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# Peachcroft Dental

## Inspection report

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## Overall summary

We carried out this unannounced comprehensive inspection on Peachcroft Dental 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 provider's infection control procedures were not operated effectively.
- Appropriate medicines and life-saving equipment were not available.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- 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.
- The provider did not have effective leadership and a culture of continuous improvement.
- The provider asked staff and patients for feedback about the services they provided.

# Summary of findings

- The provider's information governance arrangements were not operated effectively.

**Background**

The provider has four practices and this report is about Peachcroft Dental.

Peachcroft Dental is in Abingdon and provides NHS and private treatment to adults and children.

Car parking spaces, including spaces for blue badge holders, are available, in a public car park, at the front the practice.

The practice is based on the first floor above a retail business. New patients are advised of the stairs when they make contact with the practice.

The dental team includes three dentists, one hygienist, one hygiene therapist, six dental nurses, two student nurses and a receptionist.

The practice has five treatment rooms of which four are in use.

The practice is owned by an partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we obtained the views of four patients.

During the inspection we spoke with the principal dentist, two dentists, three dental nurses, and the receptionist.

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

**The practice is open:**

Monday to Friday 9.00am to 1.00pm and 2.00pm to 5.00pm.

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

- Ensure care and treatment is provided in a safe way to patients.
- 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 support, training, professional development, supervision and appraisal 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 regulations 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 the regulated activities at Peachcroft Dental are managed by an individual who is registered as a manager.

The provider accepted the clinical and managerial issues raised and started to take action 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?** | **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 provider did not have infection control procedures which reflected published guidance

In particular:

- The covering to the patient treatment chair in treatment room four was cracked.
- Cleaning equipment was not stored appropriately in the cleaning cupboard.
- The worktop covering in the decontamination room was cracked along the front.
- The worktop in treatment room three was missing covering at one end.
- Cleaning schedules were not available.
- Keyboards in clinical areas were not covered or washable.
- The tubing flexible covering on the bracket table in treatment room four was incomplete in places.
- We found an airline tube under the bracket table was held with locking forceps.
- Rubber gloves used for decontamination were changed when perished not routinely.
- Rust marks were visible on the floor in treatment room four.
- Open pouches of processed instruments seen in treatment room drawers.
- Local anaesthetic ampules were not stored in blister packs in treatment room drawers.

Records available confirmed that Hepatitis B vaccinations were carried out for nine of the 13 clinical staff.

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

- Legionella water temperature testing, in line with risk assessment actions required, was not carried out.

Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff and checks were not in place for agency and locum staff.

We looked at two staff recruitment records and records to confirm the following checks were not available:

- A full employment history.
- Proof of identity.
- Criminal records check (DBS).
- Conduct in previous employment (references).
- Eligibility to work in the UK.
- Health assessment.

Records available confirmed that four out of five clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The provider did not have policies and procedures in place to ensure clinical waste was stored appropriately in line with guidance. Specifically:

# Are services safe?

- The previous three years of clinical waste collection notes were not available.
- Open clinical waste bags were seen in an unlockable compressor room.
- We saw an unlocked clinical waste bin in the car park to the rear of the practice.
- Clinical waste bins in treatment rooms were not foot operated.
- We saw an amalgam separator on the floor outside the decontamination room. The practice told us they had two more, but we were unable to establish which chairs these machines served.

The provider did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including fire, electrical and gas appliances. Specifically:

- The fire alarm test log was not available.
- An Emergency light test log was not available.
- Fire drill log was not available.
- Emergency lights annual discharge and servicing records were not available.
- A fire risk assessment action plan was not completed in full.

The room used to house the practice compressor was also home to the gas boiler. This room experienced extreme levels of temperature. We noted the room was full of carboard boxes. A number were stored around the boiler which made ventilation ineffective.

The practice did not have arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was unavailable.

- Three X-ray units three yearly quality assurance test records were not available.
- Local rules did not indicate who the radiation protection supervisors (RPS) were.
- Radiograph grading did not follow current requirements.

**Risks to patients**

The provider had not implemented systems to assess, monitor and manage risks to patient safety. Specifically:

- Sharps risk assessment actions were not completed.
- Safer sharps processes were not followed.
- Needle stick injury information was not available in appropriate areas of the practice
- The sharps bin in the decontamination room was not labelled appropriately.
- A sharps bin in treatment room four was overdue being replaced (three months use life).

Staff knew how to respond to a medical emergency.

