Dr Andrew Holliday

Hewlett Road Dental Surgery

Inspection Report

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Overall summary

We carried out a focused inspection of Hewlett Road Dental Practice on 5 October 2017.

During the focused inspection of Hewlett Road Dental Practice on 5 October 2017 we saw evidence of a concerning nature which required the focused inspection to change to a comprehensive inspection.

The inspection was led by a CQC inspector, who was supported by a specialist dental adviser.

We carried out the inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 10 February 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

At a comprehensive inspection we always ask the following five questions to get to the heart of patients' experiences of care and treatment:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

When one or more of the five questions is not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

At the previous comprehensive inspection we found the registered provider was providing safe, effective, caring and responsive care in accordance with relevant regulations. We judged the practice was not providing well-led care in accordance with regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Hewlett Road Dental Surgery on our website www.cqc.org.uk.

We reviewed the key question of well-led as we had made recommendations for the provider relating to this key question.

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?

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 was not providing well-led care in accordance with the relevant regulations.

The provider had made insufficient improvements to put right the shortfalls and had not dealt with the regulatory breaches we found at our inspection on 10 February 2017.

Background

Hewlett Road dental surgery is in Cheltenham and provides private treatment to patients of all ages.

There is no level access for people who use wheelchairs and pushchairs. Car parking spaces, including those for patients with disabled badges, are available near the practice.

The dental team includes two dentists, one dental nurse, two dental hygienists and one cleaner. The practice has three treatment rooms.

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

On the day we spoke with two patients. This information gave us a positive view of the practice.

During the inspection we spoke with two dentists, one dental nurse, one dental hygienist and one locum dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Thursday 8am to 5:30pm and Friday 8am to 4pm.

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?

Enforcement action 

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

The practice had some systems and processes to provide safe care and treatment but these were not all up to date and followed. They did not use learning from incidents and complaints to help them improve.

There was no evidence available to show that staff received training in safeguarding, but they knew how to recognise the signs of abuse and how to report concerns.

There was no evidence available to demonstrate that staff were qualified for their roles and the practice did not completed essential recruitment checks.

Premises and equipment were clean and but not properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

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

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 a brilliant service, excellent and professional. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice did not support staff to complete training relevant to their roles and had no 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 patients who were positive about all aspects of the service the practice provided. They told us staff were professional, friendly and supportive. They said that they were given helpful, thorough and informative explanations about dental treatment, 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.

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

Summary of findings

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.

The practice did not take into account patients views. They did not demonstrate that they value compliments from patients or respond to concerns and complaints quickly and constructively.

Are services well-led?

Enforcement action 

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

The practice had no arrangements to ensure the smooth running of the service. There were no systems in place for the practice team to discuss the quality and safety of the care and treatment provided. There was no clearly defined management structure although staff felt supported and appreciated.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

The practice did not monitor clinical and non-clinical areas of their work to help them improve and learn. The practice did not ask for or listen to the views of patients and staff.

Are services safe?

Our findings

At our previous inspection on 10 February 2017 we judged the practice was providing safe care in accordance with the relevant regulations.

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events.

The practice had recorded one 'needle stick' injury to a member of staff in March 2017. The incident was recorded in the accident book. We spoke with the principal dentist who told us that the member of staff would have been referred for medical advice, but there would have only been a verbal investigation about the incident, with no written records made of any follow up investigation.

The practice did not received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

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 no 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. We asked the principal dentist about training and he told us that staff records and training had been unmonitored since June 2016. The principal dentist told us that staff completed training on their own initiative.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments which staff did not review every year. The sharps risk assessment was dated September 2015. We asked the principal dentist about ongoing risk assessment and were told that all activity in this area had stopped in June 2016. 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.

Medical emergencies

Staff knew what to do in a medical emergency. The principal dentist told us that staff had not completed training in emergency resuscitation and basic life support since June 2016. The principal dentist told us that he did not know when first aid training had last occurred and had not asked his staff about this training.

Emergency equipment and medicines were available as described in recognised guidance in a lockable cupboard. We asked about access and found that three staff members could not access the equipment if it was locked. We spoke with the principal dentist who told us that would make arrangements to leave the cupboard unlocked in future.

The practice did not have an Automated External Defibrillator (AED). The principal dentist told us that one was available at another practice about one mile away owned by the principal dentist. We asked if there was a written risk assessment to mitigate not having an AED available on site. The principal dentist told us that a risk assessment was not available and that one would not be prepared, and the practice would continue with the current working arrangement. Staff kept records of their checks of the emergency equipment and medicines to make sure these were available, within their expiry date, and in working order.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We were unable to look at staff recruitment records. The principal dentist told us that staff files were secured in a cupboard to which he had no access. The principal dentist told us that the last time the staff recruitment records would have been looked at was February 2017. There had been no staff recruitment since June 2016.

Clinical staff were qualified and registered with the General Dental Council (GDC). The principal dentist did not know if staff had professional indemnity cover and that the matter was left to each individual to consider.

