V2Ray Ltd

Pomeroy & Rust Dental Practice

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 31 March 2023 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The provider's infection control procedures were not operated effectively.
- The appointment system worked efficiently to respond to patients' needs.
- The provider did not operate effective systems to help them manage risk to patients and staff.

Summary of findings

- Staff knew how to deal with medical emergencies, but improvement was needed to ensure emergency equipment was appropriate.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's staff recruitment procedures were not operated effectively.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff training was not monitored effectively.
- The provider did not have effective leadership and a culture of continuous improvement.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Background

Pomeroy and Rust is in Bicester and provides private dental care and treatment for adults and children.

The practice is based on the first floor which is a barrier to wheelchair users and people with limited mobility. Patients are advised of this when they contact the practice.

The dental team includes 3 dentists, 3 dental nurses, of which one is a receptionist until their immunity to hepatitis is known, 1 dental hygienist and a head receptionist who supported the provider with administration duties.

The practice has 4 treatment rooms of which 3 are in use.

During the inspection we spoke with 1 dentist, 1 dental nurse, 1 dental hygienist , 1 receptionist and a head receptionist.

We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

- Monday 9.00am to 5.30pm
- Tuesday 9.00am to 5.30pm
- Wednesday 8.00am to 5.30pm
- Thursday 9.00am to 5.30pm
- Friday 9.00am to 7.00pm
- Saturday 9.00am to 3.00pm

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.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

- Take action to ensure an automated external defibrillator (AED) is available immediately to manage medical emergencies, taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council, and undertake a risk assessment if a decision is made not to have an AED on site.
- 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 Public Health England.
- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.

The provider accepted the shortfalls that we raised and took immediate action the day of our inspection to begin to address these.

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?	**No action** ✓
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 providing safe care in accordance with the relevant regulations.

Safety systems and processes, including staff recruitment, equipment, 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 infection prevention and control procedures which reflected current published guidance. We found:

- Treatment rooms one and two had an incomplete floor covering.
- The Cone-beam Computed Tomography (CBCT) room did not have complete and washable flooring.
- Local anaesthetic cartridges were not stored in individual blister packs.
- The decontamination room worktop and seal between the worktop and wall was not complete in places.

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

- The latest infection control audit indicated the practice was meeting the required standards. However, we found that the audit findings were inaccurate.
- Infection control audits were carried out annually not six monthly in line with national guidance.
- Dust was present on the overhead roof window and frame in the decontamination room.
- Reception and waiting room chairs were covered with a material substance which made effective cleaning a barrier.

Evidence presented to us confirmed that a legionella risk assessment was in progress. Completion of any resulting action plan will be reviewed at our follow up inspection.

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

- Cleaning equipment storage arrangements did not follow national guidance.
- Evidence of oversight of cleaning standard checks was not available.

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

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. Improvement was needed in areas. These included:

- COSHH risk assessments were not available for all relevant substances in use at the practice.
- COSHH risk assessments and safety data sheets were not available for the out of hours cleaner.
- A mercury spillage kit was not available.

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

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, but improvements were needed. Specifically:

- Waste collection notes were not stored in an ordered way for the required period of 3 years.
- Evidence to confirm the sanitary bin was collected was not available.

Recruitment checks had not been conducted, in accordance with relevant legislation to help them employ suitable staff. We looked at 8 staff recruitment records and evidence presented to us found:

- Two staff did not have a record of their employment history (CV).

Are services safe?

- Two staff did not have eligibility to work in the UK.
- One staff did not have a health assessment conducted.
- One staff did not have a written explanation of a gap in their employment history.
- Four did not have evidence available to confirm their conduct in their previous employment (reference) had been obtained.

Seven staff did not have a second reference in accordance with the requirement in the practices' recruitment policy.

Newly appointed staff had an informal induction of which records were not kept.

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

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus. However, the effectiveness of the vaccination was not known for one clinician.

The management of fire safety was not effective. In particular:

- Fire drills were not carried out.
- Emergency lights were not tested monthly.
- Emergency light servicing was not carried out.
- Smoke detectors were not tested weekly. Since our inspection we have received evidence to confirm this shortfall is being addressed.

Evidence presented to us confirmed that a fire safety risk assessment in progress. Completion of any resulting action plan will be reviewed at our follow up inspection.

Air conditioning servicing evidence was not available.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available. This included the cone-beam computed tomography (CBCT) equipment.

Radiation warning sign were not available on the treatment room doors containing x-ray and CBCT machines.

Risks to patients

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

An automated external defibrillator (AED) was not immediately available to manage medical emergencies, taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council. A risk assessment was in place, identifying two separate AED locations nearby if required.

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

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

Information to deliver safe care and treatment

Patient care records were complete, legible, 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

Are services safe?

The practice had systems for appropriate and safe handling of medicines.

Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents.

The practice had a system for receiving and acting on safety alerts. Improvements were needed to ensure staff had sight of relevant alerts.

The practice did not have a General Data Protection Regulation (GDPR) compliant accident record book. Since our inspection we have received evidence to confirm this shortfall has been addressed.

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 which included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training required immediate attention. We found that:

- Nasal cannulas were not available.
- Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) was not completed by all staff providing treatment to patients under sedation in the previous 12 months.

