Mr. Harold Bernard Peter Berry

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Inspection report

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Overall summary

We carried out this announced focused inspection on 14 December 2021 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.

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

Are services safe?

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

Are services effective?

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

Are services well-led?

Summary of findings

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

Background

Mr Harold Bernard Peter Berry is a well-established dental practice that offers private care to patients. The dental team consists of a dentist, a dental nurse and a receptionist. Another registered dentist is located at the same premises, and the two dentists share some staff, governance procedures and costs.

The premises are accessible to wheelchair users and there is public parking available in a nearby shopping centre.

The practice is owned by an individual who is the principal dentist there. They 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 practice is open Mondays, Tuesdays, Wednesdays from 7.30am to 6pm, and on Thursdays and Fridays from 7.30am to 1pm.

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

Our key findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff felt respected and supported.
- The provider did not have robust recruitment procedures in place to ensure only suitable staff were employed.
- There were no systems to ensure that the completion of dental care records followed guidance provided by the College of General Dentistry.
- Auditing systems were limited and did not ensure staff were following nationally recommended guidelines and procedures.
- The appointment system took account of patients' needs.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.

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.

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

- Improve the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections'.

- Implement a system so that patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

Summary of findings

- Take action to ensure all clinicians are adequately supported by a trained member of the dental team when treating patients in a dental setting taking into account the guidance issued by the General Dental Council.
- Improve and develop staff knowledge of Gillick competency and ensure all staff are aware of their responsibilities in relation to this.
- Improve systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.
- Review the location of medical emergency equipment and drugs so they can be quickly and easily accessed in the event of an incident.

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)

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. The dentist was the lead for safeguarding concerns and information about protection agencies was available in the staff area. We noted information about local domestic violence services on the noticeboard in the waiting room, making it easily accessible.

The practice had a whistleblowing policy in place which staff were aware of. They told us they felt confident to raise concerns if they had them.

The provider had an infection prevention and control policy and procedures. They mostly 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. Additional measures had been implemented to reduce the spread of Covid-19.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments which were mostly 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, although the practice's ultrasonic baths had not been serviced annually. There was no system in place to ensure that heavy duty gloves and long handled brushes were changed weekly. Staff were not testing the water temperature to ensure it was below 45 degree Celsius, before using it to manually scrub dirty instruments.

Procedures were in place to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment which had been undertaken in June 2021. Staff regularly monitored hot and cold water temperatures to ensure they were within recommended ranges.

The practice had policies and procedures in place to ensure clinical waste was segregated and external clinical waste was locked in a secure container to the rear of the property.

We checked the treatment room and noted that some of the cabinetry was rusty and chipped making it hard to clean. The dental chair had several small rips in it, and the nurse's stool was broken, exposing a dirty and dusty interior. We noted some loose and uncovered dental materials and instruments in treatment room drawers that risked aerosol contamination.

Staff told us that rubber dam was used for all root canal treatments so that patients' airways were protected.

Staff were qualified and registered with the General Dental Council and had professional indemnity cover. However, the practice did not have a recruitment policy or procedure to help them employ suitable staff. We found several shortfalls in staff's pre-employment checks. For example, no references or a Disclosure and Barring Service check (DBS) had been obtained for one recently recruited member of staff. For another member of staff, a DBS check had only been obtained some months after they had begun working at the practice. There was no proof of identity, including a recent photograph for another member.

The dentist had undergone fire marshal training in November 2020 and staff regularly undertook fire evacuation drills. Records showed that firefighting equipment was regularly serviced. However, there was no record of weekly checks as recommended in the practice's fire risk assessment or checks that the smoke detector was regularly tested to ensure it operated correctly.

Are services safe?

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. The dentist had completed continuing professional development in respect of dental radiography and had recently completed a radiography audit.

The X-ray unit in the treatment room was broken and its repair had not been actioned. The dentist told us he relied on using the X-ray unit in the other dentist's room, which sometimes caused delays for patients.

Risks to patients

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. A sharps risk assessment had been completed but the dentist was not using the safest types of needles and told us he sometimes manually re-sheathed needles. This was not in-line with the Sharp Instruments in Healthcare Regulations 2013 and had not been risk assessed.

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 was available as described in recognised guidance, although there was no portable suction or a complete set of clear face masks. The medicine to relieve angina had become out of date. Staff's checks of the equipment had failed to identify these shortfalls. The medical emergency equipment and drugs were not stored in easily accessible locations, making it difficult to reach them quickly in an emergency.

The provider had risk assessments to minimise the risk that could be caused from substances that were hazardous to health held within the practice, including cleaning materials.

Safe and appropriate use of medicines

Medicines were stored securely in the practice and although there was a system of stock control in place, we found it was not kept up to date or accurate. Anti-microbial prescribing audits were not completed to monitor that the dentist was prescribing antibiotics in line with national guidance. The name and address of the practice was not recorded on medicines container labels.