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were undated and not reviewed to help manage potential risk. The principal dentist told us that he did not know when policies had last been reviewed and

Are services safe?

that all work in relation to policies had ceased in June 2016. The policies available covered general workplace and specific dental topics. The practice had current employer's liability insurance.

We reviewed the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file and saw that it contained one material safety data sheet dated 2013. The product was not assessed in any way. No other products the practice used were listed. We spoke with the principal dentist who told us that the file was incomplete and would not be brought up to date.

We saw that fire extinguishers were last maintained in February 2017. The fire alarm system was last maintained in March 2014. The last recorded internal check of any fire protection systems had last taken place in January 2017. We spoke with the principal dentist who told us that effective management of the practice had ceased in February 2017 and there were no plans to implement an effective management system.

We saw that there was loose wiring above treatment room two which appeared to be linked to an internal speaker/ sounder. The object was hanging off the wall. We also saw that in an internal corridor, which received no natural light it did not have lighting that worked. The principal dentist told us that no maintenance had taken place in the practice since February 2017, nor was any planed.

We could not be shown a mains wiring safety certificate as required by regulations. We spoke with the principal dentist who told us that it was possible that one may be available but it could not be found due to the lack of management since February 2017.

A dental nurse worked with the dentists and dental hygienists 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. The principal dentist was unable to tell us when staff last completed infection prevention and control training. No training records were available.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment staff used for cleaning and sterilising instruments was not maintained but used in line with the manufacturers' guidance. The practice had two autoclaves. We were told one autoclave had been out of use since August 2017 and required repairs to enable it to work again. The principal dentist told us that the broken autoclave would not be repaired. The other autoclave was working and currently in use. Both autoclaves were due to be serviced and given pressure vessel certification in January 2017 but this had not been carried out. We asked the principal dentist about this and he told us that there had been a plan to carry out maintenance and servicing of the autoclaves in February 2017 but this had not taken place. There were no plans to service or maintain the equipment.

The practice last recorded infection prevention and control audit in 2013. The principal dentist told us that he was unaware of the location of a more up to date version of an infection prevention and control audit and there were no plans to carry out such an audit in the immediate future. The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment.

We could not be shown an annual infection control statement. We spoke with the principal dentist who told us that it was possible that one may be available but it could not be found due to the lack of management since February 2017.

We did not see cleaning schedules for the premises. The principal dentist told us that he was unaware of any written cleaning schedule and that one would not be written in the immediate future. The practice was clean when we inspected and patients confirmed that this was usual for the practice.

Equipment and medicines

We could not be shown servicing documentation for the equipment used. Staff did not carry out checks in line with the manufacturers' recommendations. The principal dentist told us that the compressor had been installed during January 2016 but had not been serviced or had any other certification since installation. We asked the principal dentist about this and were told that there had been a plan to service and carry out its safety certification in February 2017 but this had not taken place. There were no plans to service or maintain the equipment.

Are services safe?

The practice had suitable systems for prescribing, dispensing and storing most medicines. The medical fridge stored Glucagon, however the temperature of the fridge was not monitored. We spoke with principal dentist who told us that monitoring was not taking place of the fridge nor were there any plans to commence a monitoring system.

Radiography (X-rays)

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. They did not meet current radiation regulations but did hold some of the required information in their radiation protection file. The principal dentist told us that the radiation file was not up to and any work on the file had ceased during February 2017. The X ray units were due to have been serviced and inspected in July 2016 however these had not taken place. We also saw that the x ray unit in Surgery one had exposed inner cabling and wiring on the timing trigger. We spoke with the principal dentist who told us that servicing was due to have taken place during February 2017 but had not been done and there were no plans for this to occur. We were also told that the damaged X ray unit would be taken out of service but not repaired. We were also told that the radiation protection advisor no longer advised the practice since February 2017 and that no alternative had been arranged.

We saw evidence that the dentists justified, graded and reported on the X-rays they took. The practice last carried out a radiography audits in October 2016. The principal dentist told us that there were no plans to carry out any further audits in relation to X rays following guidance and legislation.

It was not known if clinical staff completed continuous professional development in respect of dental radiography as no records were completed. The principal dentist, who was also the radiation protection supervisor, told us that continuous professional development in respect of dental radiography was left to individual clinicians.

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection on 10 February 2017 we judged the practice was providing effective care in accordance with the relevant regulations.

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 last audited patients' dental care records in September 2016 to check that the dentists recorded the necessary information.

Health promotion & prevention

The practice provided in preventative care and supported patients in ensuring 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.

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

Staffing

Staff new to the practice were not given any induction training based on a structured induction programme. We asked the principal dentist about this and were told us that no new staff had been recruited since June 2016 and that locum staff used in the practice since June 2016 had not received any induction training. There were no plans to introduce induction training at this time. We were unable to confirm clinical staff completed the continuous professional development required for their registration with the General Dental Council as no records were kept. Staff did tell us that they kept up to date with training requirements.

