Dr. Ian Kendal

Dentistry@OceanaBoulevard

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 19 January 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 practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Summary of findings

- The practice had information governance arrangements.
- The dental clinic appeared clean.
- Staff knew their responsibilities for safeguarding vulnerable adults and children. Improvements were required to ensure accurate safeguarding processes were in place.
- The practice did not have staff recruitment procedures which reflected current legislation
- Improvements were needed to ensure that clinical staff kept up to date with current guidelines, and information related to patient care was suitably recorded within the dental care records
- Improvements were needed to protect patients' privacy within the treatment rooms
- There were ineffective systems to support continuous improvement
- There was ineffective leadership and a lack of oversight for the day-to-day management of the service.
- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers` guidance.
- Staff generally worked as a team. Improvements were needed to ensure that they were supported and involved in the delivery of care and treatment

Background

Dentistry@OceanBoulevard is in Southampton and provides 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 2 dentists, 2 dental nurses, 1 dental therapist, 1 practice manager and 2 receptionists. The practice has 3 treatment rooms.

During the inspection we spoke with all the members of staff. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Thursday 8.30am to 6pm

Friday 8.30am to 4pm

One Saturday per month 10am to 4pm

We noted innovative approaches to providing person centred care. We noted that the practice had invested in modern intra-oral scanning technology which can improve patient experience and outcomes. We also noted that the principal dentist used a microscope for some procedures.

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

Summary of findings

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed
- Ensure 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:

- Take action to ensure that each patient's privacy is maintained at all times including when they receive treatment
- Review the necessity of a second oxygen cylinder where appropriate for the practice's circumstances.

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?	**Enforcement action**
Are services effective?	**Enforcement 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 Requirements Notices and Enforcement Actions 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. Improvements were required to ensure up to date details of the local authority safeguarding teams were available to all staff.

The practice had infection control procedures which reflected published guidance.

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

Recommendations made in the Legionella risk assessment had not been actioned. In particular, there was no written scheme of control as required by the Health and Safety Executive's Approved Code of Practice (ACOP) L8. "Legionnaires' disease: The control of legionella bacteria in water systems." Although sentinel water temperature checks were being carried out, we saw records that the outlets were not delivering water of 55 degrees Celsius(C) or more after one minute. All records taken from 2022 indicated temperatures of only 35C to 45C. The risk from legionella is increased in water systems where temperatures are between 20C-45C.

Improvements were required to ensure the practice was kept clean. In general, we observed the practice was visibly clean, but we noted some surfaces were dusty within the decontamination room.

Cleaning equipment was not stored appropriately. In particular, we observed that equipment used to clean clinical areas was stored within the toilet facility.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff however we noted that the recruitment policy was not followed. In particular, some recruitment checks had not been carried out, in accordance with relevant legislation. Disclosure Barring Service (DBS) checks had not been carried out at the time of employment and references had not been obtained for 2 members of staff. Although we saw that clinical staff were vaccinated against Hepatitis B, evidence of immunity was not available for 3 members of staff. On the day of inspection, blood tests had been arranged to check this. There was no evidence of induction for 3 members of staff.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. There was no evidence of a written scheme of examination for the compressor or periodic testing and maintenance. One autoclave had not been serviced or examined in line with the manufacturer's recommendations. We saw documentation that the autoclave had a Pressure Vessel Inspection (PVI) on 21 January 2021. The autoclave was certified as safe to use. However, the report of examination also stated that the autoclave must not be used without re-examination at the recommended interval (18 months from manufacture and 14 months thereafter). There was no evidence to demonstrate timely re-examination, even though 24 months had lapsed since the inspection of January 2021.

The practice did not ensure the facilities were maintained in accordance with regulations. There was no evidence that fixed-wiring electrical safety tests had been carried out since 2010.

Are services safe?

A fire safety risk assessment was carried out in line with the legal requirements although it had not identified the need to ensure the electrical fixed-wiring installation was satisfactory. The management of fire safety was effective, including the checks and servicing of the emergency lighting and alarms. Fire-fighting equipment was maintained, and we saw staff had completed fire marshal training.

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

The required radiation protection information was not available. For example, the Local Rules had not been updated or reviewed to reflect Ionising Radiation Regulations 2017 (IRR17). There was no evidence to demonstrate the safe installation of the X-ray equipment.

A Radiation Protection Advisor had been appointed but there was no evidence that they had been consulted.

The X-ray equipment including the CBCT scanner had not been serviced and maintained according to manufacturer's requirements. There was no evidence that electro-mechanical servicing or routine performance tests had been carried out.

We did not find evidence that lasers were being used in accordance with current national guidance - Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices published by the Medicines and Healthcare products Regulatory Agency (MHRA). In particular, there was no evidence of laser training which should be updated regularly. We observed that there was no evidence that the window in the entrance to the surgery was covered or access restricted when the laser was in operation.

We found no evidence of a governance framework for the safe use of lasers, in particular, a risk assessment, Local Rules, a maintenance schedule for equipment or a quality assurance system.

