Bourbon Street Dental Care

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Inspection report

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Overall summary

We carried out this announced focused inspection on 3 August 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

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

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

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

- The dental clinic was visibly clean.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Appropriate medicines and life-saving equipment were not available.
- The practice had staff recruitment procedures which reflected current legislation.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.

Summary of findings

- The provider did not operate effective systems to help them manage risk to patients and staff.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- The provider's infection control procedures were not operated effectively
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.
- The provider did not have effective leadership and a culture of continuous improvement.

Background

Bourbon Street Dental Care is in Aylesbury and provides NHS and/or private dental care and treatment for adults and children.

The practice reception and treatment rooms are based on the first and second floor of the practice. New patients are advised of this when they contact the practice.

Car parking spaces, including dedicated parking for disabled people, are available outside the practice.

The dental team includes five dentists, four qualified dental nurses, one trainee dental nurse, two dental hygienists, one receptionist and a practice administrator. The practice has three treatment rooms.

During the inspection we spoke with three dentists, two dental nurses, a receptionist and the compliance manager.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday 8am to 5pm
- Tuesday 8am to 6pm
- Wednesday 8am to 5pm
- Thursday 8am to 6pm
- Friday 8am to 4pm

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/is not meeting are at the end of this report.

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

- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Summary of findings

The provider accepted the clinical and managerial shortfalls that we raised and took immediate action 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 asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services effective?	**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.

The practice did not have infection control procedures which reflected current published guidance. Specifically:

- A manual cleaning water temperature thermometer was unavailable.
- Two instruments used in root canal treatment were found un-pouched in surgery two.
- Clinical healing paste used after oral procedure was not date marked.
- We saw dental cement on sterilised instruments pouched and ready to use in surgery one.

Since our inspection we have received evidence to confirm these shortfalls have been addressed.

The staff carried out manual cleaning of dental instruments prior to them being placed in the ultrasonic bath. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

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

- A legionella risk assessment was carried out by someone who could not demonstrate their competency in the safe management of legionella.
- Legionella water temperature testing was not carried out routinely.

Since our inspection we have received evidence to confirm these shortfalls have been addressed.

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

Clinical waste collection notes were not stored in a way which enabled easy access.

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean. However, cleaning equipment was not stored appropriately.

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation.

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

The practice did not ensure the facilities were maintained in accordance with regulations. In particular:

- The decontamination room floor to wall seals were incomplete in places. A dusty air recirculating fan was in use in surgery three.
- Nosing to the patient stairs was missing on the second floor.
- The dental compressor was not protected from unauthorised access.

Since our inspection we have received evidence to confirm these shortfalls have been addressed.

Are services safe?

- A rusty electric water heater was present in the patient WC.
- The cupboard in surgery one, which housed the suction unit, was cluttered with paper products and equipment.

Improvements were needed to the management of fire safety. Specifically:

- Emergency lights servicing records were unavailable.
- Fire alarm servicing records were unavailable.
- Fire alarm testing was carried out monthly. Tests should be undertaken at intervals of at least weekly.
- Fire doors were wedged open throughout the practice.

- A fire risk assessment was carried out by someone who could not demonstrate their competency in fire safety. Since our inspection we have received evidence to confirm this shortfall has been addressed.

The practice did not have arrangements to ensure the safety of the X-ray equipment:

- Evidence of annual servicing for the x-ray machines was not available.
- Evidence of three yearly checks for the x-ray machines was not available.

Since our inspection we have received evidence to confirm these shortfalls have been addressed.

- X-rays taken were graded using the old grading system.

Risks to patients

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

- The sharps bin in the decontamination room was not labelled appropriately. Since our inspection we have received evidence to confirm this shortfall has been addressed.
- Sharps protocols seen did not follow the practice's policy for safer sharps.

Emergency equipment and medicines were not available and checked in accordance with national guidance. In particular:

- The defibrillator pad expiry date was March 2018.
- An EpiPen was past its use by date.
- Adult and child self-inflating bags were not available.
- Medicines and equipment checks were carried out monthly not weekly as recommended.
- Omissions were not highlighted during these checks.

Since our inspection we have received evidence to confirm these shortfalls have been addressed.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support. We were made aware that training was overdue. We were shown evidence which confirmed training was booked for 8 September 2022.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health (COSHH) but improvements were needed. Specifically:

- Control of specific substances hazardous to health (COSHH) safety data information sheets were not stored in an ordered way to ensure they could be accessed quickly in an emergency.

- COSHH warning signs were not present on neither the cleaning cupboard nor clinical waste cupboard doors. Since our inspection we have received evidence to confirm this shortfall has been addressed.

