Care Quality Commission

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Lea Bridge Road Dental Surgery

Inspection Report

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Overall summary

We carried out this unannounced inspection on 22 May 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check on concerns we had received and 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 that this practice was not 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 caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Lea Bridge Road Dental Surgery is in Leyton in the London Borough of Waltham Forest and provides NHS and private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs.

Summary of findings

The dental practice is owned by two dentist partners. The partners do not work at the practice. The dental team includes four associate dentists, five dental nurses, of whom three are trainee dental nurses and one receptionist. The practice has three treatment rooms.

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission 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 Lea Bridge Road Dental Surgery was the one of the dentist partners.

During the inspection we spoke with two dentists including one of the partners, two trainee dental nurses, and the receptionist. We also spoke with two patients. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open between 9am and 5.30pm on Mondays to Fridays.

Our key findings were:

- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had thorough staff recruitment procedures.
- 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.
- The appointment system met patients' needs.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.
- We noted that various areas of the practice were not clean and were not well maintained.
- Some equipment such as the X-ray equipment was not maintained or serviced in line with the manufacturer's instructions.
- The practice had infection control procedures which reflected published guidance. However these were not adhered to or followed by some staff.
- The practice did not have effective leadership. There was a lack of management oversight to ensure that staff understood and followed the practice policies and procedures.
- Risks related to undertaking of regulated activities had not been suitably identified and mitigated.
- Systems were not in place to assess, monitor and improve the quality of the service

We identified regulations that were not being met and the provider must:

- Ensure the practice establishes an effective system to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure systems are in place to assess, monitor and improve the quality of the service such as undertaking regular audits of various aspects of the service and ensuring that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure systems are in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are health care associated.
- Ensure that the equipment and the premises used for providing care or treatment to a service user were safe for such use and used in a safe way.

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 and should:

- Review the practice protocol and ensure staff are aware of their responsibilities as per the Duty of candour under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The principal dentist was made aware of our findings on the day of the inspection and they were formally notified of our concerns immediately after the inspection. They were given an opportunity to put forward an urgent action plan with remedial timeframes, as to how the risks could be mitigated.

Summary of findings

The provider responded appropriately within the required time frame to inform us of the urgent actions they had undertaken to mitigate the risks.

These included voluntarily closing the dental practice to make the necessary improvements.

The provider has submitted regular updates and assurances that the remedial work in relation to ensuring safety of the premises and equipment was being carried out.

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 ✗

We found that 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 Requirements Notice section at the end of this report).

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles and the practice completed essential recruitment checks.

The practice had suitable arrangements for dealing with medical and other emergencies.

The practice had systems and processes to provide safe care and treatment; these were not routinely referred to or adhered to by some staff. The practice could not demonstrate that they used learning from incidents to help them improve.

Some parts of the premises and equipment were not clean or properly maintained. The practice did not consistently follow national guidance for cleaning, sterilising and storing dental instruments.

Are services effective?

No action ✓

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as professional and helpful. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles. However there were ineffective systems to help them monitor this.

Are services caring?

No action ✓

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

We received feedback about the practice from two people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly and caring, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

Summary of findings

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action ✓

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to telephone interpreter services and had arrangements to help patients with sight loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

Requirements notice ✗

We found that 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 Requirements Notice section at the end of this report).

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely. There were arrangements for obtaining the views of patients and staff.

The practice did not have robust arrangements to ensure the smooth running of the service. The management structure was not clearly defined. There was a lack of leadership and oversight to support staff and ensure that they understood and followed relevant legislation and guidance in relation to their roles and responsibilities for the safe running of the practice.

Risks arising from undertaking of regulated activities had not been suitably identified and mitigated.

The practice did not have effective systems for monitoring clinical and non-clinical areas of their work to help them improve and learn.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff knew about these and understood their role in the process.

However incidents such as an infestation of vermin were not recorded, responded to or acted on appropriately to reduce risk and support future learning. We also found that while an issue in relation to damp and mould in one of the cupboards had been reported internally, this had not been acted upon in a timely way.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were discussed with staff, acted on and stored for future reference. The principal dentist showed us that recent safety alerts had been reviewed and acted on as appropriate.

Reliable safety systems and processes (including safeguarding)

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 received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment.

The practice followed relevant safety laws when using needles and other sharp dental items.

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

The practice had a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice.

As a result of the concerns identified during the inspection the dental provider closed the practice while the necessary remedial works could be completed. Staff followed the business continuity plan and advised patients that they could reschedule appointments at another of the dentists' locations nearby.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency medicines and equipment, with the exception of a portable suction device, were available as described in recognised guidance..

