Dr. Mohammed Fiaz

Bell Green Dental Surgery

Inspection report

91 Roseberry Avenue
Bell Green
Coventry
CV2 1NB
Tel: 02476688579

Date of inspection visit: 27 April 2022
Date of publication: 07/06/2022

Overall summary

We undertook a follow up focused inspection of Bell Green Dental Surgery on 27 April 2022. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Bell Green Dental Surgery on 12 April 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe or well-led care and was in breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Bell Green Dental Surgery on our website www.cqc.org.uk.

When one or more of the five questions are not met, we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

• Is it safe?

• Is it well-led?

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breach we found at our inspection on 12 April 2022.

Summary of findings

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspection on 12 April 2022.

Background

Bell Green Dental Surgery is in Coventry and provides NHS and private dental care and treatment for adults and children.

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 some adjustments to support patients with additional needs.

The dental team includes three dentists (including the provider), two trainee dental nurses, and two receptionists. There is a practice manager who also undertakes dental nursing and reception duties. The practice has three treatment rooms.

During the inspection we spoke with the provider, a trainee dental nurse and the practice manager. 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 5pm

Saturday from 10am to 12pm

Sunday from 10am to 12pm

We identified regulations the provider was not meeting. 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 are at the end of this report.

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

- Improve the practice's systems for environmental cleaning taking into account current national specifications for cleanliness in the NHS.

- Improve the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff.

Summary of findings

- Implement an effective system for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as United Kingdom Health Security Agency (UKHSA)

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 well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At the inspection on 27 April 2022 we found the practice had made the following improvements to comply with the regulation:

- Evidence was available to demonstrate that infection prevention and control, COSHH and sharps risk assessments had been completed. Adequate systems to minimise the risk that could be caused from substances that are hazardous to health were available at the practice. Posters regarding action to take regarding sharps injuries were available and had relevant contact details recorded. We were told that a poster would be put on display in the decontamination room. A practice health and safety risk assessment had been completed as well as Covid-19 risk assessments. We were not shown a radiological safety risk assessment.
- A legionella risk assessment had been undertaken in March 2022. Records were available to demonstrate that water temperatures were being checked.
- Some items of emergency equipment and medicines that were not available or out of date at our last inspection had still not been purchased. For example, missing items included the oxygen face masks with reservoir and tubing for both adult and child. These were ordered during this inspection. Only one dose of adrenaline was available, there was not sufficient adrenaline to provide a repeat dose if required. The provider confirmed that they would order a further supply. All other items had been ordered and were available. Logs had been developed to demonstrate the weekly checks were to be completed on medical emergency equipment in accordance with national guidance.
- Out of date or missing items in the first aid kit had been replaced.
- Bodily fluids and mercury spillage kits were available and in date.
- We were not provided with evidence of essential staff training. For example, infection prevention and control, safeguarding people, fire safety, mental capacity, data protection, or basic life support. Following this inspection, we were provided with evidence to demonstrate that basic life support training was scheduled for May 2022.
- We were provided with evidence to demonstrate that a recent gas safety check took place on 15 March 2022 and a five-year fixed wiring electrical safety check was completed on 9 June 2018. In-house portable appliance checks had been completed recently and an external company was scheduled to complete portable appliance testing within the next two weeks.
- The practice had an up to date indemnity insurance certificate on display.
- Some action had been taken to ensure that servicing and maintenance of equipment had taken place, although improvements were required. We were provided with evidence to demonstrate that two of the three pieces of X-ray equipment had been serviced and maintained according to manufacturer's requirements. We were told that the OPG (Orthopantomogram) machine was not in use. Evidence was available to demonstrate that the compressor was serviced on 21 April 2022. Not all records required were available to demonstrate that all of the equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. For example, there was no evidence of testing or validation of the ultrasonic bath. However, information was now available to demonstrate checks completed on the autoclave for example, time, steam, temperature strips were used after each cycle, these were dated and timed. Annual service information was available for the autoclaves.
- Cleaning equipment had been purchased.

Are services safe?

- Cleaning had been completed and the practice flooring appeared visibly clean. Internal painting and decorating had taken place and evidence of water damage on walls removed.
- We were told that cleaning logs had been developed but these were not available on the day of inspection. The cleaning schedule that we saw was brief and not specific about the frequency of tasks to be completed. For example, it did not include information such as the cleaning of floors, windowsill and blinds in the waiting area and recorded daily/weekly but was not specific about which.
- Checklists had been developed to demonstrate that surgeries were ready for the day and closed down at the end of the day.
- Pouches containing sterilised instruments in treatment rooms were appropriately dated.
- The decontamination of instruments was carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance.
- Floors had still not been sealed in treatment rooms or the waiting area. This was scheduled to be completed within the next two weeks. The ripped dental chair cover was removed, and dental burs were now being stored correctly in the treatment room.
- There was evidence to demonstrate that correct dental unit waterline management was carried out.

The provider had also made further improvements:

- We were told that the practice had a system for receiving and acting on national patient safety alerts, although there was no evidence of this on the premises.

Are services well-led?