Emergency equipment and medicines were not available and checked as described in recognised guidance. In particular:

- Glucagon was stored in a fridge which contained study models and staff food.
- Glucagon fridge temperature check log was not available.
- Buccal midazolam was not available.
- A pocket mask was not available.
- Portable suction was not available.
- Staff did not have training for snapping ampules and drawing up syringes.

The provider did not have adequate systems to minimise the risk that can be caused from substances that are hazardous to health (COSHH). In particular:

- A COSHH risk assessment was not available.
- COSHH identified products were not stored securely in treatment rooms and the decontamination room
- COSHH warning signage was not used appropriately.

# Are services safe?

- Flammable COSHH identified products were seen on open shelves in the compressor room. This room appeared to exceed the maximum temperature the products should the stored in.

**Information to deliver safe care and treatment**

Records were not kept securely and did not comply with General Data Protection Regulation requirements. In particular:

- Patient records were stored in filing cabinets in reception and the reception office. Keys were present but we were told these were not used to secure the cabinets.
- Completed accident record sheets were not stored securely.
- Access to the staff room was not monitored. We saw a water delivery driver enter the room a number of times unchallenged.
- Staff did not have secure storage arrangements for their personal belongings.

**Safe and appropriate use of medicines**

Audits for antimicrobial prescribing were not available.

**Track record on safety, and lessons learned and improvements**

The provider did not have a system for receiving and acting on patient 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 have 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.

**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 completed 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. In particular:

- Training was not kept in an ordered way or monitored to ensure relevant staff had carried out training at required intervals. Records showed that:
- 12 out of 14 staff had carried out Basic Life Support training in the previous 12 months.
- Six out of 14 staff had carried fire safety training in the previous 12 months.
- Ten out of 14 staff had carried out the appropriate level of safeguarding children and vulnerable adults training.
- Records showed that two dentist out of three had carried out five hours of IRMER (Radiography) training in the previous five years.

**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 monitored to ensure they were received in a timely manner.

# 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 obtained the views of four other patients.
All four patients told us staff listened and involved them in decisions about their care.

Patients said staff were compassionate and understanding. Tow told us they had been patients at Peachcroft for over 25 years.

**Privacy and dignity**

The practice had installed closed-circuit television, to improve security for patients and staff. The practice did not have the relevant protocols and procedures in place to ensure its appropriate use. Specifically:

- CCTV warning signs were not present.
- A privacy impact assessment was not available.
- A CCTV policy was not available.

Staff password protected patients' electronic care records and backed these up to secure storage. However, staff did not store paper care records securely.

**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 study models, X-ray images and an intra-oral camera.

# 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 reception and treatment rooms were based on the first floor. New patients are advised of this when they contact the practice.

Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

**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**

The practice responded to concerns and complaints appropriately and discussed outcomes with staff to share learning and improve the service.

# 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered.

**Leadership capacity and capability**

There was a lack of leadership and oversight at the practice. In particular the principal dentist agreed they had not anticipated the level of time required to manage the service effectively. The practice manager left the service a number of months prior to our inspection.

Policies and protocols were out of date and the practice was in a poor state of cleanliness in areas.

A disused treatment was used a staff room and equipment storage room. We found this room to be cluttered and untidy.

Systems and processes were not embedded among staff.

The inspection highlighted some issues which included, health and safety, radiography, equipment servicing, fire, sharps, infection control and COSHH risk management.

The information and evidence presented during the inspection process was disorganised and poorly documented. For example, staff training and recruitment records were not available.

**Culture**

The practice did not demonstrate a culture of high-quality sustainable care. In particular, the provider could not demonstrate that all of the current standards were followed.

Staff stated they felt respected, supported and valued.

**Governance and management**

The provider did not have effective governance and management arrangements. In particular, there was no evidence the policies, protocols and procedures were reviewed on a regular basis.

**Appropriate and accurate information**

The provider had ineffective information governance arrangements. In particular, patient care records and staff personal belongings were not stored securely.

**Engagement with patients, the public, staff and external partners**

The provider gathered feedback from staff through meetings and informal discussions.

**Continuous improvement and innovation**

The provider did not have appropriate quality assurance processes to encourage learning and continuous improvement. For example:

- The most recent audit seen for infection prevention and control was carried out in September 2021
- The most recent audit seen for radiography was carried out in February 2020.

# Are services well-led?

- The most recent audit seen for patient record keeping was carried out in March 2020.
- The most recent audit seen for hand hygiene was carried out in July 2020. Staff should be assessed for hand hygiene technique on at least an annual basis.

