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Orthodontic Centre Hayes

Inspection Report

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Overall summary

We carried out this unannounced inspection on 11 October 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We re-visited the practice on 18 October 2018 to gather further evidence. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found 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

Orthodontic Centre Hayes is in the London Borough of Hillingdon and provides private orthodontic treatment to adults and children. Orthodontic Centre Hayes has a fee sharing contract with another dental provider for the premises. The orthodontic practice is located on the first floor.

The dental team includes the principal dentist. The principal dentist told us that they had not seen patient within the last six months, There were no other staff

Summary of findings

members employed at the practice on the day of inspection. We were told that agency nurses and nurses from the other provider will be used if the provider sees patients in the future.

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.

At the time of the inspection and for six months preceding it, the provider had not been seeing patients so we were unable to gather any comments. We inspected the practice in response to information shared with us by NHSE.

During the inspection we spoke with the principal dentist. We spoke with the practice manager, principal dentist and one dental nurse from the other location to confirm the current arrangements in place.

The practice is open whenever patients are booked in for treatment

Our key findings were:

- The practice appeared clean and well maintained.
- The principal dentist knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems to help them manage risk. Improvements were needed so that the practice reviewed and learned from external safety alerts and information,
- The practice had suitable safeguarding processes and the principal dentist knew their responsibilities for safeguarding adults and children.
- The practice had arrangements to provide preventive care and supporting patients to ensure better oral health.
- The practice dealt with complaints positively and efficiently.
- The practice had infection control procedures which reflected published guidance.
- Improvements were needed to the arrangements for monitoring the quality of dental radiography.

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

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

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

There was as an area where the provider could make improvements. They should:

- Review the current staffing levels and ensure the practice can provide routine appointments in a timely manner to its patients.
- Review the practice's protocols for referral of patients and ensure referrals are monitored suitably.

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.

The practice had systems and processes to provide safe care and treatment.

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

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

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

Premises and equipment were clean and 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 principal dentist told us they discussed treatment with patients so they could give informed consent.

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

The principal dentist in the past had supported staff to complete training relevant to their roles and had systems to help them monitor this. Systems were in place for the future if new staff member came on board.

Are services caring?

No action

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

The principal dentist said they would give helpful, detailed and clear explanations about orthodontic treatment that would be carried out in the future.

The practice had procedures to protect patients' privacy and the principal dentist was aware of the importance of confidentiality.

Are services responsive to people's needs?

No action

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

Summary of findings

The principal dentist told us that patients could get an appointment quickly if needed.

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

Are services well-led?

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 Requirement Notices section at the end of this report).

The practice had some arrangements to ensure the smooth running of the service.

We were unable to review any dental care records as the provider told us they had not seen patient for over 6 months. All dental care records had been removed from the practice by NHSE.

Improvements were needed to the systems to monitor non-clinical areas of their work to help them improve and learn.

Requirements notice 

Are services safe?

Our findings

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

The practice had clear systems to keep patients safe.

The principal dentist 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. There were procedures in place to ensure that staff who supported the principal dentist undertook safeguarding training and were supported to recognise and report any concerns about the safety and wellbeing of patients.

There was a system to highlight vulnerable patients in their records e.g. adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who required other support such as with mobility or communication.

The practice had a whistleblowing policy.

The practice had a staff recruitment policy and procedure to help them employ suitable staff

We noted that the principal dentist was qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. There were arrangements to ensure that temporary staff working at the practice were registered with the GDC and suitably qualified.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection and firefighting equipment such as fire extinguishers were regularly tested.

The practice had suitable arrangements to ensure the safety of the radiography equipment. They met current radiation regulations and had the required information in their radiation protection file.

The principal dentist had completed continuing professional development (CPD) in respect of dental radiography.

Improvements were needed to ensure that radiography audits were carried out in line with current legislation and guidance. There were no audits available to demonstrate that the provider monitored the quality of dental radiographs and used the results of audits to make improvements as required.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were up to date and had been reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The principal dentist followed relevant safety regulation when using sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

The provider had a system in place to ensure any staff assisting the principal dentist had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. The principal dentist knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support (BLS) every year.

Emergency equipment and medicines were available as described in recognised guidance. records of their checks to make sure these were available, within their expiry date, and in working order were in place

The principal dentist told us that a dental nurse worked with them when they treated patients in line with GDC Standards for the Dental Team

Suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health were in place

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. The principal dentist and any staff helping the provider had completed infection prevention and control training and received updates as required.