Staff kept records of the checks to make sure these were available, were within their expiry date, and were in working order.

We noted that one oxygen cylinder was past its use by date. The principal dentist told us that this was used for training purposes. Staff removed this immediately.

Staff did not monitor the storage temperature for the fridge to ensure one of the emergency medicines - glucagon was stored in accordance with the manufacturer's instructions.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We looked at four staff recruitment records. These showed the practice followed their recruitment procedure.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. Three trainee dental nurses were employed at the practice and they were completing the required training towards qualification and registration with the GDC.

Monitoring health & safety and responding to risks

The practice had health and safety policies and these covered general workplace and specific dental topics. We noted that these were not followed routinely by some staff and risks to patients and staff were not assessed or managed in a number of areas.

The practice had an ongoing infestation of vermin including rats and cockroaches. We found that while the

Are services safe?

practice had employed some measures to deal with this including the use of bait and traps, the extent of the risks had not been assessed and appropriate actions had not been taken to suitably control the infestation.

Many areas of the premises were accessible to potential infestation due to having gaps and holes in the external walls, and having open vents and disused pipes.

There were also gaps and holes in internal walls and ceilings. The garden area to the rear of the practice was cluttered with debris including rubbish and carpets. There were no systems to remedy or monitor the infestation.

There was a fire safety risk assessment and procedures for dealing with an outbreak of fire and the safe evacuation of people from the building.

There were arrangements to protect patients from exposure to substances which may be hazardous to health such as cleaning and other materials. Detailed information in relation to chemical and other substances and on how to deal with accidental exposure to harmful substances and materials was available for staff. .

The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentists when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

Staff completed infection prevention and control training every year. However suitable infection prevention and control procedures were not being adhered to and some staff had limited understanding of the correct process for cleaning dental instruments. We also found that some single use dental items were made available for re-use.

Two members of staff who were responsible for cleaning and sterilising reusable dental instruments could not demonstrate that they followed or understood the practice procedures. Staff who we observed did not use appropriate personal protective equipment when cleaning. We noted that recommended guidelines were not being followed during the cleaning of the instruments.

Staff did not check instruments appropriately for debris before they were sterilised as there was no illuminated magnification device to check the suitability of the cleaning process.

Some records were not available to show that equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance. One of the two autoclaves did not have any evidence of a maintenance service since 2015 to ensure that it was working effectively. Evidence of up to date maintenance and servicing was provided for this autoclave following our inspection.

The practice had carried out an infection prevention and control audit in May 2017. The previous audit had been carried out in 2015. It is recommended that these audits are carried out twice a year to test the effectiveness of infection control procedures. We found that these were not completed correctly and did not include details of areas where improvements were needed. The audits did not identify shortcomings in the poor practices followed by staff in cleaning of instruments and in re-use of single use instruments.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems and there was a risk assessment in place which had been carried out in 2015. However there were no systems in place to monitor staff practices. Two members of staff told us that they used bleach to clean the waterlines.

We saw that cleaning schedules for the premises were not available for staff to follow and staff did not have access to appropriate cleaning equipment to clean clinical and non-clinical areas within the practice. We found areas of the premises were not clean when we inspected, including dusty and unclean floors, cupboards and drawers. The cupboard used to house a compressor and a water tank was covered in mould and the walls were visibly damp with peeling paint work.

Are services safe?

Clinical waste including disposable instruments were not stored in line with relevant guidelines. Sharps boxes were undated. Clinical waste was stored outside at the rear of the property and the waste bins were unlocked.

Equipment and medicines

We checked the servicing documentation for the equipment used at the practice and noted that service and maintenance checks were not carried out for some equipment including sterilising and X- ray equipment in line with the manufacturers' recommendations.

Regular service and maintenance for a compressor had not been undertaken since 2015 and there was no documentary evidence of service or maintenance for the other compressor. There was no documentary evidence of service or maintenance for the suction pump or the amalgam separator.

The practice had suitable systems for prescribing, dispensing and storing medicines.

The practice stored and kept records of NHS prescriptions as described in current guidance.

Radiography (X-rays)

The practice did not have suitable arrangements in line with current radiation regulations to ensure the safety of the X-ray equipment. Regular maintenance for an X-ray machine had not been undertaken since 2013.

We saw evidence that the dentists justified, graded and reported on the X-rays they took. The practice carried out X-ray audits every year following current guidance and legislation. However learning was not shared or reviewed to maintain and improve quality.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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.

