Genix Healthcare Ltd

Genix Healthcare Dental Clinic - Cirencester

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 24 November 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, the following 2 questions were asked:

- Is it safe?
- Is it well-led?

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

Our findings were:

- Overall, the practice appeared to be visibly clean. However, improvements were needed to the storage arrangements for cleaning equipment and to ensure cleaning schedules were introduced.
- The practice had infection control procedures which reflected published guidance; however, these were not consistently followed.
- Appropriate medicines and life-saving equipment were not available in accordance with current guidelines.
- The practice did not have effective systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place; improvements were needed to ensure accurate information was available to staff.

Summary of findings

- The practice had staff recruitment procedures which reflected current legislation; however we could not be assured these were consistently followed.

Background

Genix Healthcare Dental Clinic - Cirencester is part of Genix a dental group provider. The practice is in Cirencester in Gloucestershire and provides NHS and private dental care and treatment for adults and children.

There is ramped access to the practice for people who use wheelchairs and those with pushchairs. The practice is located close to local transport routes and car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 4 dentists, 5 trainee dental nurses, 1 dental therapist, 2 interim practice managers and 2 receptionists. The practice has 5 treatment rooms.

During the inspection we spoke with 2 dentists, 2 dental nurses, 2 receptionists and 1 of the interim practice managers. We also spoke with the group compliance lead and area manager on the phone. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday, Wednesday and Friday from 8:30am to 5:30pm

Tuesday and Thursday from 8:30am to 7pm

Saturday from 10:00am to 2pm

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider was not meeting are at the end of this report.

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

- Improve audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- Take action to ensure audits of radiography are undertaken in accordance with guidance to improve the quality of the service. Practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

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

Are services safe?

Our findings

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

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. We discussed with the practice manager the importance of ensuring up to date information was available to staff.

The practice had infection control procedures which reflected published guidance. Improvements were needed to ensure staff adhered to guidance, including The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05). In particular.

- Staff did not wear the correct personal protective equipment (PPE) when decontaminating dental instruments.
- We could not be assured brushes used to clean used instruments were replaced regularly as they appeared visibly soiled and worn.
- Some sterilised instruments were found stored in a surgery in damaged pouches; this compromises the sterilisation viability of the instrument.
- We could not be assured pouched instruments were dated appropriately, to ensure they were reprocessed after the correct interval.
- Records were not available to demonstrate all routine testing was carried out on the ultrasonic baths, used to clean dirty dental instruments. In addition the instrument cleaning solution was not replaced in accordance with the guidance.
- Protocols were not in place to ensure lab work was sterilised upon receipt from the laboratory.
- Staff were unsure if usage data was routinely downloaded and reviewed from the autoclave.
- In one surgery, we observed the worktop and door fronts were not impervious and easily cleanable.

There was currently no infection control lead dental nurse at the practice to oversee staff and ensure protocols were adhered to.

The practice had some procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment. However, we could not be assured these were effective. A Legionella risk assessment had not been carried out following the completion of building work at the practice. Records available, showed temperature monitoring protocols were carried out monthly, but were outside the recommended parameters and no action had been taken to address this. Temperatures also indicated there may be a risk of scalding to patients and staff and there was no evidence the risk of this had been considered and mitigated. In addition, staff were required to flush infrequently used outlets on a weekly basis, and records showed this had not been carried out since the first week of October 2023.

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

The practice was visibly clean; we noted improvements could be made to the storage arrangements of the cleaning equipment. A cleaning checklist was also not in use to enable managers to monitor the levels of cleanliness.

The practice had a recruitment policy and procedure to help them employ suitable staff and these reflected the relevant legislation. The information was disorganised and we found that recruitment procedures and continued oversight of documents were not established nor operating effectively. From the records we were shown, the group's recruitment protocols were not consistently adhered to.

Are services safe?

We also noted the system to ensure all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus was not effective as records were not available for all clinical staff. Where a risk assessment was carried out this should adequately consider and mitigate all the risks to the individual.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover. We discussed with the practice manager, the importance of ensuring clinical staff had adequate indemnity for the number of sessions they worked.

Overall, the practice ensured most equipment was safe to use, maintained and serviced according to manufacturers' instructions with the exception of one of the ultrasonic baths. In addition, we noted that staff were asked to carry out weekly checks of the compressor. Records available indicated this had not been carried out on a weekly basis since August 2023. We also noted there was no maintenance records for the implant motor; the practice manager confirmed they would contact the manufacturer and determine the servicing requirements for the implant motor.

The practice ensured the facilities were maintained in accordance with regulations.

A fire safety risk assessment was carried out in line with the legal requirements. From the records available we noted the internal routine testing of the fire safety equipment was not carried out consistently as part of the management of fire safety. For example, the weekly fire extinguisher checks had not been carried out since 23 October 2023, the fire alarm testing and the emergency lighting checks had not been carried out since June 2022. We noted the last fire drill was carried out in June 2022.

The practice had some arrangements to ensure the safety of the X-ray equipment, however improvements were needed. We saw from the records we were shown that recommendations had been made by the radiation protection advisor (RPA), following the installation of a new X-ray unit in July 2023, there was no evidence action had been taken to address this. In addition, we could not be assured protocols had been introduced to reduce the risk of exposure from an X-ray beam being directed towards a ground-floor window. Records available indicated the annual electrical and mechanical servicing of X-ray units was last carried out in May 2022. Improvements were also needed to the monitoring of staff training in relation to radiography to ensure staff carried out the appropriate training relevant to their role.