Are services safe?

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. Cleaning staff attended daily and information was displayed in each surgery relating to what needed to be covered on each visit. The practice was clean when we inspected and patients confirmed that this was usual.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. As the dentist had not been seeing patients for the last six months, no current dental care records were available for us to confirm if they were written and managed in a way that kept patients safe.

Safe and appropriate use of medicines

The principal dentist did not prescribe any medicines but was aware of current guidance with regards to prescribing them.

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues; these were updated regularly. The practice monitored and reviewed safety incidents. The practice had arrangements so that safety incidents were investigated, documented and shared where appropriate to prevent such occurrences happening again in the future. This helped it to understand risks that would lead to safety improvements.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

Improvements were needed to the systems for receiving, reviewing and acting on external safety events as well as patient and medicine safety alerts.

There was no system in place for receiving and acting on medical safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep up to date with current evidence-based practice. The principal dentist told us they assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The principal dentist was aware of guidelines around preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The principal dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The principal dentist understood the importance of obtaining and recording patients' consent to treatment. The principal dentist told us that they gave patients information about treatment options and the risks and benefits of these so that they could make informed decisions. .

The practice's consent policy included information about the Mental Capacity Act 2005. The principal dentist 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, by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

We were unable to review any current dental care records containing information about the patients' current dental needs, past treatment and medical. However the principal dentist told us they assessed patients' treatment needs in line with recognised guidance.

Effective staffing

The principal dentist had the skills, knowledge and experience to carry out their roles. The principal dentist told us that if staff were to be employed in the future they would be given a period of induction based on a structured induction programme. We confirmed that the principal dentist had completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

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

The principal dentist confirmed that they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems and processes for 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.

Improvements were needed so all referrals were monitored to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

The principal dentist was aware of their responsibility to respect people's diversity and human rights.

Privacy and dignity

The principal dentist was aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when staff were dealing with patients.

They stored paper records securely.

Involving people in decisions about care and treatment

The principal dentist told us they gave patients clear information to help them make informed choices and described the conversations they had with patients to satisfy themselves they understood their treatment options.

The principal dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, pictures, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice took account of patients' needs and preferences and organised and delivered its services to meet their needs.

The principal dentist was clear on the importance of emotional support needed by patients when delivering care.

Timely access to services

The practice had procedures to ensure that patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The principal dentist told us the practices' answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

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 complaints.

The principal dentist told us that they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. A copy of the complaints procedure and information about organisations patients could contact if not satisfied with the way the practice dealt with their concerns, was displayed in the patient waiting area.

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

Are services well-led?

Our findings

Leadership capacity and capability

The dental practice was small and the principal dentist was responsible for the overall clinical leadership and day to day management of the service.

Due to ongoing concerns that the practice was failing to complete patients' dental treatments NHS England (NHSE) had recently terminated the practice's NHS contract so that the dentist could no longer provide treatment to NHS patients.

As a result of the loss of the NHS contract the principal dentist told us that they had been forced to make the staff team redundant. They told us that they would access staff from the dental teams who shared the location or employ temporary staff should they treat privately paying patients.

Vision and strategy

The principal dentist told us that they had a clear vision and set of values. Improvements were needed so that the practice had a realistic strategy and supporting procedures to achieve priorities in the delivery of patient care and treatment.

Governance and management

Improvements were needed to support good governance and management within the practice.

The provider had some systems of clinical governance in place which included policies, protocols and procedures; however improvements were needed as the principal dentist relied on the other providers at the practice to keep theses updated.

There were clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

The practice had some systems to act on appropriate and accurate information. Improvements were needed so that the practice received and acted on external information to support quality and safety improvements.

Engagement with patients, the public, staff and external partners

The practice had in the past used patient surveys, to obtain staff and patients' views about the service.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

Improvements were needed to ensure quality assurance processes to encourage learning and continuous improvement were in place, including for example undertaking a radiology audit.

We saw that the principal dentist had completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking in-house medical emergencies and basic life support training annually.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance.** Systems and processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** There were limited systems and processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: There were ineffective systems in place to monitor the provision of services to ensure that the practice could deliver care and treatment and complete dental treatments in a safe and timely manner. • Audits were not carried out in line with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 to ensure the quality of grading, justification and reporting in relation to dental radiographs. • There were limited arrangements for reviewing, acting on and using reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA)

This section is primarily information for the provider

Requirement notices

and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE) to improve the safety of services offered.