Mr Raj Wadhwani

Burleigh Street Dentistry

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 29 June 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services 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

Burleigh Street dentistry provides mostly private general dentistry services to adults. The practice belongs to the Antwerp House Dental Group is one of seven practices owned by Mr Raj Wadhwani.

The practice has a small team of five part time staff consisting of a dentist, two dental hygienists, one dental nurse and a receptionist. There are two treatment rooms, a patient waiting area and a small reception area. It is situated in the centre of Cambridge in a busy shopping area. The provider leases the premises and is not planning to renew the lease once it expires in 2017. Plans are in place for the practice to merge with another of the provider's practices close by.

The practice opens on a Wednesday from 8am to 3.30pm, and on Thursdays and Fridays from 8am to 5pm.

Our key findings were:

- There was no separate decontamination room, access to the practice was only available via a steep staircase, there was no plumbing for hot water and one treatment room had been out of operation since March 2016 due to a leaking skylight.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Staff had been trained to handle emergencies and appropriate medicines were readily available in accordance with current guidelines
- Staff had received training appropriate for their roles and were supported in their continued professional development
- Patients were treated in a way that they liked and information about them was managed confidentially.

Summary of findings

- The practice had a programme of clinical and non-clinical audit in place.
- Staff felt well supported by the practice manager and the provider as a whole

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

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice.

There were areas where the provider could make improvements and should:

- Review the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of interviews and ensuring recruitment checks, including references, are obtained and recorded.
- Review the practice's 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.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the practice's protocols for completion of patients' medical histories giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.
- Review appraisal protocols to ensure that all clinicians working at the practice have their performance monitored and assessed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Staff had received safeguarding training and were aware of their responsibilities regarding protecting children and vulnerable adults. Significant events were recorded and learning from them was shared across the staff team. Risks to staff and patients had been identified and control measures put in place to reduce them.

Emergency medicines were checked to ensure they did not go beyond their expiry dates, however the practice did not have a full range of equipment to deal with common medical emergencies. Not all areas of the practice were visibly clean and hygienic and aspects of the practice's decontamination processes did not meet national guidance.

Are services effective?

No action

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

Patients commented that the quality of care was very good. Patients told us they were involved in decisions about their treatment and didn't feel rushed in their appointments. The dental nurse had worked at the practice for over 30 years and it was clear she knew patients well and had built up good working relationships with them. Patient information and data was handled confidentially.

Are services caring?

No action

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

Patients commented that the quality of care was very good. Patients told us they were involved in decisions about their treatment and didn't feel rushed in their appointments. The dental nurse had worked at the practice for over 30 years and it was clear she knew patients well and had built up good working relationships with them. Patient information and data was handled confidentially.

Are services responsive to people's needs?

No action

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

Although the practice was only open three days a week, patients could access appointments at another of the provider's practices. Emergency slots were available for patients experiencing dental pain. However, limitations of the premises meant that the practice could not meet the needs of wheelchair users or patients with restricted mobility.

Summary of findings

There was a clear complaints system and the practice responded appropriately and empathetically to issues raised by patients.

Are services well-led?

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

The practice had a number of policies and procedures to govern its activity and held regular staff meetings. Staff told us that they felt well supported and could raise any concerns with the practice owner and manager. However the number of gaps in quality and safety monitoring we found during our inspection demonstrated that some of the governance systems in place were not operating effectively.

Requirements notice 

Burleigh Street Dentistry

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 29 June 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the owner, the dentist, the practice manager, the dental nurse and the receptionist. We received feedback from three patients about the quality of the service, which included one comment card and two patients we spoke with during our inspection. We reviewed policies, procedures and other documents relating to the management of the service.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and a book was available to record any accidents. Staff told us that all significant incidents were reported to the practice manager. All incidents were then logged centrally by the provider, along with the action and learning outcomes for each one. Incidents were discussed at practice level but also used as learning for all the practices within the Antwerp Group. For example, as a result of a computer malware virus, all staff had been instructed not to open any email with unknown attachments.

National patient safety alerts were sent to the practice and checked by a specific member of staff to ensure that any required action from them was followed through. Staff we spoke with were aware of recent alerts affecting dental practice, and we saw that alerts had been signed as read by staff.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation. Policies were available to all staff, and clearly outlined who to contact for further guidance if they had concerns about a patient's welfare. Staff had received appropriate training in protecting patients and there was an appointed lead within the practice. Contact numbers for agencies involved in protecting people were easily accessible in the reception area.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The dentist we spoke with confirmed that they used rubber dams as far as practically possible.

