University Of East Anglia

Dental Department - University of East Anglia

Inspection report

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Date of inspection visit: 21 September 2021
Date of publication: 14/10/2021

Overall summary

We carried out this announced inspection on 21 September 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 CQC inspector who was supported by a specialist dental adviser.

As part of this inspection we asked the following 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 that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

Summary of findings

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

Background

Dental Department- University of East Anglia is a well-established practice that offers NHS treatment to students and staff of the university. It is based in the university's campus and has two treatment rooms. The dental team includes three dentists, four dental nurses, and a practice manager, all of whom are employed directly by the university. The practice is situated in a building shared with a GP practice and is fully accessible to wheelchair users.

The practice is open Monday to Friday from 9am to 5pm.

The practice is registered as 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 practice is the practice manager.

On the day of inspection, we spoke with the practice manager, a dentist and three dental nurses. We looked at practice policies and procedures and other records about how the service was managed.

Our key findings were:

- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had systems to help them manage risk to patients and staff.
- Staff felt respected, supported and valued.
- Systems for obtaining patient feedback about the service were good.
- There were limited systems in place to assess and monitor the quality of service provision and clinical care.
- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- Comprehensive procedures had been implemented to reduce the spread of Covid-19.

We identified regulations the provider was not meeting. They must:

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

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

- Ensure that appropriate checks are completed prior to agency staff commencing employment at the practice.
- Implement local safety standards for invasive procedures to prevent wrong site dental extractions.
- Implement an effective system for monitoring and recording the fridge temperature to ensure that medicines and dental care products are being stored in line with the manufacturer's guidance.

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

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays)

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 practice 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 and knew about the signs and symptoms of abuse and neglect, and how to report concerns. Information about key protection agencies was on display in the staff office area, making it easily accessible. Staff also had access to the university's student support services that they could refer any vulnerable patients to if needed.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. Latex free rubber dams were also available.

The practice used the university's recruitment procedure to help them employ suitable staff, which reflected the relevant legislation. We were not able to access recruitment records held by the university's personnel department, but staff told us that their recruitment had been thorough. References and disclosure and barring checks had been sought prior to their appointment. However, the practice did not obtain essential information about temporary agency staff it employed to ensure they were suitable to work.

The practice ensured that facilities were safe, and that equipment was serviced according to manufacturers' instructions. The university's safety services department was responsible for all fire safety for the premises and conducted regular checks of fire equipment and systems. Fire alarms were tested weekly, and there was a full building evacuation held twice a year. The practice manager told us all staff undertook evacuation chair training every year and both she and another member of staff had undertaken specific fire marshal training. We noted fire exits were clearly signposted throughout the practice.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and the practice had the required information in their radiation protection file. Rectangular collimators were in use on X-ray units to reduce patient exposure.

The dentists justified, graded and reported on the radiographs they took, although the last radiograph audit had been completed in 2019, and one had not been undertaken since then.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards and detailed the control measures that had been put in place to reduce the risks to patients and staff. This included specific Covid-19 risk assessments for each member of staff.

We noted that the practice had not implemented local safety standards for invasive procedures to prevent wrong site dental extractions.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. Sharps' bins were sited safely and labelled correctly. A safer sharps system was available in the practice, including the use of single use matrix bands and scalpels. However, one dentist did not use safer needles and a risk assessment had not been completed to justify this.

Are services safe?

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support. This training had taken place on-line last year due to Covid-19 restrictions but a hands-on course for all staff was booked for 5 October 2021.

Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order, although we noted that the defibrillator pads had become out of date. Replacement pads were ordered during our inspection.

There was a comprehensive Control of Substances Hazardous to Health (COSHH) Regulations 2002 folder in place containing chemical safety data sheets for the materials used within the practice. We noted this had been reviewed regularly to ensure its contents were up to date.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Additional measures had been implemented to the patient journey to reduce the spread of Covid 19.

Staff carried out infection prevention audits, although not as frequently as recommended in national guidance. The latest audit showed the practice was meeting the required standards.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The practice had a washer disinfector, as recommended in national guidance, although this was not used for cleaning all dirty instruments. We were told the reason for this was the cycle took too long and the practice did not have enough instruments to accommodate this. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

Legionella management was the responsibility of the university's safety services department and we saw its comprehensive water quality management plan. The practice carried out its own protein and dip slide testing, as well as weekly water temperature testing, evidence of which we viewed.

We noted that all areas of the practice were visibly clean, including the waiting area, toilet and office area. We checked treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination.

The practice used an appropriate contractor to remove dental waste from the practice and external clinical waste bins were stored securely.

Safe and appropriate use of medicines

Patients' notes we viewed showed that the dentists had been prescribing the nationally recommended dosage of antibiotics and were aware of current guidance. The practice undertook antimicrobial audits but not every year as recommended.