Information to deliver safe care and treatment

Are services safe?

Dental care records that we saw were 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.

A GDPR compliant accident book was not available. Since our inspection we have received evidence to confirm this shortfall has been addressed.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Prescription pads in the practice were not logged effectively. Since our inspection we have received evidence to confirm this shortfall has been addressed.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents.

The practice had a system for receiving and acting on safety alerts, but these were not shared with staff other than the partners. We were assured this shortfall would be addressed as soon as practicably possible.

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

- Reporting of x-ray quality changed to a new two-point grading of 'acceptable or unacceptable' in 2021. This system was not being used by any of the clinicians taking radiographs.

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.

Staff 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

There were inconsistencies in the information recorded within the dental care records we looked at. Omissions included:

- Basic Periodontal Examination (BPE) screening results.
- Medical history updates
- Diagnosis.
- Treatment options.

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

We saw evidence the dentists justified, graded and reported on the radiographs they took but improvements were needed. We found that:

- The practice carried out radiography audits six-monthly but current guidance was not being followed.
- Audits were not clinician specific.
- Weaknesses were repeatedly highlighted which meant the practice could not demonstrate improvement over time.

Effective staffing

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

We noted that the majority of the staff had completed their training since we announced our inspection.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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.

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.

The compliance manager visited the practice regularly, but their management oversight of the business was not effective.

Culture

Staff discussed their training needs at an annual appraisal. They also discussed learning needs, general wellbeing and aims for future professional development.

We saw the provider had systems in place to deal with staff poor performance.

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

Governance and management

The partners had overall responsibility for the management and clinical leadership of the practice. The compliance manager was responsible for ensuring the practice met the required standards.

The provider had a system of clinical governance in place which included policies, protocols and procedures that 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 radiography. fire safety, COSHH, infection control, medical emergencies, equipment and premises required improvement.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients and the public and demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

We noted the system for monitoring staff training required improvement to ensure staff could evidence their competency in core recommended subjects

Are services well-led?

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control but improvements were needed to ensure that radiograph audits followed current guidance.

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. 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: **Infection Control** • A manual cleaning water temperature thermometer was unavailable. • Two instruments used in root canal treatment were found un-pouched in surgery two. • Clinical healing paste, used after oral procedures, was not date marked. • We saw dental cement on sterilised instruments pouched and ready to use in surgery one. • Cleaning equipment was not stored appropriately. **Legionella** • A legionella risk assessment was carried out by someone who could not demonstrate their competency in legionella risk management. • Legionella water temperature testing was not carried out routinely. **Facilities** • The decontamination room floor to wall seals were incomplete in places. • A dusty air recirculating fan was in use in surgery three.

This section is primarily information for the provider

Requirement notices

- A rusty electric water heater was present in the patient WC.
- Step nosing to the patient stairs was missing on the second floor.
- The dental compressor was not protected from unauthorised access.
- A cupboard in surgery one, which housed the suction unit, was cluttered with paper products and equipment.

Fire Safety

- A fire risk assessment was carried out by someone who could not demonstrate their competency in fire safety risk management.
- Emergency lights servicing records were unavailable.
- Fire alarm servicing records were unavailable.
- Fire alarm testing was carried out monthly. Tests should be undertaken at weekly intervals.
- Fire doors were wedged open throughout the practice.

Radiography

- Evidence of annual servicing for the x-ray machines was not available.
- Evidence of three yearly checks for the x-ray machines was not available.
- X-rays taken were graded using the old grading system.
- The practice carried out radiography audits six-monthly but current guidance was not being followed.
- Audits were not clinician specific.
- Weaknesses were repeatedly highlighted which meant the practice could not demonstrate improvement over time.

Sharps

- The sharps bin in the decontamination room was not labelled appropriately.
- Sharps protocols seen did not follow the practice's policy for safer sharps.

Medical Emergencies

- The defibrillator pad expiry date was March 2018.
- An EpiPen had passed its recommended use date.
- Adult and child self-inflating bags were not available.

This section is primarily information for the provider

Requirement notices

- Emergency medicines and equipment checks were carried out monthly not weekly in line with national guidance.
- Omissions were not highlighted during these checks.

COSHH

- Control of specific substances hazardous to health (COSHH) Safety data sheet information were not stored in an ordered way to ensure they could be accessed quickly in an emergency.
- COSHH warning signs were not present on the neither the cleaning cupboard nor clinical waste cupboard doors.

Prescriptions

- Prescription pads in the practice were not logged effectively.

Regulation 17(1)