Medical emergencies

The practice had arrangements in place to manage emergencies and records showed that all staff had received regular training in basic life support (BLS) and the receptionist told us she had BLS training the afternoon of our inspection. However, emergency medical simulations were not regularly rehearsed by staff so that they had a chance to practice what to do in the event of an incident. Medicines were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and all medicines were checked each week to ensure they were within date for use. However we found some adrenalin that had passed its expiry date and had not been removed.

The emergency equipment and oxygen were stored in central locations known to all staff. However we noted that some essential equipment was missing such as self-inflating bags, face masks, portable suction, spacer devices and oropharyngeal airways. There was no AED within the practice. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. However the practice manager ordered all missing equipment and the AED during our inspection .

Staff recruitment

We reviewed three recruitment files and found that most pre-employment checks had been undertaken for staff. For example, qualifications, registration with the relevant professional body and checks through the Disclosure and Barring Service (DBS). Insurance and indemnity checks were undertaken to ensure dental clinicians were fit to practise. However, the dentist had been recruited without any references having been obtained before they commenced their employment, and no notes were recorded of the interview held or the questions asked.

Monitoring health & safety and responding to risks

We viewed the practice's health and safety folder which contained detailed assessments for a range of risks including those for manual handling and the use of sharps. Fire detection and firefighting equipment such as extinguishers were regularly tested, and we saw records to demonstrate this**.** The practice had carried out a fire risk assessment in June 2016 and full evacuations of the premises were rehearsed to ensure that all staff knew what to do in the event of the fire alarm sounding. Electrical equipment had been tested in March 2016 to ensure its safety.

Are services safe?

A legionella risk assessment had been carried out in July 2015 and there was regular monitoring of cold water temperatures to ensure they were at the correct level. Regular flushing of the water lines was carried out in accordance with current guidelines, at the start and end of each day, and between patients to reduce the risk of legionella bacteria forming. There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for materials used within the practice. However, we noted that the cupboard where dangerous chemicals were stored was not locked to ensure they were held securely.

We noted that there was good signage throughout the premises clearly indicating fire exits, the location of emergency equipment, and X-ray warning signs to ensure that patients and staff were protected. Steep stairs had been hazard marked to make them more visible to patients.

Infection control

There was an infection control policy in place, however this was the provider's generic one and was not specific to the practice itself or the decontamination processes used by staff. Not all areas of the practice were visibly clean. The carpet in reception area was badly marked and stained. Staff could not tell us when it had last been cleaned or shampooed and the dental nurse told us it had not been cleaned since it was laid about 18 years ago. We noted large amounts of dust that had accrued around two sky lights. The external area where the clinical waste bin was stored was littered and dirty. We noted that cleaning equipment had not been stored in line with national guidance. There was no hot water available in the practice for hand washing, or the cleaning of manual instruments and brushes which should be washed in warm water.

The waiting area, corridor, stairway and reception office were clean and uncluttered. The patient toilet was clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked two treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and modern sealed work surfaces so they could be cleaned easily. There were foot operated bins and personal protective equipment available to reduce the risk of cross infection. We checked treatment room drawers and found that all instruments had been stored correctly and their packaging had been clearly marked with the date of their expiry for safe use. However we noted some loose and uncovered local anaesthetic solution in the treatment room drawer out with their blister packs. These were within the splatter zone, and therefore risked becoming contaminated over time.

The practice did not have a separate decontamination room for the processing of dirty instruments, so all instruments were cleaned in the treatment room. The dental nurse used a system of manual scrubbing for the initial cleaning process, following inspection they were placed in an autoclave (a device used to sterilise medical and dental instruments). However we noted that the manual scrubbing was not conducted in line with national guidance as there were not enough sinks/bowls to separate the scrubbing and rinsing of instruments. When instruments had been sterilized they were pouched and stored appropriately until required. The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

All dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection.

Clinical waste was stored externally prior to removal in a locked bin that was attached to a wall to the rear of the premises. The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this.

