The Whitebridge Clinic Limited

# The Whitebridge Clinic

## Inspection report

140 Oxford Road
Kidlington
OX5 1DZ
Tel:

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## Overall summary

We carried out this announced focused inspection on 5 August 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.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Portable suction was not available.
- The practice had staff recruitment procedures which reflected current legislation, but improvements were needed.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.

# Summary of findings

- The provider did not operate effective systems to help them manage risk to patients and staff.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- The provider's infection control procedures were not operated effectively
- Staff and patients were asked for feedback about the services provided.
- The practice had information governance arrangements.
- The provider could not demonstrate effective leadership.

**Background**

The Whitebridge Clinic is in Kidlington and provides private dental care and treatment for adults and children.

The practice has made reasonable adjustments to support patients with additional access requirements. The practice is based on the ground floor. The building is accessible to wheelchair users and a disabled person's parking space is available outside the entrance.

The dental team includes three dentists, one dental hygienist, one dental therapist, four qualified dental nurses, two trainee dental nurses, one receptionist, one treatment coordinator and a practice manager. The practice has three treatment rooms.

During the inspection we spoke with two dentists, the registered manager, one dental nurse and a receptionist.

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

**The practice is open:**

- Monday 9.00am to 5.30pm
- Tuesday 9.00am to 6.30pm
- Wednesday 9.00am to 5.30pm
- Thursday 9.00am to 5.30pm
- Friday 9.00am to 4.30pm
- Saturday 9.00am to 4.30pm

**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 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?** | **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.

The practice had infection control procedures which reflected published guidance, but improvements were needed.

Infection prevention and control audits were carried out annually. Since our inspection we have received evidence to confirm this shortfall has been addressed.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment but management was not effective:

Hot water testing did not reach the recommended 50 degrees Celsius during the previous seven months checks the taps tested (seven occasions). Since our inspection we have received evidence to confirm this shortfall has been addressed.

Clinical waste was segregated and stored appropriately in line with guidance.

The previous three years clinical waste notes were available.

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

Records were not available to demonstrate that the provider carried out appropriate recruitment checks, in accordance with relevant legislation to help them employ suitable staff.

We looked at three staff recruitment folders and found that:

- One did not have evidence of their employment history.
- Two did not have evidence of previous employment references.
- One did not have evidence of eligibility to work in the UK.

During our inspection we were shown an audit report referring to recruitment which shows this shortfall was already being addressed.

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

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. Specifically:

- The gas boiler service was overdue.
- The wheelchair accessible WC contained a foot operated bin.
- Since our inspection we have received evidence to confirm both of these shortfalls have been addressed.

Improvements were needed to the management of fire safety. Specifically:

- Emergency lighting was not available on the first floor or staircase.
- A carbon monoxide detector was not available.
- Fire alarm testing was carried out weekly but did not include all of the call points in the practice building.
- Details of staff present for fire drills were not detailed in the fire record book.
- A fire risk assessment was carried out by someone who could not demonstrate their competency in fire safety.

# Are services safe?

Since our inspection we have received evidence to confirm all of these shortfalls either have been or are being addressed.

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

The practice did not have a Laser protection Advisor

- Local rules for the Laser were not available
- A Laser policy was not available.
- The x-ray machine heads in one surgery had an incomplete cover (paint had peeled away).

Since our inspection we have received evidence to confirm all of these shortfalls have been addressed.

The provider was unable to tell us how often their hand-held x-ray unit should be tested.

**Risks to patients**

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

Emergency equipment and medicines were checked in accordance with national guidance. However, we found that portable suction was not available. Since our inspection we have received evidence to confirm 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.

Face to face immediate Life Support training with airway management for staff providing treatment to patients under sedation was carried out in December 2020. We were told online training had been carried out since and face to face training was booked to take place in September 2022.

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

COSHH warning signs were not present on the cleaning cupboard door. Since our inspection we have received evidence to confirm this shortfall has been addressed.

**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.

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

**Safe and appropriate use of medicines**

Improvements were needed to ensure the practice had systems for appropriate and safe handling of medicines.

Dispensed medicines were not labelled appropriately with practice's name and address. Since our inspection we have received evidence to confirm this shortfall has been addressed.

Antimicrobial prescribing audits were 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.

**Sedation**

The practice offered conscious sedation for patients. The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training.

**Dental implants**

We saw the provision of dental implants was in accordance with national guidance.

**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 obtained patients' 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**

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 following current guidance and legislation.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction but records of these were not always kept.

Clinical staff completed continuing professional development required for their registration with the General Dental Council.

Training records were not kept in an ordered way which made finding information a barrier during our visit. Since our inspection we have received evidence to confirm this shortfall has been addressed.

**Co-ordinating care and treatment**

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

# Are services effective?

## (for example, treatment is effective)

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**

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective. Since our inspection we have received evidence to confirm this shortfall has been addressed.

**Culture**

Staff discussed their training needs at an annual appraisal. They also discussed learning needs, general wellbeing and aims for future professional development.

We saw the provider had systems in place to deal with staff poor performance.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

**Governance and management**

The partners had overall responsibility for the management and clinical leadership of the practice. The compliance manager was responsible for ensuring the practice met the required standards.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff, but systems were not routinely followed. Since our inspection we have received evidence to confirm this shortfall has been addressed.

We saw there were clear and effective processes for managing risks, issues and performance but these were not followed which resulted in poor risk management at the practice.

The management of radiography. fire safety, COSHH, infection control, medical emergencies, equipment and premises required improvement. Since our inspection we have received evidence to confirm these shortfalls have been addressed.

**Appropriate and accurate information**

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 and the public and demonstrated commitment to acting on feedback.

The practice 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**

We noted the system for monitoring staff training required improvement to ensure staff could evidence their competency in core recommended subjects

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

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br>**Regulation 17**<br>**Good governance**<br>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.<br>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.<br>In particular:<br>**Infection Control**<br>• Infection prevention and control audits were carried out annually.<br>**Legionella**<br>• Hot water testing did not reach the recommended 50 degrees Celsius during the previous seven months checks the taps tested (seven occasions).<br>**Facilities**<br>• The gas boiler service was last carried out in 2020.<br>• The wheelchair accessible WC contained a foot operated bin.<br>**Fire Safety** |

This section is primarily information for the provider

# Requirement notices

- Emergency lighting was not available on the first floor or staircase.
- A carbon monoxide detector was not available.
- Fire alarm testing was carried out weekly but did not include all of the call points in the practice building.
- A fire risk assessment was carried out by someone who could not demonstrate their competency in fire safety.

**Laser**

- The practice did not have a Laser protection Advisor
- Local rules for the Laser were not available
- A Laser policy was not available.

**Radiography**

- The x-ray machine head in one surgery had an incomplete cover (paint had peeled away).
- The provider was unable to tell us how often their hand-held x-ray unit should be tested.

**Medical Emergencies**

- Portable suction was not available.

**COSHH**

- COSHH warning signs were not present on the cleaning cupboard door.

**Medicines**

- Dispensed medicines were not labelled appropriately with the practice's name and address.

**Recruitment**

- The provider had a recruitment policy which was not being followed.

Regulation 17(1)