We saw that the practice audited patients' dental care records to check that the dentists recorded the necessary information.

Health promotion & prevention

The practice was providing preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child. This was recorded as required within patients' dental records.

The dentists told us they discussed smoking, alcohol consumption and diet with patients during appointments where this was appropriate. The practice provided health promotion leaflets to help patients with their oral health.

Staffing

Staff new to the practice had a period of induction to help them familiarise themselves with the practice policies and procedures. We confirmed qualified clinical staff completed the continuous professional development required for their registration with the General Dental Council.

The dental practice is a training practice. The trainee dentist and the dental nurses were undertaking training towards a dental nurse qualification. We spoke with one of the trainee dentists and they told us that they were supported and supervised to enable them to develop their clinical skills.

Staff had access to training and they told us they discussed training needs at annual appraisals. We saw evidence of appraisal records. However these were incomplete and did not identify staff training or development needs and how these were to be met.

Working with other services

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

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 may not be able to make informed decisions. The policy also referred to Gillick competence and the dentists were aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were kind and caring. We saw that staff treated patients respectfully and were friendly and helpful towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentists described the conversations they had with patients to satisfy themselves they understood their treatment options. Details of these discussions were recorded within patients' dental records.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Each treatment room had a screen so the dentists could show patients photographs and X-ray images when they discussed treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

Promoting equality

The practice had made some reasonable adjustments such as having a step free access for patients with disabilities.

Staff said they could provide information in different formats and languages to meet individual patients' needs.

Access to the service

The practice displayed its opening hours in the premises and in their information leaflet within the practice.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept a number of appointments free for same day appointments. The information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the previous 12 months. These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

The principal dentist had overall responsibility for the management, clinical leadership and for the day to day running of the service.

We noted that the principal dentist and the other dentist partner did not work at the practice and there were ineffective systems in place for governance and monitoring.

Staff told us that they would alert the principal dentist if there were any concerns and the principal dentist confirmed this. However they could not demonstrate that in the instances where concerns had been raised appropriate action had been taken to address the issues.

The practice had policies and procedures intended to support the management of the service and to protect patients and staff. However staff who we spoke with could not demonstrate that they fully understood or followed these policies, particularly in relation to infection control procedures.

There were limited arrangements to monitor the quality of the service and make improvements. Risk assessments were not carried out or reviewed regularly to minimise potential risks to patients and staff. Where risks had been identified, the extent of the risks had not been explored and there were ineffective systems in place to deal with and regularly monitor and mitigate risks.

There were ineffective systems in place to ensure that equipment such as some X-ray equipment was maintained for the safe delivery of treatment and services provided.

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

Leadership, openness and transparency

Staff were unaware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said they felt confident to raise concerns and issues. They knew who to raise any issues with and told us the principal dentist was approachable. However the practice did not have robust systems for acting on information or sharing learning from incidents.

The practice held some infrequent meetings where staff could raise any concerns and discuss clinical and non-clinical updates. There were limited systems in place for sharing information with the staff team.

Learning and improvement

The practice had limited quality assurance processes to encourage learning and continuous improvement. Audits including those in relation to monitoring X-rays and infection prevention and control were carried out infrequently and were not in line with current guidance. The practice did not have clear records of the results of these audits and the resulting action plans and improvements.

The dentist partners could not demonstrate that they had a commitment to learning and improvement. The dental nurses had annual appraisals. However the records from these did not show that learning needs were discussed or how these needs would be met.

Staff told us they completed mandatory training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so.

Practice seeks and acts on feedback from its patients, the public and staff

The practice used verbal comments and the NHS Friends and Family Test to obtain staff and patients' views about the service. We reviewed the results from the previous six months and found that 100% of patients who participated in this survey were either 'extremely likely' or 'likely' to recommend the practice to their friends and family.

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 The registered person did not have effective systems in place to ensure care and treatment was provided in a safe way. **How the regulation was not being met:** The provider did not have effective systems in place to: • Ensure that the premises used by the service provider were safe to use for their intended purpose and were used in a safe way. • Ensure that the equipment used by the service provider for providing care or treatment to a service user was safe for such use and used in a safe way. • Assess the risk of preventing, detecting and controlling the spread of infections. **Regulation12(1) (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to ensure that the regulated activities at Lea Bridge Road Dental Surgery were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** The provider did not have effective systems in place to :

This section is primarily information for the provider

Requirement notices

- Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
- Ensure that their audit and governance systems remain effective.

Regulation 17 (1)