Bhageerutty Smiles Limited

Bhageerutty Smiles

Inspection Report

40 Streatham Vale,
London
SW16 5TD
Tel:020 8764 6040
Website:

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Overall summary

We carried out this unannounced inspection on 30 April 2018 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 CQC inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five 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:

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

Background

Bhageerutty Smiles is located in Lambeth. The practice has some parking nearby. The dental team includes a dentist, a trainee dental nurse and a receptionist. The practice has two treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission 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. At the time of the inspection the practice did not have a registered manager in post.

Summary of findings

We were unable to speak with any patients on the day of the inspection. Three of the patients due to attend on the day of the inspection cancelled appointments. A patient that did attend their appointment did not want to speak with us.

During the inspection we spoke with a dentist, a dental nurse and a receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday to Friday 9.30 am to 5.00pm

Our key findings were:

- The practice was generally clean but improvements were required to the state of cleanliness of some areas of the practice.
- There were shortcomings in the practice's infection control procedures and required improvement
- Staff knew how to deal with emergencies. All recommended medicines and life-saving equipment for manging a medical emergency was not available.
- The practice had some systems to help them manage risk.
- The practice staff knew their responsibilities for safeguarding adults and children though no evidence was provided of up to date training.
- The practice had staff recruitment procedures.
- The clinical staff provided patients' care and treatment but improvements were required
- Staff treated patients with dignity and respect
- The practice was providing preventive care.
- The appointment system met patients' needs.
- There were no sytems to suitably monitor and record patient consent for treatment
- The practice did not monitor all referrals to make sure they were dealt with promptly.
- The practice had some systems in place to deal with complaints, but improvements were required.
- The practice did not have suitable information governance arrangements.

We identified regulations that were not being met and the provider must:

- Ensure care and treatment is provided in a safe way to patients
- Ensure that care and treatment of patients is only provided with the consent of the relevant person
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

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

- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.

Review the practice's complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.

Review the storage of dental care records to ensure they are stored securely.

- Review the practice's system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review practice protocols for patient assessments and ensure they are in compliance with current legislation and take into account relevant nationally recognised evidence-based guidance.
- Review the processes and systems in place for seeking and learning from staff feedback with a view to monitoring and improving the quality of the service.

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 

We found that 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 at the end of this report)

Staff knew how to recognise the signs of abuse and how to report concerns. Evidence of up to date training was not available.

Staff were qualified for their roles and the practice told us they completed essential recruitment checks.

The premises were generally clean and maintained. However the practice did not adequately follow national guidance for cleaning, sterilising and storing dental instruments.

The dentist did not use a rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment.

The practice did not have suitable arrangements for dealing with medical and other emergencies.

Are services effective?

Requirements notice 

We found that 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 at the end of this report)

The dentist assessed patients' needs and provided care and treatment in line with recognised guidance. However, improvements were required in regards to the maintainence of records of treatments.

The dentist discussed treatment with patients, so they could give informed consent. However improvements were required in regards the recording of consent that had been sought.

The practice had arrangements when patients needed to be referred to other dental or health care professionals.

The practice told us they had supported staff to complete training relevant to their roles. However improvements could be made to the system in place to monitor support

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations.

Staff were caring, friendly and compassionate towards patients when they spoke to them on the phone.

Summary of findings

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. However improvements were required in relation to the privacy of records.

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included people that needed translation services.

The practice had a system in place to deal with complaints, but improvements were required.

Are services well-led?

Requirements notice 

We found that this service 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).

The practice had arrangements in place in regards to the running of the service. These included some systems for the practice team to discuss the quality and safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and said they could discuss issues with the principal dentist when needed. .

The practice team kept patient dental care records which were clearly written, however some improvements were required in regards to the storage of records.

The practice had some systems in place to monitor clinical and non-clinical areas of their work to help them improve and learn but improvements were required.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays)

The principal dentist told us the practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. They also told us that they and their staff had received safeguarding training. They were not able to provide evidence of the training, or the policy because the information was kept on a computer that was not available at the practice on the day of the inspection. We spoke to the nurse about safeguarding training and they told us that they had received safeguarding training at a previous job, but had not received training since starting work at the practice. The nurse had an understanding of safeguarding issues. The principal told us that they would send us evidence of the safeguarding policy and training following the inspection. No information was sent to us.