Our findings

We found that 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.

At the inspection on 27 April 2022 we found the practice had made the following improvements to comply with the regulation(s):

- The practice had completed an audit of infection prevention and control in accordance with current guidance and legislation. Some issues for action identified in the infection prevention and control audit remained outstanding and action plans were in place to address these issues. For example, floors were not sealed in two treatment rooms or the wating area. This was scheduled to be completed within the next two weeks. We were told that an extractor fan was to be fitted in the decontamination room as currently no ventilation was provided. The practice had completed a record keeping audit on 13 April 2022. This audit reviewed NHS and medical history forms, but no other information was taken into consideration. We were told that a radiography and antimicrobial prescribing audit had been scheduled. We saw a waste audit dated December 2021.
- The provider had made some improvements to fire safety management procedures. For example, a weekly fire log implemented on 25 April 2022, recorded checks completed on fire extinguishers and smoke alarms. Records were available to demonstrate that a fire drill had taken place on 25 April 2022. Fire extinguishers were serviced in January 2022. The practice does not have emergency lighting or a fire alarm. We were told that a whistle was used to raise the alarm in the event of a fire and a torch used as emergency lighting. The practice had not included the whistle and torch on the fire safety check sheet to ensure that these were available for use in case of an emergency. The practice had completed an in-house fire risk assessment in 2019 and a further risk assessment in April 2022. The risk assessment dated April 2022 had not been completed correctly. We were told that an external professional had also completed a fire risk assessment previously. The provider was unable to find a copy of this risk assessment and confirmed that they would forward a copy. This was not received following this inspection. Combustible materials on the floor in two unused treatment rooms had been removed. We were told that one member of staff was the designated fire marshal. We were not provided with evidence to demonstrate that staff had completed fire safety training.
- A radiography file was available and local rules were on display. We were shown an email requesting registration with the Health and safety executive regarding working with ionising radiation but were not provided with the certificate to demonstrate this registration had taken place.
- The provider had not made sufficient changes to systems in place to track and monitor the use of NHS prescriptions.
- Clinical waste was securely stored. The practice now had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Evidence was available to demonstrate that extracted teeth and amalgam was stored and collected in line with requirements. The large amounts of clinical waste seen at the previous inspection had been collected by the waste handler. We were shown a recent consignment notice and told that waste was to be collected weekly.
- We were provided with evidence to demonstrate that some staff recruitment checks had been carried out, in accordance with relevant legislation. For example, we saw that hepatitis B titre levels were recorded, and a risk assessment completed as necessary for all relevant staff. We were told that disclosure and barring service checks had been completed for all staff and we reviewed four of these checks which demonstrated this. Photographic proof of

identity was available for two staff members. We were told that verbal references had been obtained but these had not been recorded. Indemnity insurance and evidence of registration with the General Dental Council was available as required. Staff were unable to locate a copy of the recruitment procedure on the day of inspection and none has been provided since.

- Work had been completed to ensure that up to date policies and procedures were available to staff, although improvements were required. The practice had up to date information available to staff in relation to safeguarding vulnerable adults and children. The provider confirmed that they would implement a 'was not bought' policy for children who are not brought to their dental appointments. The whistle blow policy had been amended to include information relating to the dental practice and contact details had been included. There was no policy regarding significant events or incidents. A closed-circuit television (CCTV policy) had been completed although this required adapting to relate to the practice. The practice had not completed a privacy impact assessment in relation to the CCTV.
- We saw no evidence of completed staff appraisals, supervision meetings or minutes of practice meetings. Induction information was available for the two dentists and the trainee dental nurses. However, those for the dental nurses had not been dated or signed by the inductor or inductee and those for the dentists had not been signed.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the Regulation was not being met There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provided had no evidence of audits, for example antimicrobial prescribing or, radiography. The record keeping audit was brief and only included information regarding medical history and NHS forms. The latest infection prevention and control audit identified issues for action which remained outstanding. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The internal fire risk assessment completed in 2022 was brief and recorded incorrect information. There was no evidence to demonstrate that a risk assessment had been completed by a competent person. • There was no documentary evidence to demonstrate that practice meetings were held and no evidence that learning from audits was discussed with staff. • The provider did not have systems in place to track and monitor the use of NHS prescriptions.

This section is primarily information for the provider

Enforcement actions

- Systems for checking medical emergency equipment were not efficient and staff training in the management of medical emergencies was overdue.
- The practice's systems for checking and monitoring equipment required improvement to take into account relevant guidance and ensure that all equipment is well maintained. In particular there were no records of validation for the ultrasonic bath.

There was additional evidence of poor governance. In particular:

- Not all relevant up to date policies and procedures were available to staff for example a policy regarding recruitment, significant events, incidents, or mental capacity. The CCTV policy required adapting to meet the requirements of the practice. There was no privacy impact assessment.
- There were no documented appraisal records for staff. Induction records required improvement.
- The provider did not have effective oversight to ensure that all staff had completed training recommended by the General Dental Council. For example, safeguarding level two, infection prevention and control, fire safety, basic life support, mental capacity and radiography.