The provider assured us that sedation would be suspended until such time as these shortfalls had been addressed.

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.

Involvement in local schemes

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 patients' consent to care and treatment in line with legislation and guidance. They 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 patient care records in line with recognised guidance.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability.

We saw evidence the dentists justified, graded and reported on the radiographs they took.

The practice did not carry out radiography audits six-monthly in line with current guidance.

Effective staffing

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

Are services effective?

(for example, treatment is effective)

Training was not monitored effectively to ensure relevant staff had carried out training at required intervals.

We looked at 8 staff training files. Evidence presented to us confirmed that:

- 4 out of 8 staff carried out leaning disability and autism training.
- 2 out of 3 clinicians carried out 5 Hours of IRMER training in the previous 5 years.
- 7 out of 8 staff carried out fire safety training in the previous 12 months.
- 4 out of 5 staff clinical staff carried out infection control training
- 5 out of 8 staff carried out basic life support in the previous 12 months.

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.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

On the day of inspection, we spoke with 3 patients who all told us staff were kind and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff we spoke with were aware of the importance of privacy and confidentiality.

Relevant policies and protocols were in place, but improvements were needed to protocols. In particular:

CCTV warning signage were not prominent.

Glass partitioning on treatment room 1 door did not fully protect patients' privacy and dignity. Since our inspection we have received evidence to confirm this shortfall has been addressed.

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

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and 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 dentist explained the methods they used to help patients understand their treatment options. These included photographs, study models, videos, 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 and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments, for patients with access requirements. Adjustments included:

- Reading aids at reception
- A portable hearing loop.

A disability access audit was not available.

Timely access to services

The practice displayed its opening hours and provided information on their website.

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. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients.

Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately.

Staff discussed outcomes to share learning and improve the service, but detailed records were not kept.

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.

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.

Culture

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

Governance and management

The provider had overall responsibility for the clinical leadership of the practice.

The provider had a system of clinical governance in place which included policies, protocols and procedures. These were accessible to all members of staff, but systems were not routinely followed.

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, recruitment, fire safety, COSHH, infection control, emergency medicines and equipment, and legionella required improvement.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice's information governance arrangements required improvement.

Engagement with patients, the public and staff

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement

The provider had quality assurance processes to encourage learning and continuous improvement, but these were not operated effectively.

- Infection control audits were not carried correctly or out at the correct intervals.
- Radiology audits were not carried out.
- Antimicrobial audits were not carried out.
- Patient care record audits were not carried out.

The provider should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

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: **Infection Control** • Treatment rooms one and two had an incomplete floor covering. • The CBCT room did not have complete and washable flooring (wood). • Local anaesthetic cartridges were not stored in individual blister packs. • The decontamination room worktop and seal between the worktop and wall was not complete in places. • The latest infection control audit indicated the practice was meeting the required standards. However, we found that audit findings were inaccurate. • Infection control audits were carried out annually not six monthly in line with national guidance. • Dust was present on the overhead roof window and frame in the decontamination room. • Cleaning equipment storage arrangements did not follow national guidance. • Evidence of oversight of cleaning standard checks was not available. **Radiography** • Radiation warning signs were not available on the treatment room doors containing x-ray and CBCT machines. • The practice did not carry out radiography audits six-monthly in line with current guidance. **Recruitment**

This section is primarily information for the provider

Requirement notices

- Two staff did not have a record of their employment history (CV).
- Two staff did not have eligibility to work in the UK.
- One staff did not have a health assessment conducted.
- One staff did not have a written explanation of a gap in their employment history.
- Four did not have evidence available to confirm their conduct in their previous employment (reference) had been obtained.

Control of Substances Hazardous to Health (COSHH)

- COSHH risk assessments were not available for all relevant substances in use at the practice.
- COSHH risk assessments and safety data sheets were not available for the out of hours cleaner.

Clinical Waste

- Waste collection notes were not stored in an ordered way for the required period of 3 years.
- Evidence to confirm the sanitary bin was collected was not available.
- A mercury spillage kit was not available.

Equipment

- Evidence of air conditioning units servicing was not available.

General Data protection Requirements (GDPR)

- The practice did not have a General Data Protection Regulation (GDPR) compliant accident record book.

Fire Safety

- Smoke detectors were not tested weekly.
- Fire drills were not carried out.
- Emergency lights were not tested monthly.
- Emergency light servicing was not carried out.

Sedation

- Nasal cannulas were not available.
- Immediate life support training (or basic life support training plus patient assessment, airway management

This section is primarily information for the provider

Requirement notices

techniques and automated external defibrillator training) was not completed by all staff providing treatment to patients under sedation in the previous 12 months.

Training

- Training was not monitored effectively to ensure relevant staff had carried out training at required intervals.
- 4 out of 8 staff carried out leaning disability and autism training.
- 2 out of 3 clinicians carried out 5 Hours of IRMER training in the previous 5 years.
- 7 out of 8 staff carried out fire safety training in the previous 12 months.
- 4 out of 5 staff clinical staff carried out infection control training
- 5 out of 8 staff carried out basic life support in the previous 12 months.

Privacy and Dignity

- CCTV warning signage were not prominent.
- Glass partitioning on treatment room 1 door did not fully protect patients' privacy and dignity.

Equality Act 2010

- A disability access audit was not available.