Glucagon medicine was kept in the fridge, but logs were not maintained to demonstrate that the fridge temperature was actively checked every day to ensure it operated effectively. We noted that the fridge's temperature was higher than the recommended level. The dental nurse told us this had been of concern for the last few days: no action had been taken to address the matter.

Prescription pads were stored securely but there was no system in place to identify if individual prescriptions were lost or stolen.

Lessons learned and improvements

The practice had procedures in place to investigate, respond to, and learn from significant events and complaints, and staff were aware of formal reporting procedures.

Are services safe?

A system was in place to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and implement any action if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We checked a sample of dental care records and saw that patients' medical histories had been regularly updated and that intra-oral examinations and soft tissue checks had been completed. However, we noted a variance in the quality of information recorded in the dental records. For example, in some notes, patients' risk of caries, periodontal disease and oral cancer had not always been recorded consistently to inform recall intervals. In other notes, the staging and grading of patients' periodontal diagnosis was not routinely recorded.

The practice had not undertaken regular audits to ensure the clinicians were following the guidance provided by the Faculty of General Dental Practice when completing dental care records.

Clinicians used specialist endodontic rotary files to enhance the delivery of care to patients.

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 dentists discussed smoking, alcohol consumption and diet with patients during appointments and details about alcohol unit consumption and smoking cessation services was available in the patient information folder in the waiting area.

Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005. Staff understood their responsibilities under the Act when treating adults who might not be able to make informed decisions. Dental care records we viewed clearly evidenced the patient consent process.

The dentists 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.

Effective staffing

We confirmed that all clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. Staffing levels had not been unduly affected by the Covid-19 pandemic, and there were enough suitably qualified staff to treat patients safely and effectively. Staff told us they did not feel rushed in their work.

The provider had current employer's liability insurance in place which was displayed in the staff office area.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Staff confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Outgoing patient referrals were monitored effectively to make sure they were dealt with promptly.

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 identified several shortfalls during our inspection including the quality of dental care records, clinical supervision, auditing and the handling of complaints which demonstrated that governance procedures in the practice needed to be strengthened.

Leadership capacity and capability

The practice manager had overall responsibility for the management of the service. Staff told us she was approachable and supportive of them. We found she was knowledgeable about the challenges the practice faced such as meeting NHS targets, catching up with the backlog of patients to be seen and increasing the number of appointments available. She took immediate action to rectify some of the shortfalls we identified during our inspection, demonstrating a commitment to improve the service.

Culture

The practice was small and friendly with a well-established staff group. Staff told us they felt respected and valued, and clearly enjoyed their job. One commented, 'we're a close-knit team that really cares about the practice'.

The practice had a duty of candour policy in place, and staff were aware of its requirements for openness and honesty with patients if things went wrong.

Governance and management

The practice had comprehensive policies, procedures and risk assessments to support the management of the service and to protect patients and staff. The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

The dentists received regular appraisal from the university's Head of Student Services. However, this person was not a qualified dental clinician, so it was not clear how the dentists' clinical knowledge and performance were meaningfully assessed. It was not clear how clinicians kept up to date with the recent guidelines and procedures as staff meetings were sporadic and one had not taken place in over two years.

The practice had a policy which detailed its complaints procedure, however there was no information on display informing patients how they could raise their concerns. We viewed two recent complaints received by the practice and noted it was not possible to ascertain if they had been managed in line with the practice's own policy.

There were limited systems in place to assess and monitor the quality of clinical care. Clinical audits for areas such as dental care records, radiography, and infection control were not undertaken in line with national recommendations. For example, no dental care records audits had been undertaken, the last radiograph audit had taken place in 2019, and infection control audits were only undertaken annually. Where audits had been completed, there was no analysis of the results or any resulting action plan. The was no evidence to show how frequently the audits would be conducted or the date of their second cycle.

Engagement with patients, the public, staff and external partners

The practice used a variety of surveys to gain patient feedback about its service. A general one which requested patients' views about waiting times for an appointment, if their medical history had been updated and the quality of care received.

Are services well-led?

In addition to this was a dentist specific survey which asked patients to comment if the dentist was polite, if they explained their treatment well and if they felt involved in decisions about their care. The practice also used the NHS Friends and Family Test. Patient responses we checked were positive. The practice manager told us that one patient's suggestion to for a bike rack outside the practice had been implemented.

Continuous improvement and innovation

The dental nurses received annual appraisal from the practice manager, evidence of which we viewed. Staff told us they found their appraisal useful as they received feedback about what they did well and areas for improvement.

The practice supported and encouraged staff to complete continuing professional development and paid for them to be members of an accredited on-line training provider.

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 **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.** **How the regulation was not being met:** **The registered person had ineffective systems or processes in place as 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:** • Sharps management procedures did not comply with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice. • There was no effective system in place to ensure essential audits were undertaken in line with nationally recommended guidelines. • There was no effective system for recording, handling and responding to patients' complaints.