ensure the management of fire safety was effective. Specifically:

- Emergency lighting in the practice was not tested appropriately.
- The emergency lights were not serviced annually.
- A carbon dioxide CO2 fire extinguisher was stored high up the waiting room wall which could cause injury to someone trying to remove it in an emergency.

Since our inspection we have been sent evidence which confirms these shortfalls have been addressed.

Risks to patients

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

Are services safe?

- Out of date dental equipment and materials in treatment room drawers.
- Local anaesthetic cartridges stored outside of their blister packs.
- Sterilised out of 'use by' date pouched instruments.
- Various part used 'single use' composite capsules in a drawer.

Since our inspection we have been sent evidence which confirms this shortfall has been addressed.

Emergency equipment and medicines were available and checked as described in recognised guidance.

We noted the size of the oxygen cylinder was 425 litres. We were shown a second cylinder which was stored in the manager's office some distance away. The manager told us they would replace the two cylinders with one 460 litre cylinder as soon as practicably possible. Since our inspection we have been sent photographic evidence which confirms this shortfall has been addressed.

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

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

A pre-General Data Protection Regulation (GDPR) accident book was in use and completed pages were not removed or stored securely. Since our inspection we have been sent photographic evidence which confirms this shortfall has been addressed.

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

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out annually.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong.

The provider 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. However, one dentist could not fully explain Gillick competence and one nurse did not know that incoming lab work needed to be disinfected.

We saw the provision of dental implants was not in accordance with national guidance. Specifically, in the surgery where implants are placed we found:

- Implant kits were pouched but not dated.
- The implant surgical drill was not serviced.
- A number of single-use implant components which had been processed and stored for possible re-use.

Since our inspection we have been sent evidence which confirms this shortfall has been addressed.

We noted implant failure rate audits were not carried out. Audits are not a requirement, but it is considered good practice to audit patient outcomes in implantology. Since our inspection we have been sent evidence which confirms this shortfall has been addressed.

Helping patients to live healthier lives

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

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

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

There were inconsistencies in the information recorded within the dental care records we looked at. Omissions included:

- Basic Periodontal Examination (BPE) screening results.
- Justification, grading and reporting of X-rays taken.
- not all risk assessments noted by all clinicians.
- Diagnosis not documented.
- Treatment options not documented.
- Generic note taking templates were not amended to be patient specific.

Periodontal status recording did not follow the current recording standards.

Since our inspection we have been sent evidence which confirms this shortfall has been addressed.

Are services effective?

(for example, treatment is effective)

Staff conveyed a good 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 provider carried out radiography audits every year following current guidance and legislation.

Effective staffing

Permanent staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

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. Improvements were needed to ensure management oversight of all outgoing referrals to ensure they were received in a timely way.

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 Notices 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

The practice demonstrated a transparent and open culture in relation to people's safety.

The practice manager was regularly reassigned to cover absent nurses, which meant time did not permit them to carry out their own practice management tasks. We were assured that agency staff would be utilised to cover absences more in future.

The information and evidence presented during the inspection process was clear and well documented.

Culture

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

Staff discussed their training needs at an annual appraisals, one to one meetings and during clinical supervision. They also discussed learning needs, general wellbeing and aims for future professional development.

Governance and management

Staff had clear responsibilities roles and systems of accountability to support good governance and management.

We saw there were clear processes for managing risks, issues and performance but these were not routinely followed which resulted in poor risk management at the practice. The management of fire safety, patient care record completion, implants provision, infection control and equipment required improvement. Since our inspection we have been sent evidence which confirms these shortfalls have all been addressed.

Appropriate and accurate information

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

The provider gathered feedback from staff through meetings, surveys, 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 had systems and processes for learning continuous improvement and innovation.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access, radiographs and infection prevention and control.

Staff kept records of the results of these audits and the resulting action plans and improvements.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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.</p> <p>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:</p> <p>Fire Safety</p> <ul style="list-style-type: none">• Emergency lighting monthly testing was not carried out appropriately.• Annual emergency light servicing was not carried out.• The carbon dioxide CO2 fire extinguisher was stored high up the waiting room wall which could cause injury to someone trying to remove it in an emergency. <p>Infection Control</p> <ul style="list-style-type: none">• Out of date dental equipment and materials were stored in drawers.• Local anaesthetic cartridges were stored outside of their blister packs.• Sterilised beyond 'use by' dated pouched instruments were stored in drawers.• Re-processed 'single use' items were stored in drawers.• A clinical waste bin in the decontamination room was broken and could not be operated by foot.• The worktop to wall seal in the decontamination room had perished in places.• Various part used 'single use' composite capsules were stored in a drawer. <p>Implants</p> <ul style="list-style-type: none">• Implant kits were pouched but not dated.

This section is primarily information for the provider

Requirement notices

- The implant surgical drill was not serviced.
- Re processed single-use implant components which had been processed and stored for possible re-use.

Data protection

- A pre-General Data Protection Regulation (GDPR) accident book was in use and completed pages were not removed and stored securely.