Risks to patients

The practice had ineffective systems to assess, monitor and manage risks to patient and staff safety. Protocols were established that dental nurses should not dispose of needles, however we could not be assured this was consistently adhered to. Some staff were aware of signs and symptoms of sepsis, we discussed the benefits of having visual prompts available to staff.

Emergency equipment and medicines were not available and checked in accordance with national guidance. We saw from the records available, that the monitoring protocols were not effective at ensuring all medicines and equipment were available and in working order. For example, there was no medicine used to treat hypoglycaemia (low blood sugar) available on the day and the automated external defibrillator (AED) fault light was showing and was beeping, indicating a problem, but no action had been taken to address this. The practice manager ensured these items were obtained on the day of the inspection.

In addition we saw the fridge temperature monitoring was not effective and the practice could not be assured temperature sensitive medicines were stored appropriately.

Staff knew how to respond to a medical emergency and told us they had completed training in emergency resuscitation and basic life support. Improvements were needed to the monitoring of staff training, as on the day of the inspection, records were not available to demonstrate all staff had carried out basic life support training.

Are services safe?

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. We saw on the day that bleach was stored in the patient toilet and the risks of this had not been considered and mitigated.

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; however, improvements were needed as there was no system in place to monitor and follow up with the referrals to ensure patients were seen in a timely manner.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. NHS prescription pads were kept secure, and a log was in place to monitor and track their use. Antimicrobial prescribing audits were carried out, improvements could be made to the audit to monitor prescribing habits and identify and drive areas of improvement.

Track record on safety, and lessons learned and improvements

There were systems in place to record and review significant events and accidents, however we could not be assured these were being followed consistently. From the records we were shown, the tracker, used to monitor incidents, was not up to date and evidence of reflection and learning following an incident was limited.

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 the provider had the capacity, values and skills to deliver high-quality, sustainable care.

Systems were in place to ensure the information and evidence presented during the inspection process was clear and well documented, however we found these systems were not always being followed and as a result, there were areas where the information was disorganised or not available.

The inspection highlighted some areas such as risk management where improvements were needed.

Culture

The practice had protocols in place to manage the service, these did not always operate effectively.

We saw staff carried out continuing professional development. Improvements could be made to the monitoring system to enable the practice manager to assure themselves that staff member's training was up-to-date and undertaken at the required intervals. Records were not available to demonstrate all staff had carried out appropriate training in important areas such as medical emergencies, infection control and radiography.

In addition, systems were in place to ensure newly appointed staff had a structured induction, however in the records we were shown, we could not be assured this was carried out consistently.

Governance and management

The practice had a system of clinical governance in place which included policies, protocols and procedures in place; however, on the day of the inspection, not all staff members felt comfortable accessing this information in the manager's office.

The 2 interim practice managers had overall responsibility for the management of the practice and were responsible for the day to day running of the service.

Improvements were needed to ensure processes for managing risks were effective. The practice did not have adequate systems in place for recognising, assessing and mitigating the risks associated with radiation and fire safety, incidents and accidents, medical emergencies, infection control and legionella.

Staff described some challenges relating to recent staff shortages that they felt had impacted on some protocols not being adhered to. The wider management team were aware of the challenges and steps had been taken to address them. They felt confident improvements would be implemented and maintained.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice had information governance arrangements and staff were aware of the importance of protecting patients' personal information. Improvements were needed to ensure personal staff files were stored securely.

Engagement with patients, the public, staff and external partners

Are services well-led?

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 confirmed they were encouraged to offer suggestions for improvements to the service.

Continuous improvement and innovation

The practice had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, antimicrobial prescribing, and infection prevention and control. Improvements should be made to the auditing protocols to ensure they are carried out in accordance with current guidelines and where appropriate have reflection and action plans in place to drive improvement.

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 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: • The monitoring of the medical emergency medicines and equipment was not carried out as recommended and did not ensure all items were available in working order and in date. • The monitoring of the fridge temperature was not effective. • Infection control protocols were not adhered to. • Cleaning equipment was not stored in accordance with guidelines, cleaning schedules were not being completed. • Incidents and accidents were not consistently recorded accurately, reviewed and used as an opportunity for shared learning. • Not all equipment was serviced and maintained according to manufacturer's guidelines. • Where risks had been identified in relation to radiation protection, no action had been taken to address them. • Internal fire checks were not carried out consistently. Fire drills were not carried out regularly. • Systems to identify and act on risks in relation to Legionella were not effective. • Substances hazardous to health were accessible to patients and the risks had not been considered and mitigated.

This section is primarily information for the provider

Requirement notices

- Staff had not adhered consistently to protocols for the handling and disposal of dental sharps.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- Recruitment protocols were not effectively managed.
- The system to ensure all clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus was not effective.
- Systems to monitor staff training and ensure this is undertaken at the required interval were ineffective.

There was additional evidence of poor governance. In particular:

- Staff did not feel comfortable accessing important, accurate information and policies.
- Referrals were not monitored to ensure patients were seen in a timely manner.

Regulation 17 (1)