A Laser Protection Advisor (LPA) or Laser Protection Supervisor (LPS) had not been appointed

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety in relation to sepsis awareness and lone working. Improvements were required to the management of sharps, as we saw that a sharps disposal bin was placed on a high shelf in the decontamination room. It was difficult to reach and the risk of spillage of contaminated sharps was increased. The inoculation injury protocol did not have contact details of the local Occupational Health service.

Emergency equipment and medicines were available and checked in accordance with national guidance. Improvements were required to ensure the logs were completed accurately as the checklists did not reflect the content of the emergency equipment kit.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. We were not assured that the Immediate Life Support (ILS) training that was completed by staff providing treatment to patients under sedation was adequate, as the course was a short online module supplied by a dental compliance company. Staff told us it took them only 40-minutes to complete the module.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, hazardous products were stored within the patient toilet and these were accessible to patients, including children.

Information to deliver safe care and treatment

Are services safe?

We observed that most patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements. However, there were exceptions; we looked at 10 sets of patient records and, of these, 3 had received treatment under conscious sedation. We saw that 2 records of the sedation process were entirely missing as they had not been scanned into the records correctly. The original paper records, we were told by staff, had been destroyed.

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. One box of Midazolam which is a controlled drug was not stored securely. We also observed that there were 2 different doses of intra-venous Midazolam stocked for conscious sedation use. The dental nurse who assisted with conscious sedation cases and prepared the medication was unaware that there were different doses and we were not assured that safeguards were in place to prevent accidental administration of the wrong dose.

Antimicrobial prescribing audits were carried out. However, the latest audit did not contain any detail of dosages or durations of the antimicrobials prescribed and we saw that 7-day courses were routinely given, which was not in line with current guidance from the College of General Dentistry (CGDent).

The practice did not have an adequate stock control system of medicines which were held on site.

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.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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 and Enforcement Actions 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.

Effective needs assessment, care and treatment

The practice did not have effective systems in place to ensure dental professionals were up to date with current evidence-based practice.

The practice offered dental treatment under conscious sedation for patients. We found the practice did not have systems to do this safely. For example, patients were not routinely cannulated prior to oral sedation in order to administer a reversal agent in the event of an emergency. Improvements could be made to have an additional oxygen cylinder available to provide supplementary support in the event of an emergency.

There was no evidence the practice carried out relevant patient checks before and after treatment. In particular, there was no evidence that Body Mass Index (BMI) assessment and physical classification system as per American Society of Anaesthesiologists (ASA) scoring system was taken, or assessments of anxiety and venous access had been carried out. There was also no evidence that vital signs were monitored throughout recovery until discharge.

Team members involved in the provision of treatment to patients under conscious sedation had not taken appropriate life support training. All staff had completed an online course claiming to be Immediate Life Support (ILS) but it was not accredited by the British Resuscitation Council. Following our inspection, the team members enrolled on a suitable course.

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.

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

Dental care records, with the exception of sedation records, were maintained in line with recognised guidance. The sedation record that we viewed had insufficient details, in particular there was no record of any pre-operative assessments or recovery and discharge. We saw that blood pressure and oxygen saturation were monitored but there were no records of levels of consciousness, respiratory rate or pulse. As a minimum, pre-operative, peri-operative and post-operative recordings should be taken and documented throughout the sedation procedure until the point of discharge. We attempted to view 2 further sedation records but the entries pertaining to the sedation process had been lost.

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.

Are services effective?

(for example, treatment is effective)

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits which used a sample size of 10. Improvements were required to ensure they are carried out at 6-monthly intervals and the sample size is increased according to current guidance which states that the sample size should not be less than 100 unless the radiographic workload is too low to support this number. The radiographic gradings could be simplified by using current quality ratings terminology.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction although this was not always recorded, and clinical staff completed continuing professional development required for their registration with the General Dental Council.

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.

The practice accepted referrals for CBCT imaging and we saw staff monitored and ensured the dentist was aware of all incoming referrals. According to guidance, dental CBCT is currently not taught sufficiently in undergraduate programmes to allow a newly qualified dentist to refer, justify or interpret dental CBCT examinations. We saw no evidence that the practice checked whether the referrers had adequate training. The operator of the CBCT equipment, the principal dentist was also unaware of this requirement. On the day of inspection, the staff set up a service level agreement for all referring dentists to ensure they had completed Level 1 (core) training as a minimum and could justify the images.

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.

Patients said staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

The practice was not set up to ensure patients' privacy and confidentiality could be observed at all times. One surgery had a glass partition separating it from a thoroughfare within the communal area, and although there was some striped frosting, it was possible to observe patients undergoing procedures.

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, 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.

The practice had made reasonable adjustments, including an enabled toilet for patients with access requirements. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

The practice displayed its opening hours and provided information on their website and social media page.

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 and Enforcement Actions 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 that there was ineffective leadership which impacted on the practice`s ability to deliver safe care. The principal dentist could not assure us that they fully understood risks pertaining to the management of the service and the delivery of care. We saw that the staff members worked well together but it was apparent that there was a lack of oversight at the practice.

The inspection highlighted issues and omissions, especially in relation to radiation protection arrangements, equipment and premises maintenance, Legionella risks and the provision of conscious sedation.