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 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:<br>**Fire Safety**<br>• The fire alarm test log was not available.<br>• An Emergency light test log was not available.<br>• Fire drill log was not available.<br>• Emergency lights annual discharge and servicing records were not available.<br>• A fire risk assessment action plan was not completed in full.<br>• The room used to house the practice compressor was also home to the gas boiler. This room experienced extreme levels of temperature. We noted the room was full of carboard boxes. A number were stored around the boiler which made ventilation ineffective.<br>**Radiography**<br>• Three X-ray units three yearly quality assurance test records were not available. |

This section is primarily information for the provider

# Requirement notices

- Local rules did not indicate who the radiation protection supervisors (RPS) were.
- Radiograph grading did not follow current requirements.

**Emergency Medicines and Equipment**

- Glucagon was stored in a fridge which contained study models and staff food.
- Glucagon fridge temperature check log was not available.
- Buccal midazolam was not available.
- A pocket mask was not available.
- Portable suction was not available.
- Staff did not have training for snapping ampules and drawing up syringes.

**COSHH**

- A control of substances hazardous to health (COSHH) risk assessment was not available.
- COSHH identified products were not stored securely in treatment rooms and the decontamination room
- COSHH warning signage was not used appropriately.
- Flammable COSHH identified products were seen on open shelves in the compressor room. This room appeared to exceed the maximum temperature the products should the stored in.

**Data Protection**

- Patient records were stored in filing cabinets in reception and the reception office. Keys were present but we were told these were not used to secure the cabinets.
- Completed accident record sheets were not stored securely.
- Staff did not have secure storage arrangements for their personal belongings.

**CCTV**

- CCTV warning signs were not present.
- A privacy impact assessment was not available.
- A CCTV policy was not available.

**Safety Alerts**

This section is primarily information for the provider

# Requirement notices

- The provider did not have a system for receiving and acting on patient safety alerts.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury<br>Surgical procedures | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br>**Regulation 18**<br>**Staffing**<br>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.<br>In particular:<br>• Training was not monitored.<br>• Records available showed that 2 out of 14 staff had not carried out Basic Life Support training in the previous 12 months.<br>• Eight out of 14 staff had not carried out fire safety training in the previous 12 months.<br>• Four out of 14 staff had not carried out the appropriate level of safeguarding children and vulnerable adults training.<br>• Records showed that two dentist out of three had carried out five hours of IRMER (Radiography) training in the previous five years. |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury<br>Surgical procedures | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014<br>**Regulation 19**<br>**Fit and Proper Persons employed** |

This section is primarily information for the provider

# Requirement notices

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 two staff recruitment records to confirm the following checks were not available:

- A full employment history.
- Proof of identity.
- Criminal records check (DBS).
- Conduct in previous employment (references).
- Eligibility to work in the UK.
- Health assessment.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |

**Regulation 12**

**Safe Care and Treatment**

The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:

**Infection prevention and Control**

- The covering to the patient treatment chair in treatment room four was cracked.
- Cleaning equipment was not stored appropriately in the cleaning cupboard.
- The worktop covering in the decontamination room was cracked along the front.
- The worktop in treatment room three was missing covering at one end.

This section is primarily information for the provider

# Requirement notices

- Cleaning schedules were not available.
- Keyboards in clinical areas were not covered or washable.
- The tubing flexible covering on the bracket table in treatment room four was incomplete in places.
- We found an airline tube under the bracket table was held with locking forceps.
- Rubber gloves used for decontamination were changed when perished not routinely.
- Rust marks were visible on the floor in treatment room four.
- Open pouches of processed instruments seen in treatment room drawers.

There were no records available to confirm that Hepatitis B vaccinations were carried out for four of the 13 clinical staff.

**Legionella**

- Legionella water temperature testing, in line with risk assessment actions required, was not carried out.

**Clinical Waste**

- The previous three years of clinical waste collection notes were not available.
- Open clinical waste bags were seen in an unlockable compressor room.
- We saw an unlocked clinical waste bin in the car park to the rear of the practice.
- Clinical waste bins in treatment rooms were not foot operated.
- We saw an amalgam separator on the floor outside the decontamination room. The practice told us they had two more, but we were unable to establish which chairs these machines served.

**Sharps**

- Sharps risk assessment actions were not completed.
- Safer sharps processes were not followed.
- Needle stick injury information was not available in appropriate areas of the practice
- The sharps bin in the decontamination room was not labelled appropriately.
- A sharps bin in treatment room four was overdue being replaced (three months use life).

This section is primarily information for the provider

# Requirement notices

**Referrals**

- Patient referrals to other dental or health care professionals were not centrally monitored to ensure they were received in a timely manner and not lost.