

Redbridge Associates Limited

HMP Wymott Prison

Inspection report

Wymott Prison
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Overall summary

We carried out this announced inspection on 30 November 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 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. 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 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 caring?

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

Are services responsive?

Summary of findings

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

Are services well-led?

We found this practice did not always provide well-led care in accordance with the relevant regulations.

Background

Redbridge Associates Limited run and provide Smart Dental Care who have a dental suite located in the healthcare centre at HMP Wymott. The suite includes a surgery and decontamination area and patients can use the main healthcare patient waiting room area.

The dental team included a dentist, a dental manager/nurse, and a dental therapist. The dentist was the clinical lead for the Smart Dental Care surgeries in the region. The practice is owned by two individuals from Redbridge Associates Ltd who have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. There was no CQC Registered Manager in place at the time of our inspection and a registered manager application was made by the provider following our inspection.

During the inspection we spoke with the dentist and dental manager/nurse. We looked at practice policies and procedures and other records about how the service is managed. The practice is open from Monday to Thursday between 8:00am and 5:00pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- The provider had systems to help them manage risk to patients and staff. However, sharps risk management protocols were not effective in ensuring staff were appropriately trained and familiar with local risk assessments.
- Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults. All staff had completed training.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- Wait times for routine treatment were up to 14 weeks.
- The provider dealt with complaints positively; however, there was no service specific policy to inform timescales for investigation.
- Governance arrangements were not always effective in ensuring policies and procedures were service specific, reviewed within agreed timeframes, and had been seen and understood by staff.
- Not all incidents were reported in accordance with policy, and systems and processes were not always effective in ensuring learning was routinely shared with staff.
- There was a culture of continuous improvement and learning; however, systems and processes did not ensure there was an effective system for the communication regarding policies and procedures and learning from incidents.

There were areas where the provider **must** make improvements.

Summary of findings

They **must**:

- Implement a system to ensure incidents are reported and investigated in line with policy, and that learning from incidents at local and regional level is shared with staff.
- Implement a system to ensure that policies, guidance and risk assessments are reviewed within timescale and are service specific.
- Implement a system to ensure policies, guidance and risk assessments are reviewed by staff including, within induction, and as required.
- Implement a system to ensure that eligible staff receive sharps handling training.

There were areas where the provider **should** make improvements.

They **should**:

- Ensure there is always a registered manager in place.

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 and premises and radiography (X-rays)

Staff knew their responsibilities if they had concerns about the safety of adults who were vulnerable due to their circumstances; one patient was placed under enhanced monitoring by the prison following the reporting of a safeguarding concern by the dentist. All staff had received safeguarding training. The provider had a Children and Adults at Risk Safeguarding Policy that had been updated in June 2022. The policy required completion; the name of the practice safeguarding lead and deputy safeguarding lead were blank.

The provider followed 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. The provider had an infection prevention and control policy dated March 2018; we identified some necessary improvements as the policy was not service specific and had not been reviewed at least every two years as recommended by the British Dental Association (BDA). Furthermore, it did not contain reference to use of personal protective equipment; spillage procedures; or the risk of transmitting infection and sharps injuries. Staff told us there was not a system in place to ensure they had read revised policies and procedures; however, they were able to find them on the provider's intranet when required.

Staff completed infection prevention and control training and received updates as required.

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

The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems. Staff told us there were no action plans from the 'prison owned' Legionella risk assessment however, a copy was not stored in the surgery that was not in line with best practice.

We saw effective cleaning schedules to ensure the practice was kept clean and, when we inspected, we saw the practice was visibly clean. Staff told us they would raise concern with the prison if there were concerns with the meeting of required standards such as the floor.

The infection control lead carried out infection prevention and control (IPC) audits twice a year; 100% compliance was achieved in an IPC audit in October 2022 demonstrating required standards were met.

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. The dentist chair was the responsibility of the prison to maintain; good joint working with the prison had enabled timely repair following a breakdown.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. The provider carried out radiography audits every year following current guidance and legislation in corroboration with colleagues at a nearby location. Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

Are services safe?

The provider had implemented systems to assess, monitor and manage risks to patient safety. For example, the provider's risk register had been reviewed in December 2022; the dental manager held weekly telephone meetings with the owner to report on quality and safety; and quarterly reports were submitted to NHSE commissioners for their review.

The provider had current employer's liability insurance.

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.

Staff had completed sepsis awareness training. Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic or immediate life support, as required.

