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Hitchin Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 3 March 2020 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.

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 not 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?

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

Are services well-led?

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

Background

Hitchin Dental is a well-established practice that offers both private and NHS treatment to about 2,500 patients. The dental team consists of a dentist, a dental nurse, a hygienist and a receptionist. There are three treatment rooms. The practice opens on Mondays to Thursdays from 9 am to 5 pm, and on Fridays from 9 am to 3 pm. There is no level access for wheelchair users. Parking is available on streets nearby.

The practice is owned by an individual who is the dentist there. He has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

Summary of findings

On the day of inspection, we collected 40 CQC comment cards filled in by patients and spoke with another two.

During the inspection we spoke with the dentist, the nurse and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- Staff treated patients with care, dignity and respect. We received many positive comments from patients about the caring and empathetic nature of staff and the effectiveness of their treatment.
- The practice was small and friendly, something which patients appreciated.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff felt involved and supported and worked as a team.
- Staff did not follow national public guidance when decontaminating dirty instruments.
- The management of risk in the practice was limited and control measures to reduce potential hazards had not always been implemented.
- Audit systems within the practice were limited and had not been used effectively to drive improvement.
- Governance systems were lacking.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

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

- Implement an effective system for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- Take action to ensure the availability of an interpreter service for patients who do not speak English as their first language.
- Take action to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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?	**Requirements notice** ✖
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

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

We found this practice was not providing safe 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.

The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Information about protection agencies was available around the practice making it easily accessible to staff and patients. However, evidence to show that some staff had undertaken safeguarding training was not available.

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

The dentist used dental dam in line with guidance from British Endodontic Society when providing root canal treatment.

The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running.

The practice had a recruitment policy in place, although it did not include guidance about obtaining DBS checks for staff. We requested to view the most recently employed member of staff's recruitment file, but this was not available. However, missing information was sent to us following our inspection.

A fire risk had been completed by the principal dentist, but it was very limited in scope. We saw that fire extinguishers had been tested regularly but there was no evidence to show that staff had received fire training. Staff did not regularly practice evacuating the building and there were no records of smoke alarm checks. We noted two of the practice's fire escapes were blocked, in one instance not allowing the door to open fully. Although the gas boiler had been serviced just prior to our inspection, there was no evidence to show that it had been serviced each year to ensure its safe operation. Fixed wire electrical testing had not been completed.

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, although staff did not conduct TST tests for each sterilisation cycle conducted on its older autoclave. The practice did not follow national guidance for cleaning dirty instruments. For example, we noted that staff did not wash their hands prior to the decontamination procedures. Heavy duty gloves and long handled brushes were not changed weekly, and cleaning solution was not measured to ensure the right amount was added to the water. Staff scrubbed instruments above the water line, risking contaminated splashing. We also noted that the autoclave tray was over filled, thereby blocking the holes needed for effective steam penetration. Instruments had been dated with the date they had been processed, and not their expiry date as recommended in national guidance.

We noted that all areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked two treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. We noted the back was missing from the hygienist's chair and parts were very rusty, making it hard to clean. We viewed numerous rusty burs mixed in a box in the main treatment room drawer and a pouched matirx band that appeared dirty.

Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. However, staff did not remove their masks and gloves, when exiting treatment rooms, risking possible contamination of non-clinical areas.

A legionella risk assessment had been undertaken just prior to our inspection. Several urgent 'priority one' recommendations had been made and although an action plan had been written to address these recommendations, no timescales had been set for their completion. We were not provided with evidence to show that monthly water temperatures had been taken at sentinel water points or

Are services safe?

that little used outlets in the hygienist's room were flushed through regularly to control legionella bacteria accruing. The portable air conditioning unit in one treatment room had not been serviced.

The provider had risk assessments in place for the control of substances that were hazardous to health (COSHH), although safety data sheets were not available for some cleaning products used in the practice. We noted that there was no lock on the cupboard where dangerous cleaning materials were stored.

Clinical waste bags were stored in front of a fire exit and had not been labelled or dated.

The practice had arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. Rectangular collimation was used on the X-ray unit to reduce patient exposure. We found the justification and grading on taking X-rays in the patient notes we viewed, but not always their reporting.

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Risks to patients

A general risk assessment had been completed for the practice, but it was not specific to the practice. Its recommendations to provide regular updates and training in infection control, to ensure staff received moving and handling training, to visually inspect electrical items every six months and for clinicians never to work unaccompanied had not been implemented by staff. The dentist occasionally provided treatment to residents at a local care home but a risk assessment for this had not been completed. A risk assessment had also not been completed for all types of sharps used in the practice, although the dentist was using the safest types of needles. Clincal staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus.

