Peacock and Shrestha

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Inspection report

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Date of inspection visit: 20 July 2021
Date of publication: 12/08/2021

Overall summary

We carried out this announced focused inspection on 20 July 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

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

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

Peacock and Shrestha is a well-established practice based in Norwich, that provides NHS treatment to about 15,000 patients. The dental team includes three dentists, two dental hygienists, a practice manger and six dental nurses. The practice has six treatment rooms, not all of which were operational at the time of our inspection.

There is portable ramp access to the practice for wheelchair users.

The practice is owned by a partnership and as a condition of registration must have a person registered with the CQC 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. The registered manager at the practice is one of the partners.

The practice is open Monday to Fridays from 8am to 5pm.

During the inspection we spoke with three dentists, the practice manager, two dental nurses and reception staff. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The provider had infection control procedures which reflected published guidance.
- The provider had systems to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider dealt with complaints positively and efficiently.
- Dental care records did not always follow guidance provided by the Faculty of General Dental Practice.
- Hot water temperatures did not always reach the required temperatures to prevent legionella bacteria build up.
- There was a system for recording, investigating and reviewing incidents or significant events. However there was no evidence to show how learning from incidents and accidents was used to drive improvement and safety.

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

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.

- Improve the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

- Implement a system to identify individual lost or missing prescriptions.

Summary of findings

- Take action to ensure all clinicians are adequately supported by a trained member of the dental team when treating patients in a dental setting taking into account the guidance issued by the General Dental Council.

- Implement a system for monitoring and recording the fridge temperature to ensure that medicines and dental care products were stored in line with the manufacturer's guidance.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** 
Are services effective?	**No action** 
Are services well-led?	**Requirements notice** 

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Information about protection agencies was available around the practice both in treatment rooms and staff areas making it easily accessible. We saw evidence that staff had received safeguarding training and both the partners had lead responsibility for safeguarding concerns. The practice had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

All staff had disclosure and barring checks in place to ensure they were suitable to work. The practice had a whistleblowing policy in place which staff were aware of.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. We noted that effective operating standards and measures had been implemented to reduce the spread of Covid 19.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The practice manager undertook regular audits of infection control procedures twice a year. The latest audit showed the practice was meeting the required standards.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Recommendations in the risk assessment had been actioned, apart from the need to undertake and record monthly descaling of taps, and we noted some limescale build under the taps in one treatment room. We also noted many occasions where the recorded temperature of the hot water had not achieved 55 degrees as required. No action had been taken by staff to raise this or address this.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean. We noted some loose and uncovered dental materials and instruments in treatment room drawers that risked aerosol contamination and that local anaesthetic cartridges had been removed from their packaging thereby compromising their sterility.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. External clinical waste bins were locked and sited securely.

All but one dentist used rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment .There was no records of alternative methods used to protect patients' airways.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for locum staff. These reflected the relevant legislation. We looked at three staff recruitment records which demonstrated the recruitment procedure had been followed. The provider should consider keeping a copy of all references, with other recruitment information for ease of access.

Are services safe?

The dentists were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical appliances, although fixed wire testing had not taken place to ensure the safety of the premises.

Records showed that fire detection and firefighting equipment was regularly tested. Fire exits were free from obstruction and clearly signposted throughout the practice. The provider had conducted their own fire risk assessment on 16 July 2021. Staff told us they had only undertaken a full timed evacuation procedure from the building for the first time the day before of our inspection.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. Rectangular collimation was used to reduce patient exposure. The provider should consider implementing step wedge testing and a processing time-temperature graph to evaluate the performance of the X-ray machine and processing.

The dentists had completed continuing professional development in respect of dental radiography.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards in the practice and detailed the control measures that had been put in place to reduce the risks to patients and staff. Additional assessments had been completed for risks associated with the Covid-19 pandemic.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. None of the dentists used the safest types of needle as recommended in national guidance. A risk assessment had been completed in relation to this.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. However, the frequency of checks of the medical oxygen cylinder and AED needed to be reviewed to meet Resuscitation Council standards. We found the medical emergency kit was located in the dental surgery and could risk staff being exposed to aerosol generating procedures.

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

Safe and appropriate use of medicines

The dentists were aware of current guidance with regards to prescribing medicines and regular audits were conducted to ensure they were following national guidelines.

The fridge's temperature, where Glucagon was held, was not monitored to ensure it operated within the correct temperature range.

Prescription pads were held securely, although there was no system in place to easily identify individual lost or missing prescriptions.

Track record on safety, and lessons learned and improvements

The practice had an incident reporting policy in place and specific forms were available to complete in relation to these. Staff were diligent in recording any accidents that occurred in the practice and we noted detailed accounts of a range of

Are services safe?

accidents including patient falls, sharps' injuries, and injuries from a shattered glass coffee flask. However, there was no evidence to show how learning from these incidents had been used to prevent their recurrence and improve safety. The provider stated a new reporting system had been introduced a few months prior to our visit which would address this shortfall.

The provider had a system for receiving and acting on national safety alerts, which were downloaded and distributed to staff if relevant. One of the dentists had taken swift action to report a box of paracetamol tablets that were found discoloured on opening.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice. We saw the dentists assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Patients' dental care records had been audited to check that the dentists recorded the necessary information. However, they had not been effective in identifying some of the shortfalls we found. For example, information and patients' risk level of caries, gum disease, oral cancer and non-carious tooth surface loss had not always been recorded. Patients' medical history updates had not been recorded at every course of treatment.