Staff told us they could not discuss training needs at annual appraisals as none had taken place. We saw no evidence of completed appraisals. We spoke with the principal dentist who could not remember the last specific date when appraisals had taken place but it could have been 2015 with repeats due in June 2016 not taking place then or since that date. We were told that staff could verbally discuss training if they requested but that records were not kept.

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 did not monitor urgent referrals to make sure they were dealt with promptly. The principal dentist told us that there was no practice process to monitor referrals although one dentist had started a personal system of referral monitoring. There were no plans to implement a monitoring system.

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

At our inspection on 10 February 2017 we judged the practice was providing caring services in accordance with the relevant regulations.

Respect, dignity, compassion and empathy

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

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. 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.

There were magazines in the waiting room. The practice provided drinking water on request.

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. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as referrals for orthodontic work or implants.

Each treatment room had a screen so the dentists could show patients photographs, videos and X-ray images when they discussed treatment options. Staff could also use videos to explain treatment options to patients needing more complex treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection on 10 February 2017 we judged the practice was providing responsive services in accordance with the relevant regulations.

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 no patients for whom they needed to make adjustments to enable them to receive treatment.

Promoting equality

The practice made reasonable adjustments for patients with disabilities. These included a stair chair lift.

Access to the service

The practice displayed its opening hours in the premises and on their website.

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 appointments free for same day appointments.. The website 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. However the practice did not follow the complaints policy. We were told by the principal dentist that each individual clinician was responsible for dealing with their own complaints Staff told us they would tell the responsible clinician about any formal or informal comments or concerns straight away so patients received a response.

The clinicians 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 did not record details of complaints. We could not confirm if the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service. We spoke with the principal dentist who told us that there was no practice system for monitoring complaints and that it was left up to individual dentists to deal with each complaint. All recorded information would be placed in patient care notes. Compliments were not recorded.

Are services well-led?

Our findings

At our inspection on 10 February 2017 we judged the practice was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 5 October 2017 we noted the practice had not made the following improvements to meet the requirement notice:

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure the practice recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure the training, learning and development needs of staff members are monitored to ensure they undertake appropriate training and the information was collated and reviewed at appropriate intervals.
- Ensure a performance review system is establish and provides and effective process for the on-going assessment, appraisal and supervision of all staff.

  The practice had not made improvements in relation to recommendations:

- Review the practice infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance with particular attention to the Annual Infection Control statement.
- Review maintenance records regarding the electrical hard wiring of the practice.

This demonstrated that the provider had taken no action to address the shortfalls we found when we inspected on 5 October 2017.

Governance arrangements

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

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff, although these had not been updated since June 2016. These included arrangements to monitor the quality of the service and make improvements although the last audits had taken place in September 2016.

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 aware 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 the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the principal dentist was approachable, would listen to their concerns and act appropriately. The principal dentist discussed concerns verbally, but no staff meetings had taken place since September 2016. It was clear the practice worked as a team and dealt with issues professionally, however they were working in a generally unmanaged practice. We spoke with the principal dentist who told us that management had reduced significantly since June 2016 and in effect ceased in February 2017.

The practice had not held meetings since June 2016 where staff could raise any concerns and discuss clinical and non-clinical updates. Immediate discussions were arranged to share urgent information, although these were not recorded. The principal dentist kept no records of any verbal team meetings and could not remember when the last such conversations had taken place. The principal dentist attended the practice on three half days a week which he told us restricted his contact with staff.

Learning and improvement

The practice quality assurance processes to encourage learning and continuous improvement last took place in September 2016. These included audits of dental care

Are services well-led?

records, radiographs and infection prevention and control. They had clear records of the results of those audits and the resulting action plans and improvements. The principal dentist told us that none had taken place since then and there no plans to carry out such work.

The principal dentist showed a verbal commitment to learning and improvement and valued the contributions made to the team by individual members of staff. The whole staff team had no annual appraisals. The principal dentist told us that there was no intention to commence appraisals in the future and that only verbal support towards training was given.

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 verbal support and encouragement for them to do so. We spoke with the principal dentist who told us that staff were not directed towards training, no practice records were maintained and training was not arranged.

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

The practice used a suggestion box to obtain patients' views about the service. We saw no examples of suggestions from patients the practice had acted on.

Patients had not completed any surveys that we could be shown. The principal dentist was unsure of the date of the last patient survey and could not show us an example. We were told that there was no intention to complete a survey at this time.

This section is primarily information for the provider

Enforcement actions

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 equipment being used to care for and treat service users was not safe for use. In particular: there was no regular servicing or regulation testing of the autoclave, compressor, or X-ray equipment.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not have effective governance systems in place which assessed, monitored and improved the quality and safety of services provided. • The provider did not have fully effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. • Records relating to the provision and management of regulated activities were not created and, amended appropriately in accordance with current guidance. • Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to carry out. • There was limited evidence of appraisals and limited evidence of induction for new staff when they started working at the practice.