Staff told us they had suitable equipment to enable them to carry out their work. The dentist described the equipment provided as not the newest but perfectly functional. He had provided some of his own equipment such as a curing lamp and filling materials.

We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were

Are services safe?

always recorded in patients' clinical notes. Prescription pads were held securely and there was a system in place to monitor and track blank prescription forms through the practice.

There was a system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we reviewed demonstrated that the X-ray equipment was regularly tested and serviced. However evidence that the practice had informed the Health and Safety Executive (HSE) that it undertook radiography was not available during our inspection but the practice informed the HSE the day following our inspection, evidence of which we viewed.

A Radiation Protection Advisor and Radiation Protection Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available, which staff had signed. Those staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training.

We viewed a sample of dental care records which showed that the practice did not always record the justification or grade of the x-ray in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Our discussion with the dentist and review of four dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues. Antibiotic prescribing and patients' recall frequencies also met national guidance. However not all dental care records we reviewed contained an up to date medical history for the patient.

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping, infection control and waiting time for patients.

Health promotion & prevention

A number of oral health care products were available for sale to patients in the reception area including interdental brushes, toothpaste and dental floss. However information about oral health care for patients was limited as there were no leaflets or displays available in the waiting area about oral health care

Dental care records we observed demonstrated that dentists had given oral health advice to patients and that referrals to the hygienist were made if appropriate. Two part-time dental hygienists were employed by the practice to provide treatment and give advice to patients on the prevention of decay and gum disease. Patients also had access to the provider's oral health educator who was based at another practice nearby for advice and treatment.

Staffing

Staff we spoke with told us the staffing levels were suitable for the small size of the service and the dentist always worked with a dental nurse. However, the hygienists worked alone and without support of a dental nurse. We drew to the attention of the provider the advice given in the General Dental Council's Standard (6.2.2) for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

The practice had access to staff working in other Antwerp Group services nearby if needed to cover unexpected staff shortages. The practice manager was also a dental nurse and could provide additional support if needed.

Files we viewed demonstrated that staff were appropriately qualified, trained and where required, had current professional validation. Training certificates showed that staff had undertaken training including safeguarding vulnerable people, information governance and basic life support. However not all staff had received an annual appraisal of their performance and both the dentist and dental nurse reported they had never received an appraisal.

The practice had appropriate Employer's Liability insurance in place.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves A log of the referrals was kept centrally and a specific member of staff was responsible for co-ordinating and monitoring all referrals made with the group's practices. However, patients were not given a copy of their referral for their information. Urgent referrals were followed up with a phone call to ensure that they had been received.

Consent to care and treatment

Patients we spoke with told us that they were provided with good information during their consultation and that they had the opportunity to ask questions before agreeing to a particular treatment. Most patients were provided with a plan which outlined the proposed treatment and cost involved.

Staff told us they had received training in the Mental Capacity Act (MCA) provided by Cambridgeshire County Council. Staff we spoke with had a good knowledge of both the MCA and Gillick competencies, and how it related to their work with patients.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients we spoke with told us they were treated in a way that they liked by staff.

The practice's patient waiting area was completely separate to the main reception area allowing for good confidentiality. Computers were password protected and the computer screen was not overlooked which ensured patients' confidential information could not be viewed at reception. Conversations between patients and the dentist could not be heard from outside the treatment room which protected patient's privacy. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining their confidentiality. We observed that the receptionist was polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

The dental nurse had worked at practice for nearly 30 years and knew patients well. She often rang them personally to encourage them to make an appointment, especially if they had not attended in a long while. She also rang patients following complex treatment to check on their health and well-being. In one instance she had driven a patient who had broken their ankle to their home, to save the patient's husband having to collect her.

Involvement in decisions about care and treatment

Patients told us that their dental health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They reported that they felt listened to and supported by staff and had sufficient time during consultations. They confirmed that had been given a plan which outlined their treatment and its costs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients we spoke with were satisfied with the appointments system and told us that getting through on the phone was easy. One person told us he had been offered an appointment at another of the provider's practices when he couldn't be accommodated at Burleigh Street.

Information was available about appointments in the patient information leaflet. This included opening times, details of the staff team, fees and the services provided. The practice opened on Wednesdays from 8am to 3.30pm, and Thursdays and Fridays from 8am to 5pm. A half an hour emergency slot was available each day to accommodate patients who needed an urgent appointment, and patients could be fitted in between fixed appointments if needed. Patients were able to receive text or email reminders for their appointments.