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

Sharps risk management protocols were not effective. The sharps policy was dated October 2018 and was overdue review. The date of completion, name of the assessor, and their signature had not been completed in the sharps risk assessment. The risk assessment was not service specific in that there was no reference to the prison who held responsibility for the collection and destruction of the sharp's bins. Furthermore, the dental manager/nurse was not aware there was a sharps risk assessment and told us they had 'never' completed training in the safe handling of sharps. The sharp's policy stated that team members were regularly trained in the safe handling of sharps and were consulted on health and safety at team practice meetings and informally. Staff told us there were limited, structured meetings.

Following a sharps incident a member of staff told us they had overlooked reporting this in the accident book and, whilst correct processes were followed to mitigate the risks following the incident, it was not recorded as a significant event to ensure learning and improvement was in place.

Information to deliver safe care and treatment

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

Dental care records were stored electronically and managed in a way that kept patients safe. A record keeping audit completed in October 2022 found good clinical record keeping with no actions required.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist. No referrals were made in quarter 2, 2022/3.

Safe and appropriate use of medicines

The provider had systems for the appropriate and safe handling of emergency medicines that ensured medicines did not pass their expiry date and enough medicines were available if required.

The dentist was aware of current guidance with regards to prescribing medicines. Antimicrobial prescribing audits were carried out annually with the next due in quarter 4 during 2022/3. The dentist told us they had prescribed antimicrobials once in the previous six months and looked at alternative treatments wherever possible.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. However, we identified some necessary improvements to ensure that all incidents were reported in line with policy. There had been one safety incident during the previous quarter and, whilst correct procedures were followed to minimise risks following a sustained sharps' injury, the incident had not been reported in the accident reporting book. This meant there may have been missed opportunities for investigation and to identify learning from the incident. Furthermore, staff told us they were not aware there was a system for cascading learning from incidents across the provider's local and regional locations.

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. The dentist was the clinical regional lead and attended the north west managed clinical network (MCN) to share information and enable them to keep informed of most recent initiatives. Feedback following an audit of fluoride prescribing was planned to be delivered at a future MCN to review if guidelines were followed for every patient to establish if more could be done to help with the prevention of tooth decay.

Helping patients to live healthier lives

Staff provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them. The dentist where applicable discussed smoking, alcohol consumption, the risks of substance use, and diet with patients during appointments; the dentist was proactive in empowering patients to take responsibility for their own oral health in line with the 'Healthy Mouth Project' philosophy. (The Healthy Mouth Project was a study that demonstrated the extent of the oral health problems experienced by vulnerable people).

Consent to care and treatment

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

Staff understood the importance of obtaining and recording patients' consent to treatment. They described how they would use visual aids, or an interpreter, for example to ensure a patient understood and had the information required to consent to their treatment. We observed one patient had previously been referred to special care dentistry when it was found they lacked capacity to consent to their treatment and care.

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 dentists 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 mostly had the skills, knowledge and experience to carry out their roles. Newly appointed staff had an induction; however, this was not always effective in ensuring they were aware of current or new policies and procedures and had all the necessary training, such as the management of sharps for their roles. Clinical staff completed the continuing professional development required for their registration with the General Dental Council. Mandatory training compliance was 100% at an appropriate level for staff roles and all staff had received an appraisal.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. The dentist confirmed they referred patients to specialists in primary and secondary care for treatment the practice did not provide. They regularly liaised with the GP and nursing staff in the prison healthcare department regarding a patient's blood results and medicines.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Staff were aware of their responsibility to respect people's diversity and human rights. We saw staff treated patients kindly and were friendly towards patients throughout their visit; patients we spoke with were complimentary about their care.

Privacy and dignity

Staff were aware of the importance respecting patients' privacy and confidentiality and managed this well given the presenting challenges within the prison environment.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and ensured patients understood the information they were given. Staff would seek guidance from the learning disability nurse where appropriate and the dentist took time to explain their oral health needs. Within the September 2022 practice survey, 95% of patients reported that their treatment was explained to them.

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 mostly delivered services to meet the patients' needs. A dentist, dental manager/nurse, and dental therapist provided a full range of treatments. However, there was no dental nurse cover to address annual leave or sick leave which meant the provision of treatment and care was, at times, curtailed. This was included in the provider's risk register and the recruitment of a second dental nurse was underway. The dentist and dental technician took annual leave simultaneously at times to maximise the number of appointments they could provide.

Staff were clear about the importance of emotional support needed by patients when delivering care and had a good understanding of supporting the specific vulnerabilities many adults experienced within the prison setting.

