Puresmile Marlow Ltd

Courthouse Dental

Inspection report

The Old Courthouse
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Date of inspection visit: 4 March 2023
Date of publication: 27/03/2024

Overall summary

We carried out this announced comprehensive inspection on 4 March 2024 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 two specialist dental advisors.

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.
- Improvements were needed to the practice's infection control procedures.
- 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.
- Staff recruitment procedures were not operated effectively.
- The practice did not have arrangements to ensure the safety of the X-ray equipment.

Summary of findings

- The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health.
- The clinicians provided patients' care and treatment in line with current guidelines.
- The provider did not have effective fire safety management procedures.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff training was not monitored effectively.
- The practice did not have effective governance and management arrangements.

Background

Courthouse Dental is in Marlow, Buckinghamshire and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 5 dentists, 2 dental nurses, -a student dental nurse, 2 dental hygienists, a receptionist and the practice manager.

The practice has 3 treatment rooms.

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

During the inspection we spoke with a dentist, a dental nurse, the student dental nurse and a manager from another of the provider's locations.

The practice manager and the provider were not present at the practice during our visit.

The practice is open:

- Monday to Friday 9am to 5.30pm

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.

Summary of findings

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

- Improve and develop staff awareness of autism and learning disabilities and ensure all staff receive appropriate training in this.

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.

Improvements were needed to the practice's infection control procedures.. We found:

- Out of date dental materials were present in treatment room 3.
- Out of date local anaesthetic cartridges were present in treatment room 3.
- Clinical cotton rolls were stored in open containers in every treatment room.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment.

The practice had policies and procedures in place to ensure clinical waste was segregated in line with guidance. However, clinical waste collection notes for the previous three years were not available.

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.

We reviewed 9 staff recruitment folders and found:

- Four out of nine had evidence of conduct in previous employment (reference).
- Four out of nine had evidence to confirm that induction had been carried out for 5 staff.
- Eight out of nine had evidence of a Disclosure and Baring Service (DBS) check.
- Five out of nine had evidence of eligibility to work in the UK.
- Six out of nine had evidence of a health assessment.
- Eight out of nine had evidence of photographic identification.
- One clinical staff member's folder did not have evidence of current professional indemnity cover.
- The implantologist's professional indemnity cover certificate did not include the placements of implants.

A second reference had not been obtained for 5 staff. The recruitment policy stated that 2 references would be sought for every job applicant.

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

- The five yearly electrical installation (fixed wiring) test was carried out in 2017. The result of the test was unsatisfactory. Evidence of remedial action was not available.
- The most current test was due in 2022. We were not provided evidence to confirm this was carried out.
- Portable appliance safety testing protocols were not available.
- There were no records available to confirm that fire drills had taken place.
- Emergency lighting was not tested monthly.

Are services safe?

- The fire alarm was not tested weekly.
- There was no evidence available to confirm the fire alarm had been serviced.
- There was no evidence available to confirm the emergency lighting had been serviced.
- A fire exit route at the rear of the practice was obstructed by a car seat and trolley. Both were removed during our visit.

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

The practice did not have arrangements in place to ensure the required radiation protection information was available. Specifically:

- The room which was to be used to house the Orthopantomogram (OPG) x-ray machine had been audited before the machine was installed. Evidence to confirm the actions required from the audit had been carried out were not available.
- A critical examination (CE) was not available for the OPG x-ray machine. When an x-ray machine is installed the installer or engineer is required to carry out a CE to ensure that the equipment is safe to use.

Risks to patients and staff

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety.

- A sharps risk assessment was not available.

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

- COSHH substances were not stored securely.
- COSHH storage areas were not signed appropriately.
- Risk assessments and safety data sheets were not available for every COSHH identified substance.
- The clinical waste bin was not tethered to a fixed point to prevent unauthorised removal from the practice property.

The OPG x-ray machine and medical emergency medicines and equipment kits were situated in a room at the rear of the ground floor of the practice. This area was neither lockable nor monitored by staff when not in use.

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 had systems in place for appropriate and safe handling of medicines. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice could not demonstrate that they had a system for receiving and acting on patient and staff safety alerts.

The practice accident book was not General Data Protection Regulation (GDPR) compliant.

Completed accident book records were not placed in secure storage in line with GDPR protocols.