Tackling inequity and promoting equality

The premises were not accessible to wheelchair users, but patients could be referred to another of the provider's practices nearby. Information about the practice was not available in any other languages, or formats such as braille or audio. There was no portable hearing loop to assist patients with hearing impairments, and the practice's steep stairs made it inaccessible to people with restricted mobility.

Concerns & complaints

The practice had a complaints' policy and a procedure that set out how complaints would be addressed, the timeframes for responding. Information about the procedure was available in the patient waiting room, however it did not contain details of other agencies that could be contacted such as the dental complaints service or the General Dental Council.

We viewed the practice's complaints' log which showed that two recent complaints had been dealt with in a responsive and empathetic way. Learning points had also been documented to ensure the complaint did not re-occur. A central log of complaints from all the practices in the Antwerp Group was held so that any themes or trends in complaints could be identify.

Are services well-led?

Our findings

Governance arrangements

The practice was very small and therefore came under the same governance and management system as the provider's Newmarket Road branch. The practice manager for Newmarket Road, also had management responsibility for Burleigh Road dentistry

There was a full range of policies and procedures in use at the practice and we saw that staff had signed to say they had read key policies in relation to health and safety, infection control, safeguarding and radiography. Updates to polices were discussed at the staff meetings and we noted that the Access to Records policy had been discussed at the meeting of May 2016.

Monthly staff meetings were held at the Newmarket Road site on a Monday. However none of the staff from Burleigh Road were able to attend as the practice was closed on this day. The practice manager told us she was going to review this, and perhaps change the date of the meeting to allow staff from Burleigh Road to attend. Staff told us that they did receive minutes of the meetings, even though they did not attend and reported that communication systems were good.

A weekly and monthly management reporting system was in place to ensure the provider was kept up to date with key issues in each of his seven practices, and a web based management tool had recently been introduced to help staff track their work. A mystery caller was used to check that patients were given the correct information from reception staff, and findings were shared at specific administrative meetings involving staff from all sites. However, on the day of the inspection we identified a number of areas that required improvement. These included the checking of medical emergency equipment and medicines; the quality of dental care records; the robustness of recruitment procedures, and ensuring infection control and decontamination systems met national guidance. This demonstrated that some of the governance systems in place were not operating effectively.

Leadership, openness and transparency

Staff told us they enjoyed their work and the small size of the practice which meant that communication systems were good. They told us they felt supported and valued in their work and reported there was an open culture within the practice. They reported that they had the opportunity to, and felt comfortable, raising any concerns with the practice manager or owner of the practice who were approachable and responsive to their needs.

One staff member told us that her job had been re-evaluated and changed to make it less stressful for them: something they had greatly appreciated. Another, that they had received excellent support when learning how to use the provider's computerised records system.

Learning and improvement

The provider ran his own educational academy which provided a forum for training and research discussion on a range of issues. Regular audits and checks were undertaken to ensure standards were maintained in a range of areas including radiography, infection control and the quality of clinical records.

All the staff we spoke with felt supported by the practice and reported that they were encouraged to develop their knowledge and skills. One dental nurse told us she had received lots of training in the previous two years, since the provider had taken over ownership of the practice.

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

The practice regularly monitored patient comments left on the NHS choices web site. The practice also participated in the NHS Friends and Family Test, and recent results were on display in the patient waiting area. Results of patients' reviews on NHS Choices and Google were discussed at the practice staff meetings, evidence of which we viewed.

The practice gathered feedback from staff through staff meetings, appraisals and discussion. The provider had recently conducted a staff survey across all the practices in the group to find out staffs' views on their job satisfaction, their training and development, the recognition of their work and the support received from their manager.

Staff told us that the provider listened to them and implemented their suggestions. For example, one staff member suggested that the process for confirming appointment times with patients was changed and this had been implemented.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HCSA 2008 Regulations 2014 Good Governance** How the regulation was not being met: The provider did not operate effective systems and processes to ensure compliance with the regulations. The provider did not have effective systems in place to assess and monitor the quality of clinical care. This included the checking of medical emergency equipment and medicines; the quality of dental care records; the robustness of recruitment procedures, and ensuring infection control and decontamination systems met national guidance. **Regulation 17 (1)**