IDH Limited

Mydentist - Cornhill - Banbury

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 13 January 2013 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 ask five key questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- The dental practice was visibly clean.
- The practice's infection control procedures were not effective.
- Staff knew how to deal with medical emergencies.
- The provider did not operate effective systems to help them manage risk to patients and staff.

Summary of findings

- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures were not operated effectively.
- The clinicians provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff training was not monitored effectively.
- The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.
- The practice did not have effective leadership and a culture of continuous improvement.

Background

The provider is part of a dental group, with multiple practices. This report is about Mydentist - Cornhill - Banbury.

Mydentist - Cornhill - Banbury is in Banbury and provides NHS and private dental care and treatment for adults and children.

There is step free 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 reasonable adjustments to support patients with additional access requirements. These include:

- A wheelchair accessible toilet;
- Hearing loop;
- Reading aids;
- Step free access and
- Ground floor surgeries

The dental team includes 7 dentists, 2 dental specialist, 2 dental nurses, 3 student dental nurses, 2 dental hygienists, 1 treatment coordinator, 2 reception staff and a practice manager.

The practice has 8 treatment rooms.

During the inspection we spoke with 2 dentist, 2 dental nurses, 2 compliance officers, the area manager and three practice managers from the providers other dental practices.

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

The practice is open:

- Monday 8.30am to 6.30pm
- Tuesday 8.30am to 6.30pm
- Wednesday 8.30am to 6.30pm
- Thursday 8.30am to 6.30pm
- Friday 9.00am to 5.00pm

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

Summary of findings

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate training necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed.

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

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

We were told the provider became aware of the shortfalls during the two weeks prior to our visit and managers from three other practices were working to make improvements. The provider's management team, who were present at the inspection, agreed with our 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 always ask the following five questions of services.

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

We found this practice was not providing safe 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.

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 did not have effective management of infection control procedures. Specifically:

- We were told that Infection control audits had not been carried out at appropriate intervals between 02/09/2021 and 09/01/2023.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems:

- Evidence of legionella water temperature and bacteria tests, in line with risk assessment actions required, was not available for the period July 2022 and January 2023.

The provider confirmed tests had not been carried out but restarted as a result of our inspection announcement.

There was not an effective cleaning process in place to ensure the practice was kept clean. In particular:

- Cleaning standards checks were not carried out
- Storage arrangements for the cleaning equipment did not follow national guidance.

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

We looked at 4 staff recruitment records. Evidence presented to us confirmed that:

- None out of 4 had evidence of conduct in their previous employment (references).
- Two out of 4 had evidence of a full employment history.
- Three out of four had a medical history.
- One out of 4 had a disclosure and barring (DBS) check.
- Two out of 4 had immunity to Hepatitis B.
- Two out of four received a structured induction.

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

The provider did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. These included:

- Annual fire risk assessment reviews were not carried out.
- Fire alarm tests were not carried out appropriately.
- An external wooden fire exit door had swollen in size and was hard to open.

Are services safe?

- Emergency lights annual discharge and servicing records were not available.
- A fire risk assessment action plan (from 2019) was not completed in full.
- The electricity supply cupboard on the patient stairs to the first floor was unlocked.

Records of monthly emergency light tests, carried out since February 2019, did not indicate that 21 emergency lights did not work. This was identified at every annual service carried out during this period, but actions were not taken to remedy this.
Action had been taken to rectify this prior to our visit.

A fire exit door was blocked by a 'do not use' sign and hazard warning tape. A second exit was blocked by rubbish bags and clothing debris. Action was taken on the day of our visit to rectify both of these shortfalls.

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

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 available and checked in accordance with national guidance

Staff knew how to respond to a medical emergency.

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

- Control of substances hazardous to health (COSHH) risk assessments were not backed up with data safety sheets for every COSHH identified product used in the practice.
- COSHH products were not stored securely or storage facilities labelled appropriately.

Information to deliver safe care and treatment

Dental care records we saw were 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.

A GDPR compliant accident book was not available.

Safe and appropriate use of medicines

We were shown an antimicrobial prescribing audit which was carried out the week prior to our visit:

- The sample size of records audited was not adequate.
- There was no evidence of the results of the audit and any resulting action plan.
- A previous audit was not available.

Track record on safety, and lessons learned and improvements

The provider had systems in place for reviewing and investigating incidents and accidents. The practice did not adopt these.

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 did not follow the systems in place to ensure dental professionals were up to date with current evidence-based practice. In particular:

- Reporting of x-ray quality changed to a new two-point grading of 'acceptable or unacceptable' in 2021. This system was not being used by any of the clinicians taking radiographs.

We were shown a radiography audit which was carried out the week prior to our visit:

- The record sample size did not meet current requirements.
- There was no evidence of the results of the audit and any resulting action plan.
- A previous audit was not available.

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.

Effective staffing

Evidence was not available to demonstrate all staff had the skills, knowledge and experience to carry out their roles.

Training was not kept in an ordered way or monitored to ensure relevant staff had carried out training at required intervals.

We looked at 7 staff training files. Evidence presented to us confirmed that:

- Five out of 7 staff carried out Basic Life Support training in the previous 12 months.
- Three out of 7 staff carried fire safety training in the previous 12 months.
- Three out of 7 staff carried out infection prevention and control training.
- Three out of 7 staff carried out the appropriate level of safeguarding children training.
- Five out of 7 staff carried out the appropriate level of safeguarding vulnerable adults training.