Glucagon was kept in the fridge; however, the fridge's temperature was not monitored to ensure it operated effectively.

Track record on safety, and lessons learned and improvements

The dentist told us there had not been any unusual events that occurred in the practice. However, staff told us of two incidents that had occurred, but there was no record of either.

The dentist did not have a system for receiving and acting on national patient safety alerts and was not aware of recent alerts affecting dental products.

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. We saw the dentist assessed patients' needs and delivered care and treatment. However, found this was not always in line with current guidance or supported by clear clinical pathways and protocols. For example, patient basic periodontal examinations had not always been recorded and there were no diagnoses recorded in line with the British Society of Periodontists guidance. There was no record of the type of local anaesthetic given, or their batch number and expiry dates. Patients' recall intervals and social histories were not routinely documented. There was limited evidence to show that treatment options had been fully discussed with patients in the records we viewed.

Helping patients to live healthier lives

A dental hygienist was employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease. There was a range of leaflets in the waiting area giving patients information about gum disease, cracked teeth, plaque and sensitive teeth.

There was a selection of dental products for sale to patients including interdental brushes, mouthwash, toothbrushes and floss.

Consent to care and treatment

The practice did not have a specific policy in relation to the Mental Capacity Act and Gillick guidelines. We found staff had a limited knowledge and understating of their requirements.

Patients did not routinely receive written plans outlining their treatment and its cost, so that they could make informed decisions about it. One patient told us they were never made aware of the costs of their treatment and just trusted that they were charged appropriately by the dentist.

Effective staffing

We confirmed the dentist completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role.

Staffing levels at the practice had not been unduly affected by the Covid-19 pandemic and staff told us they had enough time to do their job. The dental hygienist did not always work with chairside support, and a risk assessment had not been completed for this.

Co-ordinating care and treatment

Staff confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. However, there was no formal system in place to track referrals and ensure they were responded to 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 identified several shortfalls during our inspection including the quality of dental care records, the recruitment of staff, auditing procedures and the checking of emergency equipment and medicines which demonstrated that governance procedures in the practice needed to be strengthened.

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 dentist was responsible for the management of the service. We found he did not have full oversight of the governance procedures in the practice and relied on the other dentist who was registered at the same location.

Culture

Staff stated they felt valued and enjoyed their work. They stated that the dentist was supportive and approachable.

The practice had a specific Duty of Candour policy in place, although we found the dentist had a limited understanding of his responsibilities under it.

Governance and management

There were some processes for managing risks, issues and performance. However, we noted that the practice did not have some key polices in place, for example in relation to recruitment procedures and patient consent. For polices that were available, there was little evidence to show that staff had read and fully understood them.

Communication across the practice was structured around regular meetings. Staff told us these provided a good forum to discuss practice issues and they felt able and willing to raise their concerns in them.

Information about how patients could raise their concerns was available in the waiting area. We were told that there had not been any patient complaints received since 2005.

Engagement with patients, the public, staff and external partners

There were limited ways that patients could provide feedback about the service. We viewed four surveys that had been completed a week or so before our inspection. Prior to this, a patient survey had only been undertaken in 2016, some five years previously. We asked for examples where patients suggestion to improve the practice had been implemented but were not provided with any.

Continuous improvement and innovation

Staff were supported in their training and had personal development plans in place. The dentist had completed a radiography audit but had not undertaken other audits in essential areas such as infection control, dental care records and anti-microbial prescribing. Without these, the dentist was not able to assure himself that he was following nationally recommended guidance and procedures.

Staff told us they had received an appraisal of the performance, although this had not been every year.

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 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. How the regulation was not being met: The registered person had ineffective systems or processes in place as 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: • There was no 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 Public Health England. • There was no effective system in place to ensure clinicians recorded in the patients' dental care records or elsewhere the reason for taking X-rays, a report on the findings and the quality of the image in compliance with Ionising Radiation (Medical Exposure) Regulations 2017. • There was no system in place to ensure the practice was in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

This section is primarily information for the provider

Requirement notices

- There was no system to ensure that incidents or significant events were recorded, investigated and reviewed with a view to preventing further occurrences, and ensuring that improvements were made as a result.
- There was no system to ensure effective checks of medical emergency equipment and medicines met guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
- There was no system in place to ensure appropriate recruitment checks were completed prior to new staff commencing employment at the practice.
- There was no system to ensure that an accurate record of medicines held on site was kept. The practice's name and address were not included on container labels.
- There was no system to ensure staff had a through understating and awareness of the requirements of the Mental Capacity 2005 and The Duty of Candour.

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:

- There was no effective system in place to ensure essential audits were undertaken in line with nationally recommended guidelines.

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- There were no systems to ensure that the completion of dental care records followed guidance provided by the College of General Dentistry.