Mr David Jarrett

B74 Dental Practice

Inspection report

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Overall summary

We undertook a focused inspection of B74 Dental Practice on 5 October 2021. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of B74 Dental Practice on 8 June 2021 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe or well led care and was in breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for B74 Dental Practice on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is it safe?

• Is it well-led?

When one or more of the five questions are not met we require the service to make improvements and send us an action plan (requirement notice only). We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

Our findings were:

Are services safe?

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

Summary of findings

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 8 June 2021.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspection on 8 June 2021.

Background

B74 Dental is in Streetly, Sutton Coldfield and provides private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available at the front of the practice.

The dental team includes one dentist (the provider) and one dental nurse who also works on reception. The practice has one treatment room.

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.

During the inspection we spoke with one dentist (the provider). We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday - closed

Tuesday 9am – 1pm, 2pm – 5.30pm

Wednesday – by appointment

Thursday - closed

Friday 9am – 1pm, 2pm – 5.30pm

Saturday – by appointment

Sunday - closed

Our key findings were:

- Staff had completed training, to an appropriate level, in the safeguarding of vulnerable adults and children.
- The provider had sufficient amounts of in date medical oxygen, adrenaline and other equipment to respond to a medical emergency.

Summary of findings

- Sepsis oversight and management was established.
- The provider had effective oversight and was aware of the current guidance with regards to prescribing medicines
- Further action was required to ensure that appropriate information was recorded on dispensing labels.
- A stock control system had been introduced for medicines held on the premises.
- Improvements were required to the system for recording, investigating and reviewing incidents or significant events.
- Systems for checking medical emergency equipment did not ensure that these were checked at the required frequency.
- Staff had completed training in the management of medical emergencies.
- The provider had effective oversight ensuring all clinical waste was removed safely.
- Evidence was not available to demonstrate that the provider had taken action to implement all recommendations in the practice's Legionella risk assessment.
- Infection prevention and control audits were not undertaken at regular intervals.
- The provider had actioned the majority of recommendations from the previous fire risk assessment. One issue remained outstanding.
- A five-year fixed wiring test was carried out in June 2021.
- A centrally monitored system had been implemented to ensure patient referrals to other dental or health care professionals were received in a timely manner and not lost.
- A system had been implemented for receiving and responding to patient safety alerts, recalls and rapid response reports.
- There was a sharps risk assessment but this did not include details of all sharp objects in use at the practice.
- Further action should be taken to develop a system for the on-going assessment, supervision and appraisal of staff.
- Policies and procedures had been reviewed on an annual basis or as needed if updates were required.
- Action has been taken to ensure the clinician takes into account guidance provided by the Faculty of General Dental Practice when completing dental care records and guidance on the Safe use of X-ray Equipment or HP-CRCE-010. the reason for taking X-rays, a report on the findings and the quality of the image is being recorded in the patients' dental care records or elsewhere in compliance with Ionising Radiation (Medical Exposure) Regulations 2017.
- Some further improvements are required to the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance, and staff follow them.
- Audits had been scheduled for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice, but these had not yet been completed.

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.

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

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

- Improve the practice's protocols for medicines management and ensure all medicines are stored and dispensed of safely and securely.

- Implement an effective system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

Summary of findings

- Improve and develop the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance, and staff follow them.

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

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 well-led?	**Requirements notice** ✗

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At our previous inspection on 8 June 2021 we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 5 October 2021 we found the practice had made the following improvements to comply with the regulation:

- Evidence was available to demonstrate that the provider and dental nurse had completed training to level 2 in the safeguarding of vulnerable adults and children. Training certificates for the dental nurse demonstrated that update training in the safeguarding of vulnerable adults had taken place in July 2021.
- The provider had purchased medical emergency equipment to replace that which was missing at the last inspection of the practice. For example, portable suction, self-inflating bags and masks. The provider was also able to demonstrate that in date medical oxygen and adrenaline was available in sufficient amounts to respond to a medical emergency.
- Sepsis oversight and management was now established. NICE guidelines regarding sepsis were on display in the decontamination room as well as a risk assessment developed by the Sepsis Trust. The provider discussed the update training that they had completed regarding sepsis recognition, diagnosis and early management.
- The provider was aware of the current guidance with regards to prescribing medicines and had access to and read the Faculty of General Dental Practice (FGDP) prescribing guidelines.
- Some improvements were required to dispensing labels for medicines. Labels seen did not record the practice name and address. The provider confirmed that they would ensure that appropriate labels were made available as soon as possible. The provider confirmed that they had not dispensed any medication since the last inspection of the practice.
- There was a log of stock for medicines held on the premises.
- The system for recording, investigating and reviewing incidents or significant events required improvement. We saw that there was a patient safety policy and form for reporting patient violence or aggression. However, there was no policy regarding significant events or accidents and no guidance for staff. The provider had developed a log to record any patient safety or significant events. We were told that there had been no significant events since the last inspection of the practice.