Staff had completed training in resuscitation and basic life support. Most emergency equipment and medicines were available as described in recognised guidance, and missing equipment such as the spacer device and a replacement adult self-inflating bag were on order at the time of our inspection. However, staff were not keeping a record of the regular checks of equipment as recommended in national guidance. We viewed only one checklist dated the 16 February 2020. This log was incomplete as it did not include prompts to check the expiry date of the Glucagon.

Safe and appropriate use of medicines

The dentist was aware of current guidance with regards to prescribing medicines. However, the fridge's temperature, in which Glucagon was kept, was not monitored to ensure it operated effectively. Patient prescriptions were not tracked or monitored to identify their theft or loss.

An antimicrobial audit had been undertaken to assess if the dentist was prescribing according to national guidelines.

Lessons learned and improvements

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

The dentist told us he received MHRA and national patient safety alerts but there was no clear system for disseminating them to ensure all staff had seen and read them.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 40 comments cards that had been completed by patients prior to our inspection. The comments received reflected that patients were very satisfied with their treatment and the staff who provided it. They told us their treatment had been pain free and effective, and the dentist made them feel safe.

Our review of dental care records indicated that patients' dental assessments were recorded out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC), although some notes were not fully legible.

Helping patients to live healthier lives

A part-time dental hygienist was employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease.

We noted some information in the waiting area for patients in relation to oral health, and free samples of toothpaste were available on the reception desk.

Consent to care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment, although dental care records we viewed did not always demonstrate that a meaningful consent process had occurred.

We found that staff had a limited understanding of the Mental Capacity Act and its implications when treating patients who might not able to make decision for themselves. For example, the dentist had treated one patient with a known diagnosis of advanced Alzheimer's disease, but had not completed a Mental Capacity Assessment to undertake the treatment in line with legislation. He relied on care home staff to provide consent on behalf of the patient. Minutes we viewed of a staff meeting recorded as having occurred in December 2019, stated that all staff had undertaken a two-hour training in patient consent. However, one staff member told us they were not aware of this meeting having taken place.

Staff were aware of Gillick guidelines and the need to consider these when treating young people under 16 years of age.

Effective staffing

The staff team was very small consisting of one dentist, one nurse, a hygienist and a receptionist. The hygienist worked without chairside support which is not in line with best practice guidance. No risk assessment had been completed for this.

It was not possible for us to confirm if clinical staff had completed the continuing professional development required for their registration with the General Dental Council, as the practice did not have an up to date overview of staff training. Two staff told us they were behind on the essential training and were aware they needed to catch up with it.

Co-ordinating care and treatment

The dentist told us they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. The practice also had systems and processes for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice did not actively monitor non-NHS referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

We received many positive comments from patients about the empathetic nature of the practice's staff. Patients described staff as consistently caring, cheerful and respectful. Patients told us that staff worked well with their children and that they always felt listened to. Nervous patients told that staff worked hard to make them feel relaxed.

Staff told us they regularly looked after patients' children in the waiting room, so their parents could attend their appointment without distraction and rang patients after complex treatments to check on their welfare.

Privacy and dignity

The reception area was not particularly private and during our inspection we overheard patients talking about their medical histories at the reception desk. The practice had a private area to the rear of reception, so staff agreed to display and sign informing patients of this.

All consultations were carried out in the privacy of the treatment room and we noted that the door was closed during procedures to protect patients' privacy. We noted blinds were on the downstairs window to prevent passers-by looking in.

Involving people in decisions about care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment. However, dental records we reviewed did not always show which treatment options had been discussed with patients or fully document the consent process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had its own website which gave patients information about the services it offered and emergency contact details. The waiting room contained magazines for patients to read, and books for children to keep them occupied whilst waiting.

The practice had not made reasonable adjustments for patients with disabilities. There was no portable ramp access to assist patients in wheelchairs and no portable hearing induction loop for those who wore a hearing aid. Staff were not aware of translation services to support patients who did not speak or understand English.

Two weeks before our inspection, we sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service. 40 cards were completed, giving a patient response rate of 80%. All views expressed by patients were very positive about the care and treatment provided by the practice, although two respondents told us they sometimes had to wait as previous appointments ran over time.

Timely access to services

At the time of our inspection the practice was able to register new patients. Reception staff told us there was a two to three day wait for an appointment, and anyone in pain would be seen the same day. There were specific emergency slots put aside each day. The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Other local practices covered any patient emergency appointments whilst the dentist was on annual leave or unavailable.

Following patient feedback, the practice had decided to provide longer emergency appointment times so that these did not overlap with regular patient appointment times.