The principal dentist told us the practice had a whistleblowing policy. Staff told us that they felt confident they could raise concerns without fear of recrimination.

The dentist did not use a rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment. There was no risk assessment in place to identify what was used instead of a rubber dam.

The principal dentist told us the practice had a staff recruitment policy and procedure to help them employ suitable staff. We were not able to see the content of the policy on the day of the inspection because the information, we were told, was kept on a laptop that was not available at the practice on the day of the inspection.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had indemnity insurance.

The practice ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. For example we saw that the practice had undertaken an electrical installation test.

The practice told us that they had undertaken test of their equipment to sterilise and clean equipment. The service documents that evidenced this was on a computer that was not available at the practice on the day of the inspection. The provider told us that they would send us evidence of this servicing after the inspection but this information was not sent to us.

Records showed that fire detection and firefighting equipment such as fire extinguishers were regularly tested.

The principal dentist told us that the information that evidenced their compliance with current radiation regulations was on a computer that was not available at the practice on the day of the inspection. They told us that it contained details of their radiation protection advisor as well as the maintenance of radiation equipment and radiographic training.

We were told that radiography audits were undertaken, though none was available for us to view. The provider told us they would provide evidence of this after the inspection but this was not provided.

Risks to patients

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support (BLS) every year. We saw evidence of immunisation checks and BLS training for the dentist; we did not see this information for other staff.

The practice had some of the recommended emergency equipment and medicines as described in recognised guidance. Some recommended equipment including oral glucose, midazolam and portable suction equipment and oxygen masks was not available. An Automated External Defibrillator (AED) was also not available.

We spoke with the provider about this and they told us that the week before the inspection they had ordered the missing items. The principal dentist told us that the they had taken the AED home to practice using it. Following the inspection we spoke with the provider on the telephone and they told us that the items they ordered had arrived at the practice and they had returned the AED to the practice. The provider told us they would confirm this via an email but this was not sent to us.

A dental nurse always worked with the dentist.

Are services safe?

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice did not adequately follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

An infection control policy was available but there there were no proper arrangements in place to transport instruments, and there were no recent records of the validation of the sterilisation equipment. The only records they could show us were from 2017. The practice had no visors for staff to use to protect their eyes and face from splashes during manual cleaning of dental instruments.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. There were some evidence of water testing and dental unit water line management but there were gaps in these records. The practice was generally clean when we inspected, but there was room for improvement in regards to cleanliness. For example there was dust found in some of the drawers we inspected in one of the treatment rooms.

The principal dentist told us they carried out infection prevention and control audits twice a year; no audits were made available to us for inspection. We did see an infection control audit from the local commissioning team that had taken place in August 2017. There were a number of issues that this audit found that the provider had not acted upon. For example improvements to the transporting of instruments that we had found were still an issue during this inspection.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were accurate, complete, and legible. Improvements were required in regards to the security of records kept. For example we found that some care records were kept in an unlocked desk in the hallway of the practice. We pointed this out to the provider and they told us they would move the records to a lockable secure location.

Patient referrals to other service providers contained specific information which allowed appropriate referrals in line with practice protocols and current guidance. However improvements were required as there was no system in place to monitor referrals that were sent.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

The dentist was aware of current guidance with regards to prescribing medicines.

Track record on safety

The principal dentist told us there were risk assessments in relation to safety issues. We were unable to see risk asessments that had been carried out because they had been saved on a laptop that was not available in the practice on the day of the inspection.

The practice had a system in place to monitor and review incidents. There had been no safety incidents in the last year.

Lessons learned and improvements

There were some systems for reviewing and investigating when things went wrong. The principal dentist told us that when things went wrong they would speak to staff and have informal meetings. However improvements were required. There were no records of meetings that had taken place.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had some systems to keep the dental practitioner up to date with current evidence-based practice. We saw that clinicians generally assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. However there was some improvements required in relation to how the practice kept records of discussions about assessments and treatments.

Helping patients to live healthier lives

The dentist told us that they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments.

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

Consent to care and treatment

The practice did not adequately obtain consent for all care and treatment.