The information and evidence presented during the inspection process was poorly documented. It was entirely possible that equipment had been installed and maintained according to guidance, but records had been mislaid.

Culture

Staff we spoke with told us that the principal dentist was kind and cared about staff well-being. They also told us that they enjoyed working at the practice, but they were not always listened to when they raised concerns about the service.

The practice did not have arrangements for staff to discuss their training needs during annual appraisals.

Governance and management

The practice's management and governance structure required improvements.

The practice policies and procedures were not reviewed or monitored effectively to ensure that they reflected current guidance and legislation.

For example, the recruitment policy stated that an offer of employment would be subject to satisfactory references and DBS checks but we saw this policy was not followed. We saw the whistleblowing policy was dated 20 April 2021 and made reference to a practice manager who was no longer employed at the practice.

The practice did not have clear and effective processes for managing risks. Essential requirements and equipment checks had not been undertaken on a regular basis. The Legionella risk assessment had been carried out, but recommendations had been disregarded.

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

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings and informal discussions. Staff were able to offer suggestions for improvements to the service and said these were listened to but not always acted on.

Continuous improvement and innovation

Are services well-led?

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access, radiographs and infection prevention and control. We noted that there were several inaccuracies within the infection prevention and control audits. For example, the latest audit stated that all decontamination equipment records were available, handpieces were washed by a specific device and there were contractual arrangements for the maintenance of sterilisers. We saw another audit stating that autoclaves were serviced every 6 months, the compressor was serviced annually, Hepatitis B responses were checked, and sharps bins were wall mounted. On the day of inspection, our findings did not reflect these statements. Additionally, the infection control audits were not being carried out at 6-monthly intervals as per guidance.

Improvements were required to ensure the radiography audits were completed every 6 months and used a suitable sample size in line with guidance. The antimicrobial prescribing audit did not contain enough detail to identify how improvements could be made to prescribing habits for the reduction of antibiotic resistance.

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **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 ineffective systems for assessing the risks relating to the storage of substances hazardous to health, legionella and radiography. 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: • Audits of infection prevention and control did not reflect the systems and processes within the practice and had failed to identify issues. They were not completed at six-monthly intervals according to guidance. • Radiographic audits were not completed at the recommended intervals and did not use data from a suitable sample size.

This section is primarily information for the provider

Requirement notices

There was additional evidence of poor governance. In particular:

- The practice policies and procedures were not reviewed or monitored effectively to ensure that they reflected current guidance and legislation.
- There were inadequate arrangements to assess staff learning and development needs.
- Inductions of new staff were not recorded.

Regulation 17 (1)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 19 Fit and proper persons employed** The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: • Disclosure and Barring Service (DBS) checks had not been carried out at the time of employment for all members of staff. The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • Evidence of hepatitis B immunity was unavailable for 3 members of staff. • There were no records in respect of satisfactory evidence of conduct in previous employment (references) for 2 members of staff. Regulation 19(1)(2) & (3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

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 **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: There were ineffective arrangements to ensure the use of X-ray equipment was in accordance with Ionising radiation Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17): • Routine performance tests had not been carried out. • Annual electro-mechanical servicing had not been carried out. • There was no evidence that the X-ray equipment had been installed safely. • There was no evidence that a Radiation Protection Advisor had been consulted. • Local Rules had not been updated or reviewed. There were no arrangements to ensure the safety of laser equipment. • No Laser Protection Advisor or Laser Protection Supervisor had been appointed • There was no evidence of laser training • There was no governance framework for the safe use of lasers. • There was no evidence that the window in the entrance to the surgery was covered or access restricted when the laser was in operation. The risks associated with water systems were not regularly reviewed and mitigated.

This section is primarily information for the provider

Enforcement actions

- There was no evidence that the Legionella risk assessment had been reviewed or actioned.
- There was no written scheme of control
- Hot water was not reaching 55Celsius after one minute and no action had been taken to rectify this.

There were ineffective arrangements to manage risks associated with the use of equipment and premises.

- There was no evidence of fixed-wiring electrical safety tests.
- There was no evidence of a written scheme of examination for the air receiver (compressor) or periodic testing and maintenance.
- There was no evidence that one autoclave had been serviced in line with the manufacturer's guidance to ensure it was safe to use.
- Cleaning equipment for healthcare environments was not stored appropriately to minimise the risk of cross contamination within the patient and staff toilet facility.
- Hazardous products were stored insecurely within the patient toilet.

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 delivered under conscious sedation. In particular

- Patients were not routinely cannulated prior to oral sedation.
- Team members involved in the provision of treatment to patients under conscious sedation had not taken appropriate life support training.
- There was no evidence that pre -operative checks were carried out. In particular, Body Mass Index (BMI) assessment, American Society of Anaesthesiologists (ASA) status, assessment of anxiety and venous access. There was also no evidence that vital signs were monitored throughout recovery until discharge.

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

This section is primarily information for the provider

Enforcement actions

- The dental nurse was unaware that there were two different strengths of the sedating medication, intra-venous Midazolam. Adequate safeguards were not in place to prevent accidental administration of the wrong dose.
- One box of the controlled drug Midazolam was not stored securely

Regulation12 (1)