Are services effective?

(for example, treatment is effective)

- None of the 7 staff carried out learning disability and autism training.

.Evidence to confirm that staff appraisals were carried out was not available.

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 but these were not centrally monitored to ensure they were received in a timely manner.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

Staff gave patients clear information to help them make informed choices about their treatment.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear about the importance of emotional support needed by patients when delivering care.

The practice made reasonable adjustments to support patients with additional access requirements. These included:

- A wheelchair accessible toilet;
- Hearing loop;
- Reading aids;
- Step free access and
- Ground floor surgeries.

Staff had carried out a disability access audit in 2019. Some of the actions identified from this audit remained outstanding at the time of our inspection.

We observed that the waste paper and sanitary bins in the wheelchair accessible toilet were foot operated which presented a barrier to disabled wheelchair users. The waste paper bin was changed during our visit.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice had an appointment system to respond to patients' needs.

Listening and learning from concerns and complaints

We were shown the provider's complaints management system. Evidence was not available to confirm the practice had responded to a number of complaints appropriately.

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

There was a lack of leadership and oversight at the practice.

The practice manager was not present during our visit. We reminded the provider's support staff that the manager was also the safeguarding, complaints and fire safety lead for the practice.

Systems and processes were not embedded among staff.
The inspection highlighted issues which included, health and safety, radiography, fire, recruitment, training, infection control and COSHH risk management.

The information and evidence presented during the inspection process was disorganised and poorly documented.

Culture

The provider had arrangements in place for staff to discuss their training needs during annual appraisals, but these were not followed by the practice.

Governance and management

The practice did not follow the provider's governance and management arrangements.

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.

The practice could not demonstrate they gathered feedback from staff through meetings. We were presented with four differently dated sets of minutes however; the contents of each set of minutes were the same.

Staff we spoke to told us they were unaware that a staff survey had been carried out for all of the provider's staff.

Continuous improvement and innovation

The provider had systems and processes for learning, continuous improvement and innovation but they were followed by the practice.

We were shown a patient treatment record audit which was carried out the week prior to our visit:

- There was no evidence of the results of the audit and any resulting action plan.
- A previous audit was not available.

Are services well-led?

The practice had not undertaken effective audits of disability access, radiographs and infection prevention and control in accordance with current guidance and legislation.

There was no evidence staff kept records of the results of these audits and any 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	Regulation 17 HSCA (RA) Regulations 2014 Good governance *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:* ***Fire Safety*** • *Annual fire risk assessment reviews were not carried out.* • *Fire alarm tests were not carried out appropriately.* • *Emergency light* testing was not effective. • An external wooden fire exit door had swollen in size and was hard to open. • A fire risk assessment action plan (from 2019) was not completed in full. • The electricity supply cupboard on the patient stairs to the first floor was unlocked. **Radiography** • Reporting of x-ray quality two-point grading of 'acceptable or unacceptable' was not being used by any of the clinicians taking radiographs. **Legionella** • Evidence of legionella water temperature and bacteria tests, in line with risk assessment actions required, was not available for the period July 2022 and January 2023. **Audits** • Radiography audits had no evidence of the results of the audit and any resulting action plan. A previous audit was not available. **Infection Prevention and Control** • Cleaning standards audits were not carried out

This section is primarily information for the provider

Requirement notices

- Storage arrangements for the cleaning equipment did not follow national guidance.
- Infection control audits had not been carried out at appropriate intervals between 02/09/2021 and 09/01/2023.

COSHH

- Control of substances hazardous to health (COSHH) risk assessments were not backed up with data safety sheets for every COSHH identified product used in the practice.
- COSHH products were not stored securely or storage facilities labelled appropriately.

General Data Protection Regulations (GDPR)

- We observed that the accident book did not comply with General Data Protection Regulations.

Equality Act 2010

- The sanitary bin in the wheelchair accessible toilet was foot operated.
- A disability access audit was carried out in 2019. Some of the actions identified from this audit remained outstanding at the time of our inspection.

Complaints

Evidence was not available to confirm the practice had responded to a number of complaints appropriately.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18** **Staffing** The registered person did not ensure persons employed in the provision of the regulated activity received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties. In particular:

This section is primarily information for the provider

Requirement notices

Training was not kept in an ordered way or monitored to ensure relevant staff had carried out training at required intervals.

We looked at 7 staff training files.

Evidence presented to us confirmed that:

- Five out of 7 staff carried out Basic Life Support training in the previous 12 months.
- Three out of 7 staff carried fire safety training in the previous 12 months.
- Three out of 7 staff carried out infection prevention and control training.
- Three out of 7 staff carried out the appropriate level of safeguarding children training.
- Five out of 7 staff carried out the appropriate level of safeguarding vulnerable adults training.
- None of the 7 staff carried out learning disability and autism training.

Evidence to confirm that staff appraisals were carried out was not available.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not ensure that recruitment procedures were operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed. In particular: Recruitment checks were not monitored to ensure they were completed or stored appropriately. We looked at 4 staff recruitment records. Evidence presented to us confirmed that: • None out of 4 had evidence of conduct in their previous employment (references). • Two out of 4 had evidence of a full employment history. • Three out of four had a medical history.

This section is primarily information for the provider

Requirement notices

- One out of 4 had a disclosure and barring (DBS) check.
- Two out of 4 had immunity to Hepatitis B.