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 were unable to confirm that the provision of dental implants was in accordance with national guidance. Implant placing equipment was unavailable on the day of our visit as it was being used by the implantologist at another location.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Involvement in local schemes

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. They understood their responsibilities under the Mental Capacity Act 2005.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed patient care records in line with recognised guidance.

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

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

The practice carried out radiography audits six-monthly following current guidance and legislation.

Effective staffing

Evidence was not available to demonstrate staff had the skills, knowledge and experience to carry out their roles. We reviewed 12 staff training records and found that:

- Nine out of 12 staff carried out learning disability and autism training.
- Ten out of 12 staff carried out fire safety training in the previous 12 months.
- Eleven out of 12 staff carried out infection prevention and control training.
- Eleven out of 12 staff carried out the required level of child and vulnerable adult safeguarding training.

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)

The dentist 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 dentist explained the methods they used to help patients understand their treatment options. These included for example photographs, study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

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

Evidence presented to us confirmed that a disability access audit was in progress. Completion of any resulting action plans will be reviewed at our follow up visit.

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.

Information about the practice's complaint procedure was displayed behind the reception desk which made it inaccessible to patients.

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.

Culture

Staff stated they felt respected, supported and valued.

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

There was no evidence to confirm that the practice's policies, protocols and procedures were reviewed on a regular basis. The last review seen was dated 2018.

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, the public, staff and external partners

There was no evidence available to confirm that staff gathered feedback from patients, the public and external partners.

There was no evidence available to confirm that the practice gathered feedback from staff through surveys, and informal discussions.

Continuous improvement

Training was not monitored effectively.

Evidence was not available to confirm that all 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 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: **Infection Control** • Out of date dental materials were present in treatment room 3. • Out of date local anaesthetic cartridges were present in treatment room 3. • Clinical cotton rolls were stored in open containers in every treatment room. • 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** • The five yearly electrical installation (fixed wiring) test was carried out in 2017. The result of the test was unsatisfactory. Evidence of remedial action was not available. • The most current test was due in 2022. We were not provided evidence to confirm this was carried out. • Portable appliance safety testing protocols were not available. • There were no records available to confirm that fire drills had taken place. • Emergency lighting was not tested monthly. • The fire alarm was not tested weekly. • There was no evidence available to confirm the fire alarm had been serviced. • There was no evidence available to confirm the emergency lighting had been serviced.

This section is primarily information for the provider

Requirement notices

- A fire exit route at the rear of the practice was obstructed by a car seat and trolley.

Radiography

- The room which was to be used to house the Orthopantomogram x-ray (OPG x-ray) machine had been audited before the machine was installed. Evidence to confirm the actions required from the audit had been carried out were not available.
- A critical examination (CE) was not available for the OPG x-ray machine.

Health & Safety

- The Orthopantomogram x-ray (OPG x-ray) machine and medical emergency medicines and equipment kits were situated in a room at the rear of the ground floor of the practice. This area was neither lockable nor monitored by staff when not in use.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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:

Sharps

- A sharps risk assessment was not available.

Control of Substances Hazardous to Health (COSHH)

- COSHH substances were not stored securely.
- COSHH storage areas were not signed appropriately.
- Risk assessments and safety data sheets were not available for every COSHH identified substance.
- The clinical waste bin was not tethered to a fixed point to prevent unauthorised removal from the practice property.

This section is primarily information for the provider

Requirement notices

- Clinical waste collection notes for the previous three years were not available.

Indemnity

- One clinical staff member's folder did not have evidence of current professional indemnity cover.
- The implantologist's professional indemnity cover certificate did not include the placements of implants.

General Data Protection Regulation (GDPR)

- The accident book was not GDPR compliant.
- Completed pages were not removed to secure storage.

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 reviewed 12 staff training records and found that: • Ten out of 12 staff carried out fire safety training in the previous 12 months. • Eleven out of 12 staff carried out infection prevention and control training. • Eleven out of 12 staff carried out the required level of child and vulnerable adult safeguarding training.

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 Recruitment checks were not monitored to ensure they were completed or stored appropriately. We looked at 9 staff recruitment records. Evidence presented to us confirmed that:

This section is primarily information for the provider

Requirement notices

- Conduct in previous employment (reference) had not been obtained for 5 staff.
- Evidence was not available to confirm that induction had been carried out for 5 staff.
- A Disclosure and Baring Service (DBS) check was not available for 1 staff member.
- Evidence of eligibility to work in the UK was not available for 3 staff.
- A health assessment was not available for 3 staff.
- Photographic identification was not available for 1 staff member.