The dentist had some understanding of the importance of obtaining and recording patients' consent to treatment. The dentist told us that they gave patients information about treatment options and the risks and benefits of these so that they could make informed decisions. However there was no record of consent to treatment found in the records we checked. We spoke with the provider about this and they told us that they did not ask patients to complete consent forms, apart from NHS FP17 form which patients sign to consent to examinations. .

The principal dentist told us the practice had consent policy included information about the Mental Capacity Act 2005. However, no policy was made available to us to check. The staff we spoke with did not have a comprehensive understanding on consent issues for adults or when treating young people under 16 years of age.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist assessed patients' treatment needs, However improvements were required. For example there were no records of soft tissue checks or basic periodontal examination (BPE). We spoke with the provider about this and they told us they would make improvements to the record keeping.

Effective staffing

The principal dentist told us they completed the continuing professional development required for their registration with the General Dental Council. However we were not able to see evidence of this on the day of the inspection. No information was provided to us after the inspection.

Staff told us that they discussed training needs with the dentist

Co-ordinating care and treatment

The dentist confirmed that they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. The practice also had systems and processes for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice did not monitor all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. We saw that staff were respectful when speaking to patients on the phone, and to people that came into the practice.

Staff were aware of their responsibility to respect people's diversity and human rights.

We saw that staff treated patients with respect and were friendly towards patients at the reception desk and over the telephone.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the requirements under the Equality Act .Interpretation services were available for patients who did not have English. Staff told us this was available through telephone interpretation services.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example showing them models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day.

They took part in an emergency on-call arrangement with another local practice and 111 out of hours service.

The practice answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint.

There had been no complaints in the last year.

The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so that patients received a response. Staff were unable to find a copy of the complaints procedure when we asked them to produce one. When we asked the principal dentist about this they referred us to a ' code of practice for patient complaints' that was hanging on the wall. The policy had details of two external organisations that patients could contact if they were not happy with the providers response to a complaint. One of these organisations the Family Health Services Authority (FHSA) had been replaced by other bodies in the mid 90's. The provider told us they would review the complaints policy.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist had the experience, capacity and skills to lead the practice but did not have systems in place to support good governance.

Vision and strategy

There was lack of vision and strategy for the practice.

Culture

Staff stated they felt respected, supported and valued.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff we spoke with told us that they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They were also responsible for the day to day running of the service.

The practice did not have systems in place to support good governance. For example staff were not aware of audits and risk assessments that the principal told us had been undertaken, a number of key policies, procedures, risk assessments and medical emergency items were removed from the practice without the knowledge of staff. The provider told us they would ensure these items would be brought back to the practice following the inspection but they did not confirm this to us when we requested for them to do this.

Appropriate and accurate information

The practice had some information governance arrangements and staff had a general understanding of the importance of these in protecting patients' personal information

Engagement with patients, the public, staff and external partners

The practice did not have adequate systems in pace to involve patients, the public, staff and external partners in the running of the service. The provider told us they did involve patients in the running of the service and seeked feedback but they were unable to explain how they did this. They told us they would review arrangements for engaging with stakeholders.

Continuous improvement and innovation

There were no systems and processes for learning, continuous improvement and innovation.

The principal dentist told us the practice had quality assurance processes to encourage learning and continuous improvement. They said this included audits of dental care records, radiographs and infection prevention and control. However these were not available for us to review on the day of the inspection The staff we spoke with were not able to explain how any of the audits had been used for learning or development.

The dentist told us that they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. However these were not available for us to review on the day of the inspection No evidence was provided to us after the inspection.

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 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** The provider did not have systems in place to adequately show care and treatment of service users was being provided with the consent of the relevant person. In particular: • There were no system to suitably monitor and record patient consent for treatments undertaken.

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 **How the regulation was not being met:** The provider did not have robust systems in place to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. In particular : • Infection control procedures were not being adequately followed • Not all medical emergency equipment was available for use at the practice

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The provider did not have effective systems in place to ensure that the regulated activities at Bhageerutty Smile were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In particular:

- The service did not have clear systems to ensure effective oversight of risks relating to equipment and some emergency medical equipment was not in place.
- The service did not have a clear system to ensure oversight of training for staff including infection control training, basic life support and safeguaring training.
- The provider did not have adequate systems in place to ensure that audits and governance systems remained effective.