Helping patients to live healthier lives

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health. Two hygienists were employed at the practice give support and advice to patients around oral health and gum disease. One of the nurses had undertaken training in oral health instruction.

The practice took part in national oral health campaigns and one dentist provided free oral health advice and training to a local Gurkha group, as they spoke Nepalese.

The dentists were aware of the principals of the Delivering Better Oral Health toolkit. However, dental care records we viewed did not always demonstrate it had been implemented. For example, greater detail was needed as to the actual amounts of alcohol drunk and the number of cigarettes smoked by patients, and it was not always clear if advice had been provided around these. The provider told us measures were in place to improve this.

Consent to care and treatment

Staff understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who were looked after. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. Due to recent Covid-19 restrictions the provider had stopped providing written treatment plans to patients. We discussed alternative ways of providing this important information to patients with the provider.

Effective staffing

We confirmed the dentist completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role. Staff new to the practice had a structured induction programme.

Staffing levels had been unduly affected by the Covid-19 pandemic with three staff having had to shield, and one dentist leaving for maternity leave. One of the partners told us they were looking to recruit more nurses and dentist as a result. Despite this, staff reported that they had enough time to do their work and did not feel rushed in their job. The practice's chaperone policy stated that all clinicians needed to work with chair side support, however we noted that the dental hygienists did not have any and no risk assessment had been completed for this.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

Staff confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. This was done on-line so that referrals could be monitored.

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

The two partners each took responsibility for different areas of the governance and financial management of the practice. One partner dealt with the financial areas and the other with staffing and personnel issues. They were supported by a part-time practice manager who worked two days a week. We noted that governance systems in the practice needed to be strengthened. For example, there was no effective system to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice, or evidence of the implementation of Delivering Better Oral Health guidance. There was no system for monitoring and recording the fridge temperature where medicines were stored, or for ensuring action was taken when hot water temperatures did not reach safe levels. Safety incidents were recorded but learning from them was not shared across the staff team. Fixed wire testing had not been undertaken to ensure the safety of the building. Mechanisms to obtain meaningful patient feedback were limited.

The partners had recognised the need for additional management support to ensure a strengthened approach to governance and were looking to recruit additional management support.

Staff described senior leaders in the practice as very supportive, approachable and responsive. They told us that senior staff had prioritised their safety during the Covid 19 pandemic and they felt very safe at work as a result. One member of staff told us that managers were very understanding of their family commitments.

Culture

Staff demonstrated a transparent and open culture in relation to people's safety. Staff were responsive to our findings, and it was clear they were keen to remedy the shortfalls we had identified.

The provider had a specific Duty of Candour policy in place, and openness and honesty were demonstrated when responding to the complaints we reviewed.

Governance and management

There were some processes for managing risks, issues and performance. The practice had comprehensive policies, procedures and risk assessments to support the management of the service and to protect patients and staff.

There were monthly practice meetings which all staff attended. Not all staff found these an effective forum for communication however and minutes we viewed indicated the meetings could be used more effectively to deliver key messages and policies.

The practice had a policy which detailed its complaints' procedure, and details of how to complain were available in the waiting area. We viewed into recent complaints received and noted they had been investigated and responded to in a timely, empathetic and professional way.

Engagement with patients, the public, staff and external partners

The practice used its own survey to gather feedback from patients which covered areas such as the quality of the practice's décor, reception, appointments, dentists and treatment information. The last survey had been completed in 2019. Despite having nearly 15,000 patients, only five surveys had been collected, and their results yet to be analysed.

Are services well-led?

The practice did respond to patients' suggestions and their requests for appointment reminders and to continue with cash payments had been implemented.

Continuous improvement and innovation

Staff discussed their training needs at an annual appraisal also discussed learning needs, general wellbeing and aims for future professional development. Staff valued the appraisals one reported that they had 'come out beaming', following theirs.

The partners supported and encouraged staff to complete continuing professional development. Staff told us their requests for training were met and one dental nurse told us they were looking forward to undertaking a suturing course. Another dental nurse reported that the partners allowed them to work flexibly so they could complete a paramedic course.

Both partners were members of several national dental bodies, as well as the local dental committee to help keep the practice up to date with the latest guidance.

The provider had some quality assurance processes to encourage continuous improvement. Audits were undertaken however we found they were not always used effectively to drive improvement. For example, the dental care records audit had failed to identify some of the shortfalls we found, and shortfalls that had been identified, were repeated year after year. Staff told us that audit results were discussed at the practice meetings, but we did not find evidence of this in the minutes we reviewed. The radiography audit lacked detail and the reflection of its findings.

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
Surgical procedures Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Good Governance** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice. • There were no systems to ensure the clinicians took into account the guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when promoting the maintenance of good oral health • There was no effective system for ensuring hot water temperatures reached required temperatures to prevent legionella bacteria build up. • There was no effective system to ensure fixed wire testing was undertaken to ensure the safety of the premises.

This section is primarily information for the provider

Requirement notices

- There was a system for recording, investigating and reviewing incidents or significant events. However there was no evidence to show how learning from incidents and accidents was used to drive improvement and safety.

Regulation 17 (1)