The Boathouse Dental Surgery

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 11 October 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 practice was visibly clean.
- The practice's infection control procedures were not effective.
- Staff knew how to deal with medical emergencies.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- Staff recruitment procedures were not operated effectively.
- The clinicians provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff training was not monitored effectively.
- The provider did not have effective leadership and a culture of continuous improvement.

Background

The Boathouse Surgery is in Goring and provides NHS and private dental care and treatment for adults and children.

The practice is not fully accessible to wheelchair users. Patients are advised of the access barrier when they contact the practice.

The dental team includes 6 dentists, 2 dental nurses, 2 student dental nurses, 3 dental hygienists, and 2 receptionists.

The practice has 3 treatment rooms.

During the inspection we spoke with 2 dentists, 1 dental nurses, 1 student dental nurse, 1 dental hygienist and 2 receptionists.

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

The practice is open:

- Monday 8.30am to 5.30pm
- Tuesday 8.30am to 6.45pm
- Wednesday 9.00am to 7.00pm
- Thursday 9.00am to 5.00pm
- Friday 8.30am to 4.00pm
- Saturday 9.00am to 1.00pm

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 training necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and specific 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:

Summary of findings

- Implement an effective system for monitoring and recording the fridge temperature to ensure that medicines and dental care products are being stored in line with the manufacturer's guidance.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- 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?	**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, 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 infection control procedures which reflected current published guidance. In particular:

- A manual scrubbing brush and glove replacement protocol was not in place to ensure regular changes occurred.
- Waiting room seating had material coverings. A cleaning protocol was not in place to ensure regular cleaning took place.
- Surgery 1 and 2's floor covering was damaged which posed an infection control risk.
- Surgery 1's operator chair covering was incomplete (tear).
- The practice had not carried out infection prevention and control audits six-monthly following current guidance and legislation since February 2018. We have since received evidence which confirms this shortfall has been addressed.
- Hand hygiene audits were not carried out. We have since received evidence which confirms this shortfall has been addressed.

Recommendations made in the Legionella risk assessment, carried out in 2015,had not been actioned. We have since received evidence which confirms this shortfall has been addressed.

The practice did not have a trained lead for the management of legionella. We have since received evidence which confirms this shortfall has been addressed.

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

The practice appeared clean, though improvements were needed. Specifically:

- Colour coded cleaning equipment was not separated when stored which increased the risk of cross infection.
- Oversight of the external contractor's cleaning standards could not be evidenced by staff.

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

We reviewed staff recruitment folders and found:

- Conduct in previous employment (reference) had not been obtained for 6 staff.
- A second reference had had not been obtained for 7 staff. The recruitment policy stated that 2 references would be sought for every successful job applicant.
- Evidence was not available to confirm that induction had been carried out for 10 staff.
- A Disclosure and Baring Service (DBS) check was not available for 1 staff member.

One clinical staff member did not have professional indemnity cover in place.

One staff member was a non-responder to hepatitis vaccinations, there was no evidence of action taken by the practice as a result.

Are services safe?

A second staff member had received 2 doses of the vaccination. There was no evidence of action taken by the practice as a result of not knowing their immunity to Hepatitis B.

The provider did not have effective fire safety management procedures. In particular:

- The five yearly electrical installation (fixed wiring) test result was carried out in September 2023. The result was unsatisfactory. No action had been taken as a result.
- Portable appliance testing had not been carried out.
- A fire risk assessment had been carried out by a member of staff who could not demonstrate competence in the management of fire safety.
- The recent fire drill detailed the time of evacuation not the time taken to evacuate the building.
- Emergency lighting was not available.
- A fire exit route was obstructed by a fence.

We have since received evidence which confirms these shortfalls have been addressed.

The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was unavailable. Including cone-beam computed tomography (CBCT) X-ray equipment.

- CBCT local rules did not include the name and contact details of the radiation protection advisor.
- The CBCT unit had not been serviced since 2019. We have since received evidence which confirms this shortfall has been addressed.
- Local rules for the CBCT equipment were not reviewed to ensure they were up to date and remained effective.
- Monthly quality assurance tests (known as phantom tests) were not carried out. We have since received evidence which confirms this shortfall has been addressed.
- Local rules for the intraoral x-ray machines did not include the name and contact details of the radiation protection advisor.
- Surgery 2 collimator was damaged which meant the rectangular collimator could not be fitted. A rectangular collimator is a device that limits the radiation output of an X-ray source.
- Local rules for the intraoral x-ray machines were not reviewed to ensure they were up to date and remained effective.

