The Composite Bonding Company

The Composite Bonding Company

Inspection report

71 Middleton Road
Manchester
M8 4JY
Tel: 01617950591

Date of inspection visit: 25 October 2021
Date of publication: 06/12/2021

Overall summary

We carried out this announced focussed inspection on 25 October 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

• 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:

Are services safe?

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

Are services effective?

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

Are services well-led?

Summary of findings

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

Background

The Composite Bonding Company is in Manchester and provides private dental care and treatment for adults.

There is ramp access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes a dental hygienist and therapist, a dentist and two dental nurses. The practice has one treatment room.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC 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. The registered manager at The Composite Bonding Company is the dental hygienist and therapist.

During the inspection we spoke with the dental hygienist and therapist and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Tuesday and Wednesday from 10:00am to 8:00pm

Thursday from 8:00am to 5:00pm

Our key findings were:

- The practice appeared to be visibly clean and tidy.
- The provider had infection control procedures. Minor improvements are required to bring these fully in line with nationally recognised guidance.
- Staff knew how to deal with emergencies. Not all emergency equipment was available on the day of inspection. These were ordered immediately.
- Improvements could be made to the process for managing the risks associated with the carrying out of the regulated activities. These included the risks associated with Legionella, fire and referring patients to other healthcare providers.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had information governance arrangements.

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

Summary of findings

- 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

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** 
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)

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. This reflected guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Improvements could be made to the infection control processes. The heavy-duty gloves used to manually clean instruments were not changed weekly and re-usable instruments were not always bagged and there was no evidence to say these were re-processed at the end of each clinical day.

The provider had arrangements for transporting, cleaning, checking and sterilising instruments in line with HTM 01-05. The records showed equipment used by staff for sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The provider had implemented standard operating procedures in line with national guidance on COVID-19. Screening and triaging were undertaken prior to patients attending the premises and immediately upon arrival to identify COVID-19 positive individuals and those who may have been exposed to the virus.

A legionella risk assessment had been carried out in August 2020. We noted the provider had addressed some of the actions identified in the risk assessment. However, some other actions identified had not been addressed such as ones relating to the cold-water storage tank and the calorifier. These were medium risk priorities and required actioning within six months. The registered manager told us these actions had been escalated to the landlord but had not been completed.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean.

Clinical waste was stored in a locked waste bin. To access this bin staff had to leave the practice and walk down a public street to access it. In addition, the clinical waste bin could be access by members of the public and was not secured to the wall. We discussed this with staff who assured us it would be addressed.

Staff carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards. However, we noted the audit had not identified the issues we found on the day of inspection.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The provider 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. We looked at three staff recruitment records. These showed the provider followed their recruitment procedure.

Are services safe?

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. The fire risk assessment stated that fire doors should be fitted within the premises. We were told that this was the responsibility of the landlord and had been escalated to them. However, these had not been installed.

The practice had some arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. The provider was using a mobile X-ray machine. We saw evidence of a risk assessment which had been carried out and approved by the Radiation Protection Advisor (RPA). This had identified the location of the isolation switch being outside of the surgery and the operator to stand next to this when taking an X-ray. However, now this door was obstructed, and the operator stood at a different door when taking an X-ray. This was some distance from the isolation switch. We discussed this issue with staff, and we were told they would contact the RPA for advice about this.

We saw evidence the clinicians justified, graded and reported on the radiographs they took. The provider carried out radiography audits. We noted this audit was not clinician specific. In addition, the audit did not specify the reason for X-rays which were not diagnostically acceptable. We were told this would be addressed at the next audit.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken. However, the risk assessment did not include the

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Staff had an awareness of the risks associated with sepsis. Sepsis prompts for staff and patient information posters were displayed throughout the practice. This helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

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

Emergency equipment and medicines were not all available as described in recognised guidance. There were no self-inflating bags or portable suction device. In addition, the glucagon had not had its expiry date adjusted to reflect it was not stored between 2'C and 8'C.

A dental nurse worked with the clinicians when they treated patients in line with General Dental Council Standards for the Dental Team.

Are services safe?

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health. However, not all substances within the practice had documented risk assessments. We were told this was because they were stored on a computer and they had been lost. We were told they were currently updating these risk assessments.

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 registered manager how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

We asked the registered manager about the system for referring patients with suspected oral cancer under the national two-week wait arrangements. They were unsure how to do this. We discussed the importance of this process and we were assured this would be immediately addressed.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

Where there had been a safety incident, we saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. We noted the defibrillator which the provider had was one which had historical recalls for. They had acquired this defibrillator after the recalls had been published. We asked if staff were aware of these recalls and they were not. The provider took action to contact the manufacturer to ensure this piece of equipment was not one which had been recalled.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dental hygienist and therapist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The clinicians gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

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 dental care records containing information about the patients' current dental needs, past treatment and medical histories. The clinicians assessed patients' treatment needs in line with recognised guidance.

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements.

Effective staffing

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

Are services effective?

(for example, treatment is effective)

Staff new to the practice had a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

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.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

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

The staff focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The registered manager had overall responsibility for the management and clinical leadership of the practice. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

Systems and processes were not working effectively to appropriately manage the risks associated with the carrying out of the regulated activities. In particular:

- The system for ensuring infection control procedures reflected nationally recognised guidance was not effective.
- The system for ensuring medical emergency equipment reflected nationally recognised guidance was not effective.
- Liaison with the landlord had not been effective. Actions highlighted in the Legionella and fire risk assessments had not been completed or followed up.
- There was not a system in place to refer patients with suspected oral cancer under the national two-week wait arrangements.
- The system to ensure the risks associated with the use of radiation had not been appropriately managed.
- The system in place to ensure all hazardous substances are risk assessed was not effective.

After the inspection we were sent an action plan to address the issues identified.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example surveys, audits and external body reviews were used to ensure and improve performance. Performance information was combined with the views of patients.

The provider 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

Are services well-led?

Staff involved patients, the public, staff and external partners to support the service.

The provider used comment cards and online feedback to obtain patients' views about the service.

The provider gathered feedback from staff through meetings 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

The provider had systems and processes for learning, continuous improvement and innovation.

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. Staff kept records of the results of these audits and the resulting action plans and improvements. However, the infection prevention and control did not reflect our findings on the day of inspection and the X-ray audit was not clinician specific. We were told these audits would be completed again.

The registered manager showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 system for ensuring infection prevention and control procedures reflect nationally recognised guidance was not effective. Heavy duty gloves were not changed weekly and not all re-usable instruments were pouched. • The system for ensuring medical emergency equipment reflected nationally recognised guidance was not effective. There were no self-inflating bags, portable suction device or spacer device. In addition, the glucagon had not had its expiry date adjusted to reflect it was not stored in a temperature-controlled environment. • Medium risk actions highlighted in the Legionella risk assessment had not been completed within the time frames stated. • Not all actions identified in the fire risk assessment had been actioned in a timely manner. Fire doors had not been installed within the premises. • The systems for managing the risks associated with the use of radiation had not been managed appropriately. • The system in place to ensure all hazardous substances are risk assessed was not effective. 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 improve the quality and safety of the services being provided. In particular:

This section is primarily information for the provider

Requirement notices

- The infection prevention and control audit did not reflect our findings on the day of inspection.
- The X-ray audit was not clinician specific and did not specify why radiographs were not diagnostically acceptable.

There was additional evidence of poor governance. In particular:

- There was not a system in place to refer patients with suspected oral cancer under the national two-week wait arrangements.

Regulation 17 (1)