Timely access to services

Waiting times for routine appointments were up to 14 weeks. Waiting times for patients requiring follow up treatment was 7 weeks. Appointments were allocated on the patient electronic clinical information system and emergency slots were available each day, which was good. In the September 2022 practice survey, 95% of patients reported they found it easy to make an appointment.

The dentist routinely visited patients on the wings to triage men where concerns were noted within their applications. This ensured patients were seen according to clinical need and enabled face-to-face advice to be given regarding their oral health whilst they waited for an appointment.

The surgery had been proactive in addressing patients who did not attend their appointments. Patients were required to complete a medical history form before an appointment was arranged (unless there was urgent need) which had been effective in driving up attendance. Staff knew their patients well and took every opportunity to speak with them in order to build relations and encourage attendance. Do not attend rates were 7% during quarter 2, 2022.

Listening and learning from concerns and complaints

We reviewed a copy of the provider's complaints policy that was a document entitled 'The principles of Good Complaint Handling' produced by a Government organisation. Whilst this set out best practice for the investigation of complaints, it was out of date (published 2009), was not service specific, and did not set out local practice guidelines for the management of complaints. Whilst the provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The lack of specific guidelines meant there was a risk of inconsistency in their management. Most complaints concerned waiting times for care and treatment. the dentist oversaw and responded to each complaint; there was one complaint during quarter 2, 2022/3 that was investigated and not upheld.

Are services well-led?

Our findings

We found this practice did not always provide well-led care in accordance with the relevant regulations.

Leadership capacity and capability

We found leaders mostly had the capacity, values and skills to deliver high-quality, sustainable care. At the time of our inspection there had been no CQC registered manager in place since June 2022, as the applicant's application had been rejected due to missing information. Following our inspection, an application for the role of registered manager was received from one of the owners of Redbridge Associates (who run and provide Smart Dental Care) and this remained in progress at the time of this report.

We saw the provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice such as in the recruitment of a further dental nurse.

Culture

The practice aimed to have a culture of high-quality, sustainable care ensuring they met the needs of vulnerable patients. Practice was not supported, however, by a culture of policies and procedures that reflected the vision, values and culture of the organisation.

Staff discussed their training needs within annual appraisals and the provider had arrangements to ensure staff training was up to date. There was a culture of honesty and transparency that was demonstrated when responding to complaints.

Governance and management

The practice had a system of clinical governance in place that was mostly well structured and effective in ensuring the safe delivery of treatment and care. The information and evidence presented during the inspection process was clear and well documented.

Whilst local leaders were mostly knowledgeable about issues and priorities relating to the quality and safety of the service, we were not assured there was always sufficient oversight at owner level, for example, in ensuring a registered manager was in place. Systems and processes also required strengthening to ensure that:

- Incidents are reported and investigated in line with policy, and that learning from incidents at local and regional level are shared with staff.
- All eligible staff receive sharps handling training.
- Systems and process ensure that policies, guidance and risk assessments are reviewed within timescales, are service specific, and are reviewed by staff.
- Staff inductions ensure new members of staff are familiar with policies, procedures, and guidance and receive the required training for their roles.

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

Feedback from patients was obtained in a practice survey, the most recent was completed in September 2022. This captured views on required improvements, such as wait times, as well as compliments from people who used the service. One respondent recommended 'shorter waits' but acknowledged the staff were always busy.

Are services well-led?

Engagement with staff was not consistent with the owners of Redbridge Associates Ltd. A structured system to engage with all staff would support with the cascading of learning from incidents, the introduction of new policies, and other service updates as required.

Continuous improvement and innovation

The provider had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs, an infection prevention and control audit, and an anti-microbial prescribing audit. The dentist sought opportunities for continuous improvement through information shared within the north west managed clinical network (MCN) meetings they attended. The dental manager had completed an introduction to dental practice management course during March 2022.

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 Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) Systems and processes must be established and operated effectively to ensure compliance with the requirements in this Part. Such systems or processes must enable the registered person to – assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity; and assess, monitor and mitigate the risks relating to the health, safety welfare of service users and others. How the regulation was not being met • Systems and processes did not ensure that all incidents were reported and investigated in line with policy, and that learning from incidents at local and regional level were shared with staff. • Systems and processes did not ensure that policies, guidance and risk assessments were reviewed within recommended time frames and were service specific. • Systems and processes were not effective in ensuring staff were regularly updated with service updates such as learning from incidents and following the introduction of new policies. • Systems and processes did not ensure that staff inductions ensured all eligible staff had received sharps handling training, and were informed of relevant policies, procedures and guidance.