Risks to patients and staff

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety. In particular, relating to sharps safety and sepsis awareness.

Emergency equipment and medicines were not available and checked in accordance with national guidance. In particular:

- A Volumatic spacer was not available. We have since received evidence which confirms this shortfall has been addressed.
- Aspirin was not dispersible.
- A child size self-inflating bag was not available.
- Size 0, 2 and 4 oropharyngeal airways were not available.
- Size 1 and 3 clear facemasks were not available. We have since received evidence which confirms this shortfall has been addressed.
- Weekly checks were not carried out to ensure emergency equipment was available and fit for use.
- Glucagon, a medicine used to treat low blood glucose levels, was stored in a fridge which was not temperature monitored.
- One member of staff could not demonstrate an understanding of the identification and management of sepsis.

Are services safe?

Staff knew how to respond to a medical emergency. However, we noted that 1 out of 15 staff had not completed training in emergency resuscitation and basic life support every year. We have since received evidence which confirms at basic life support training is booked to take place on 11 November 2023.

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

- COSHH control sheets were not available for every COSHH identified product.
- The clinical waste bin was not tethered to a fixed point to prevent unauthorised removal from the practice property.
- The sanitary bin in the patient and staff toilet was not specific to requirements. Environmental Protection Act 1990 – the "duty of care" policy that employees should not be responsible for the management of this sanitary waste. We have since received evidence which confirms this shortfall has been addressed.

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

The practice did not have systems for appropriate and safe handling of medicines.

- Prescriptions were not monitored as described in current guidance.
- 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.

The accidence book was not GDPR compliant.

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.

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.

The practice had not carried out patient care record audits since January 2017. We have since received evidence which confirms this shortfall has been addressed.

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 had not carried out radiography audits six-monthly following current guidance and legislation since 2021. We have since received evidence which confirms this shortfall has been addressed.

Effective staffing

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

- Four out of 9 clinicians did not carry out 5 hours of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) training in the previous 5 years.
- One out of 15 staff did not carry out learning disability and autism training.
- Four of 15 staff did not carry out fire safety training in the previous 12 months.

We have since received evidence which confirms this shortfall has been addressed.

The practice did not carry out a structured induction for newly appointed staff.

Are services effective?

(for example, treatment is effective)

Staff did not receive formal appraisals.

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.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. 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 dentists explained the methods they used to help patients understand their treatment options. These included for example photographs, study models, videos, 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 and preferences.

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

Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients. However, actions remained outstanding at the time of our visit.

A hearing loop was not available for patients who were hearing aid wearers. We have since received evidence which confirms this shortfall has been addressed.

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 during the working day and 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.

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

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective.

We saw the practice had ineffective processes to support and develop staff with additional roles and responsibilities. For example, the lead receptionist was asked to carry out management tasks without any training.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

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

We saw no evidence of completed staff appraisals.

Governance and management

The provider had a system of clinical governance in place which included policies, protocols and procedures but systems were not followed.

The management of radiography, fire safety, health and safety, recruitment, COSHH, infection control, training, equipment and premises required immediate improvement.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of protecting patients' personal information.

Engagement with patients

Staff demonstrated a commitment to acting on feedback.

There was no evidence the practice gathered feedback from staff through meetings, surveys, and informal discussions.

Continuous improvement

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

The practice had undertaken an audit of disability access. Actions from this audit remained outstanding at the time of our visit.

Training was not monitored effectively.

Evidence was not available to confirm that relevant staff had completed the 'highly recommended' training as per General Dental Council professional standards.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not ensure that recruitment procedures were operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed. In particular, recruitment checks were not monitored to ensure they were completed or stored appropriately. We looked at 15 staff recruitment records. Evidence presented to us confirmed that: • Conduct in previous employment (references) had not been obtained for 6 staff. • Professional indemnity had expired for one clinician on 8 October 2023. • Evidence was not available to confirm that induction had been carried out for 10 staff • A Disclosure and Baring Service (DBS) check was not available for 1 staff member.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 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: **Fire Safety** • The five yearly electrical installation (fixed wiring) test result was unsatisfactory. No action had been taken as a result. • Portable appliance testing had not been carried out.