The provider had also made further improvements:

- Action has been taken to ensure the provider takes into account guidance provided by the Faculty of General Dental Practice when completing dental care records and guidance on the Safe use of X-ray Equipment or HP-CRCE-010. The provider is now recording the justification for taking X-rays, a report on the findings and the quality of the image in the patients' dental care records. The provider is now in compliance with Ionising Radiation (Medical Exposure) Regulations 2017 in this respect.

These improvements showed the provider had taken action to comply with the regulation(s): when we inspected on 5 October 2021.

Are services well-led?

Our findings

We found that this practice was not providing well led care and was not complying 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).

At our previous inspection on 8 June2021 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 5 October 2021 we found the practice had made the following improvements to comply with the regulation:

- Systems for checking medical emergency equipment required improvement. Checks were not completed at the required frequency as suggested in the Resuscitation Council guidelines. Routine checks were completed and logged monthly, however; the log had not been updated since August 2021.
- Staff had completed training in the management of medical emergencies and training certificates were seen demonstrating this. The provider and dental nurse had completed update training in August 2021.
- The provider had included gypsum in their contract for the safe removal and disposal clinical waste. We saw evidence to demonstrate that gypsum waste was to be removed with the next scheduled removal of clinical waste.
- The provider had not taken action to implement all recommendations in the practice's Legionella risk assessment. We saw evidence to demonstrate that some action had been taken, for example; the provider had completed some legionella training and undertook further update training following this inspection. We were shown a log to demonstrate that regular flushing was taking place of infrequently used water outlets. However, on the day of inspection we were not shown logs of hot and cold-water temperatures. At the last inspection of the practice we saw that water temperature had been infrequently tested and hot water was below the recommended guidance temperatures.
- Infection prevention and control audits were not undertaken at regular intervals. We were shown the last infection prevention and control audit which was dated July 2020. There were no issues for action identified from this audit. Health Technical Memorandum 01- 05 recommends that infection prevention and control audits are completed six-monthly.
- The provider had not actioned all recommendations from the previous fire risk assessment. Evidence was available to demonstrate that the majority of issues had been addressed. We saw that one recommendation had not been acted upon. The provider confirmed that they would schedule a further risk assessment and take action to address any issues identified.
- A five-year fixed wiring test had been completed and the certificate shows that wiring was satisfactory.
- The provider had implemented a system to ensure patient referrals to other dental or health care professionals were monitored to ensure they were received in a timely manner and not lost. A referral logbook had been introduced and any referrals made were being tracked through the electronic referral system.
- A system had been implemented for receiving and responding to patient safety alerts, recalls and rapid response reports. A logbook was used to record details of any alerts received and action taken.
- The provider had developed a sharps risk assessment, although improvements were required as this did not record details of all sharp objects in use at the practice. The provider confirmed that this would be updated immediately.

Are services well-led?

- There was no evidence that a system had been established for the on-going assessment, supervision and appraisal of staff. The provider had developed separate policies for induction and appraisal. We were told that the practice would be employing staff before the end of 2021 and an induction and appraisal system would be implemented for the new staff.
- Evidence was available to demonstrate that policies and procedures had been reviewed in August or September 2021. The provider was aware that these should be reviewed on an annual basis or as needed if updates were required.

The practice had also made further improvements:

- Some further improvements are required to the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation. We looked at a sample of patient records and saw that there was no evidence of treatment options, risks and benefits being recorded on each occasion in patient records. The provider confirmed that a new computerised system was to be implemented which should help to address this issue.
- The provider had not completed any audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice. The provider had not prescribed any antimicrobials since the last inspection and had a schedule for audits going forward.

These improvements showed the provider had taken some action to improve the quality of services for patients and comply with the regulation(s): when we inspected on 5 October 2021.

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: Systems for checking medical emergency equipment were not at the required frequency. The provider had not taken action to implement all recommendations in the practice's Legionella risk assessment. Infection prevention and control audits were not undertaken at regular intervals. The provider had not actioned all recommendations from the previous fire risk assessment. There was additional evidence of poor governance in particular: There was no evidence that a system had been established for the on-going assessment, supervision and appraisal of staff. Regulation 17(1)