Mr. Ashruf Peer

Mr Ashruf Peer - Bicester

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 17 April 2023 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The practice's infection control procedures were not effective.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Improvements were needed to systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures were not operated effectively.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with respect.

Summary of findings

- Improvements were needed to protocols to protect patients' privacy.
- 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.
- There was effective culture of continuous improvement.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.

Background

Ashruf Peer Bicester, trading as Bicester Dental Care. is in Bicester 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:

- 2 dentists
- 1 practice manager (who is also a nurse)
- 2 student dental nurses

The practice has 3 treatment rooms.

During the inspection we spoke with 2 dentists, 2 trainee dental nurses, and the practice manager.

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

The practice is open:

- Monday 8.00am to 5.30pm
- Tuesday 8.00am to 5.30pm
- Wednesday 8.00am to 5.30pm
- Thursday 8.00am to 5.30pm
- Friday 8.00am to 12.30pm

We identified regulations the provider was/is 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.

Summary of findings

There were areas where the provider could make improvements.

They should:

- Improve the practice protocols to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

The provider accepted the shortfalls that we raised and took immediate action on the day of our inspection to begin to address these.

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report, but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**No action** ✓
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 providing safe care in accordance with the relevant regulations.

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice did not have effective management of infection control procedures. Specifically:

- A patient treatment chair and operator stool in treatment room 3 were torn in places.
- A sharps bin in treatment room 3 was not dated or assembled correctly.
- Cotton roll rolls were not stored correctly in treatment room 2. We have since received evidence to confirm this shortfall has been addressed.
- Clinical staff wore material long sleeved gowns, plastic sleeve protectors were not available.

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 and stored appropriately in line with guidance.

The practice was unable to evidence that there was an effective schedule in place to ensure it was kept clean.

- The provider could not evidence that they had oversight of cleaning standards.
- Cleaning equipment was not stored in line with national infection control standards. We have since received evidence to confirm this shortfall has been addressed.

Recruitment checks had not been conducted, in accordance with relevant legislation to help them employ suitable staff. We reviewed three staff recruitment records. Evidence presented to us confirmed that:

- 1 out of 3 had eligibility to work in the UK.
- None had received a health assessment.
- 2 out of 3 had received a disclosure and baring service (DBS) check
- 1 out of 3 had a full employment history.

A second reference was not obtained, in line with the practice's recruitment policy.

A locum hygienist had been employed. The practice could not assure themselves that appropriate recruitment checks had been performed. We have since received evidence to confirm this shortfall has been addressed.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire safety risk assessment was conducted in line with the legal requirements. The management of fire safety was not effective. In particular:

- The fire alarm was not tested weekly.
- The fire alarm was not serviced at appropriate intervals...
- Actions remained outstanding from the fire risk assessment.
- The emergency lights were not tested monthly.

Are services safe?

- Fire drills were not carried out annually.
- A five yearly electrical installation (fixed wiring) check was not available

The practice did not have arrangements to ensure the safe use of the X-ray equipment. In particular:

- Rectangular collimators were not available in treatment rooms 1 and 3.
- Monthly quality assurance tests, known as phantom tests, for the CBCT were not available.
- The practice did not notify the Health and Safety Executive they were working with ionising radiation.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

The practice's management of the control of substances that are hazardous to health (COSHH) required improvement. In particular:

- COSHH applicable products were not stored securely.
- COSHH risk assessments were not available for all applicable substances.

Arrangements were not in place to protect items from falling off a window ledge, onto the public path below, in the decontamination room.

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 for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice had a system for receiving and acting on safety alerts.

A general data protection regulation (GDPR) accident book was not available. We have since received evidence to confirm this shortfall has been addressed.

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.

Sedation

The practice offered conscious sedation for patients. Sedation was carried out by a visiting seditionist.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability.

Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) was not available for the staff providing treatment to patients under sedation.
We were assured that sedation would be suspended until training was in place.

Dental implants

We saw the provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

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

involvement in local schemes

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

Consent to care and treatment

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

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

Monitoring care and treatment

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

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.

The justified, grading and reporting on the radiographs taken was not routinely recorded on in patient care records..

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

Effective staffing

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

Newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

Are services effective?

(for example, treatment is effective)

Agency staff received informal induction. Records of these were not kept.

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.

Referrals were not centrally monitored to ensure they were received in a timely manner and not lost.

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 we spoke to were aware of the importance of privacy and confidentiality.

However, glass partitioning on treatment room 1 and 2 doors did not fully protect patients' privacy and dignity.

Staff password protected patients' electronic care records and backed these up to secure storage.

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 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.

The practice had made reasonable adjustments which included:

- A hearing loop
- Reading aids , by way of a large print facility clinipad

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.

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.

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 Notice 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. They were proud to work in the practice.

Governance and management

The provider had overall responsibility for the clinical leadership of the practice.

The provider had a system of clinical governance in place which included policies, protocols and procedures. These were accessible to all members of staff, but systems were not routinely followed.

We saw there were clear and effective processes for managing risks, issues and performance but these were not followed which resulted in poor risk management at the practice.

The management of recruitment, fire safety, COSHH, infection control and sedation required improvement.

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.

Engagement with patients, the public and staff

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

Feedback from staff was obtained through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement

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.

Staff kept records of the results of these audits and the resulting action plans and improvements.

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. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: **Infection Control** • Local anaesthetic cartridges which were present in all three treatment rooms were not stored in blister packs. • A patient treatment chair and operator stool in treatment room 3 were torn in places. • A sharps bin in treatment room 3 was not dated or assembled correctly. • Cotton roll rolls were not stored correctly in treatment room 2. • Clinical staff wore material long sleeved gowns, plastic sleeve protectors were not available. **Cleaning** • The provider could not evidence that they had oversight of cleaning standards. • Cleaning equipment was not stored in line with national infection control standards.

This section is primarily information for the provider

Requirement notices

Radiography

- Rectangular collimators were not available in treatment rooms 1 and 3.
- Monthly quality assurance tests, known as phantom tests, for the CBCT were not available.
- The practice did not notify the Health and Safety Executive they were working with ionising radiation.

Recruitment

Recruitment checks had not been conducted, in accordance with relevant legislation to help them employ suitable staff. We reviewed three staff recruitment records.

Evidence presented to us confirmed that:

- 1 out of 3 had eligibility to work in the UK.
- None had received a health assessment.
- 2 out of 3 had received a disclosure and baring service (DBS) check
- 1 out of 3 had a full employment history.

A locum hygienist had been employed. The practice could not assure themselves that appropriate recruitment checks had been performed.

Control of Substances Hazardous to Health (COSHH)

- COSHH applicable products were not stored securely
- COSHH risk assessments were not available for all applicable substances.

General Data protection Requirements (GDPR)

- The practice did not have a General Data Protection Regulation (GDPR) compliant accident record book.

Fire Safety

- The fire alarm was not tested weekly.
- The fire alarm was not serviced at appropriate intervals...
- .Actions remained outstanding from the fire risk assessment.
- The emergency lights were not tested monthly.
- Fire drills were not carried out annually.

This section is primarily information for the provider

Requirement notices

- A five yearly electrical installation (fixed wiring) check was not available

Sedation

- Immediate life support training (or basic life support training plus patient assessment, airway management techniques and automated external defibrillator training) was not completed by all staff providing treatment to patients under sedation in the previous 12 months.

Privacy and Dignity

- Glass partitioning on treatment room 1 and 2 door did not fully protect patients' privacy and dignity.