A hygienist worked once a fortnight and was able to offer patients appointments from 8 am.

The practice did not offer a text or telephone appointment reminder service, but patients could request to have a telephone reminder.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints. Information about how patients could raise their concerns was available in the waiting room however, it did not contain any information about other agencies patients could contact if they were unhappy with the service received. The receptionist was not clear about the practice's complaints procedure and did not have any written information available that could be given directly to patient if they wanted to raise concerns.

The dentist told us that there had been no patient complaints in the previous three years. It was not possible for us to assess how the practice had managed a complaint received in 2017, as no paperwork had been kept in relation to it.

Are services well-led?

Our findings

Leadership capacity and capability

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.

The dentist had overall responsibility for both the management and clinical leadership of the practice. We found he did not have the capacity and knowledge to deliver high-quality, sustainable care. He worked in relative isolation and had struggled to keep up with current polices and procedures. As there was not a dedicated practice manager, he had relied heavily on a nurse for assistance with many administrative tasks, but she had recently left the practice. He told us our inspection had highlighted many areas for improvement he appeared keen to implement changes as a result.

Culture

The practice was small and friendly and had built up a loyal and established patient base over the years. Staff told us they enjoyed their job and felt valued in their work. Staff reported the dentist listened to them and implemented their ideas. For example, their suggestions for Christmas decorations to brighten up the practice and for cooking appliances such as a microwave and toaster had been implemented.

The practice had a duty of candour policy in place, and staff had a satisfactory knowledge of its requirements.

Governance and management

The practice did not have robust governance procedures in place. We identified a number of shortfalls during our inspection including the recruitment of staff, the control of infection, and the maintenance of the building, which demonstrated that governance procedures in the practice were ineffective.

The practice's policies were generic and there was no evidence to show that staff had read and fully understood them. Some did not reflect actual practice. Risk management was limited, and recommendations from various risk assessments had not always been implemented.

Communication systems between staff were very informal. We were shown a summary of meetings held in the practice in the previous year, but staff told us they did not recall attending these meetings. One staff member told us they would value greater opportunities to communicate with the dentist.

Engagement with patients, the public and external partners.

The provider used surveys and verbal comments to obtain patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example, staff told us that a card payment machine and email invoices had been introduced because of patients' feedback.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used. We viewed about 20 recent responses and noted that patients would recommend the practice.

Continuous improvement and innovation

Staff received an annual appraisal of their performance and had personal development plans in place. However, the practice did not keep an overview of the training staff had undertaken and there was no evidence available to demonstrate that all staff had received essential training in areas such as infection control, equalities and diversity, information governance and mental capacity training as recommended by General Dental Council professional standards.

Staff undertook some audits, but these had not always been used effectively to drive improvement. For example, the infection control audit had not identified the shortfalls we found in the practice's decontamination procedures, and similar shortfalls were identified in the dental records audits in 2018 and again in 2019.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met.** • Some of the practice's infection control procedures did not meet the Department of Health's Technical Memorandum 01-05: Decontamination in primary care dental practices. For example, staff did not wash their hands prior to the decontamination procedures. Heavy duty gloves and long handled brushes were not changed weekly, and cleaning solution was not measured to ensure the right amount was added to the water. Staff scrubbed instruments above the water line, risking contaminated splashing. The autoclave tray was over filled, thereby blocking the holes needed for effective steam penetration. Instruments had been dated correctly. • Prescriptions issued to patients were not monitored or tracked which meant missing or lost prescriptions could not be identified. • The fridge temperature was not monitored to ensure that medicines and dental care products were stored in line with the manufacturer's guidance. • Fixed wire testing had not been completed every five years, and the practice's gas boiler and air conditioning unit had not been serviced regularly to ensure its safety. • Fire safety management was limited. Staff had not received fire training, smoke alarms had not been checked and fire exits were blocked. • Legionella management was limited. Water temperature testing was not conducted regularly, and little used water lines were not flushed through regularly. • Clinical waste was not labelled and stored according to national guidelines.

This section is primarily information for the provider

Requirement notices

- Patients referrals were not actively tracked and monitored to ensure their safe arrival.
- Staff did not have a thorough knowledge of the Mental Capacity Act, and their responsibilities under it, when treating patients who could not make decision for themselves.

Regulation 12 (1)

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 (1) 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 practice's systems for monitoring and mitigating the various risks arising from the undertaking of the regulated activities were limited, and control measures had not always been implemented. For example, the safety of the premises and the use of sharps within the practice had not been fully assessed. • There was no system in place to effectively monitor essential staff training and ensure it was kept up to date. **Regulation 17 (1)**