This section is primarily information for the provider

Requirement notices

- Emergency lighting was not available.
- A fire exit route was obstructed by a fence.

Medical Emergencies

- A Volumatic spacer was not available.
- Aspirin was not dispersible.
- A child size self-inflating bag was not available.
- Size 0, 2 and 4 oropharyngeal airways were not available.
- Size 1 and 3 clear facemasks were not available.
- Weekly checks were not carried out to ensure emergency equipment was available and fit for use.
- Glucagon, a medicine used to treat low blood glucose levels, was stored in a fridge which was not temperature monitored.

Legionella

- Monthly water temperature testing of sentinel taps was not carried out in line with the legionella risk assessment action plan.

Radiography

- Surgery 2 x-ray collimator was damaged (split) which meant a rectangular collimator could not be fitted. A rectangular collimator is a device that limits the radiation output of an X-ray source.
- The CBCT unit had not been serviced since 2019.

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 prevention and control** - A manual scrubbing brush and glove replacement protocol was not in place to ensure regular changes occurred.

This section is primarily information for the provider

Requirement notices

- Waiting room seating had material coverings. A cleaning protocol was not in place to ensure regular cleaning took place.
- Surgery 1's flooring surface was incomplete in places.
- Surgery 2's flooring surface was incomplete in places.
- Surgery 1's operator chair covering was incomplete (tear).

Environmental Cleaning

- Colour coded cleaning equipment was not separated when stored which increased the risk of cross infection.
- Oversight of the external contractor's cleaning standards could not be evidenced by staff.

Fire Safety

- A fire risk assessment had been carried out by a member of staff who could not demonstrate competence in the management of fire safety.
- The recent fire drill detailed the time of evacuation not the time taken to evacuate the building.

Sepsis

- One member of staff could not demonstrate an understanding of the identification and management of Sepsis.

Control of Substances Hazardous to Health (COSHH)

- COSHH control sheets were not available for every COSHH identified product.
- The clinical waste bin was not tethered to a fixed point to prevent unauthorised removal from the practice property.
- The sanitary bin in the patient and staff toilet was not specific to requirements. Environmental Protection Act 1990 – the "duty of care" policy that employees should not be responsible for the management of this sanitary waste.

Medicines

- A prescription pad stock control system was not in place.
- Individual prescription tracking was not carried out.
- The practice's name and address was not routinely included on dispensed medicines.

General Data Protection Regulation (GDPR)

This section is primarily information for the provider

Requirement notices

- The accidence book was not GDPR compliant.

Equality Act

- A hearing loop was not available for patients who were hearing aid wearers.

Cone Bean Computed Tomography (CBCT)

- CBCT Local rules did not include the name and contact details of the radiation protection advisor.
- Monthly quality assurance tests (known as phantom tests) were not carried out.
- CBCT radiograph audits were not carried out.
- Local rules were not reviewed to ensure they were up to date and remained effective.

Radiography

- Local rules for the intraoral x-ray machines did not include the name and contact details of the radiation protection advisor.
- Local rules were not reviewed to ensure they were up to date and remained effective.

Legionella

- The practice did not have a trained lead for the management of legionella.

Continuous Improvement

- Infection control audits were last carried out in February 2018.
- Hand hygiene audits were not carried out.
- Radiography audits were last carried out in June 2021.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure persons employed in the provision of the regulated activity received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties. We looked at 15 staff training records. Evidence presented to us confirmed that:

This section is primarily information for the provider

Requirement notices

- Four out of 9 clinicians did not carry out 5 hours of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) training in the previous 5 years.
- One out of 15 staff did not carry out learning disability and autism training.
- Four of 15 staff did not carry out fire safety training in the previous 12 months.
- One of 15 staff did not carry out basic life support training in the previous 12 months.

Appraisals

- Staff did not receive formal appraisals.