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Fair Green Dental Practice

Inspection Report

Fair Green Dental Practice
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Overall summary

We carried out this announced inspection on 11 June 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Fair Green Dental Practice is a well-established service based in Diss and offers NHS general treatment to approximately 16,000 patients. Another provider is located at the same address, and although registered separately, they both operate as one practice, with shared expenses, staff and governance arrangements.

The dental team across both providers consist of two dentists, three dental nurses, and a receptionist. There

Summary of findings

are two treatment rooms. The practice opens on Mondays to Thursdays from 8.30 am to 5.30 pm, and on Fridays from 8.30 am to 4.30 pm. There is portable ramp access for wheelchair users and parking close by.

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

On the day of inspection, we collected 44 CQC comment cards filled in by patients and spoke with another three.

During the inspection we spoke with both dentists, two nurses and the receptionists. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- Staff treated patients with dignity and respect, and we received many positive comments from patients about the caring and empathetic nature of the dentists.
- The practice was small and friendly, something which both patients and staff appreciated.
- The practice appeared clean and well maintained.
- The appointment system met patients' needs and patients could get an emergency appointment easily.
- Staff recruitment procedures were not robust and staff had been employed without appropriate checks having been obtained.
- Patient dental care records did not reflect standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- The management of risk in the practice was limited and identified hazards had not been managed adequately.
- The practice's infection control procedures did not comply with national guidance.

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

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

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

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

- Review the practice's protocols for the use of dental dams for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking X-rays, a report on the findings and the quality of the image in compliance with Ionising Radiation (Medical Exposure) Regulations 2017.
- Review the practice's protocols for monitoring and recording the fridge temperature to ensure that medicines and dental care products are being stored in line with the manufacturer's guidance.
- Review staff understanding of the Mental Capacity Act and Gillick competency guidelines so that they are aware of their responsibilities in relation to them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requirements notice 

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Not all staff had received appropriate training in the protection of vulnerable adults and the practice's policies and procedures had not been regularly reviewed and updated. Staff recruitment procedures were not robust and essential pre-employment checks had not been completed.

Dental dams were not used routinely to protect patients' airways during root canal treatment.

The practice had arrangements for dealing with medical and other emergencies, although some equipment was not fit for safe use and checks of it were not as frequent as recommended in national guidance.

Some of the practice's infection control procedures did not follow recognised national guidance.

Risk assessment within the practice was limited and recommendations to protect patients and staff were not always followed.

Are services effective?

No action

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

We received many comments from patients indicating that they had received effective treatment. However, some dental care records we viewed lacked detail and required improvement to demonstrate that the dentists were following national professional guidance.

Staff did not have a clear understanding of the Mental Capacity Act 2005, or of Gillick competence guidelines and how this might impact on patients' treatment decisions.

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

Are services caring?

No action

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

We received feedback about the practice from 47 patients. Patients spoke highly of the practice's staff and had clearly built up strong relationships with them over the years. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist. They also valued the continuity of care they received from their dentist.

Summary of findings

Are services responsive to people's needs?

No action

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

The practice's appointment system took account of patients' needs and they could get an appointment quickly if in pain.

The practice had made some reasonable adjustments to accommodate patients with disabilities including a downstairs treatment room. However, there was no accessible toilet, or hearing loop to assist those patients with hearing aids. Information was not available in any other languages or formats such as large print.

We were not able to assess how the practice managed patients' complaints as staff stated none had been received.

Are services well-led?

Requirements notice 

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

We found a significant number of shortfalls in key questions we inspected, indicating that the practice was not well-led. Staff were not following current best practice guidance in several areas including dental record keeping, recruitment, medicines management, risk assessment and infection control. There was limited understanding of NICE guidelines and amalgam regulations amongst the dentists.

Policies and procedures to govern activities had not been regularly reviewed or updated..

There were no robust systems to assess and monitor the quality of service provision. None of the staff had received an appraisal of their working practices.

Are services safe?

Our findings

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

The practice had some safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. However, these concerned the protection of children only, and there was no guidance available in relation to vulnerable adults. The information was also out of date and not been reviewed for some years. There was no named lead in the practice for safeguarding and not all staff had received appropriate safeguarding training.

We found that the dentists did not always use dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. No dental dams were available for patients who might be allergic to latex. Root canal irrigation solution was not in-keeping with recommended guidance.

The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running. This was not kept off site, so it could be accessed in the event of an incident. Although it had been reviewed, it referenced health care organisations that no longer existed.

The practice had a recruitment policy in place which reflected relevant legislation, although the policy was not being followed. We viewed the personnel files for two staff. One had been employed without any references or record of their interview. Another staff member had been employed without a DBS check, references or photograph proof of their identity.

At the time of our inspection a fire risk had just been completed and the practice was in the process of implementing its recommendations. Staff practiced timed fire drills every few months, although none had received any fire or extinguisher handling training. There was insufficient signage to indicate that compressed gas was stored in the building. Fixed wire testing had last been completed in 2010 and had not been undertaken every five years as recommended.

The provider had some risk assessments in place for the control of substances that were hazardous to health (COSHH). However, the folder was very untidy, making information difficult to find and its contents had not been reviewed since 2011.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. However, there was no rectangular collimation on one X-ray unit to reduce patient exposure. We found limited recording of the justification on taking X-rays in the patient notes we viewed.

Risks to patients

A general risk assessment had been completed for the practice, but its recommendations to visually inspect electrical equipment every six months and for staff to have moving and handling training had not been implemented.

The dentists were using the safest types of needles to prevent injury. A specific sharps risk assessment had been undertaken but was limited in scope and its application. It only identified risks in relation to the use of needles and did not include other instruments such as matrix bands, scalpels and scissors. Although not wall mounted, sharps boxes were sited safely.

Staff had completed yearly training in resuscitation and basic life support, although did not regularly rehearse emergency medical simulations so that they had an opportunity to practise their skills. Most emergency equipment and medicines were available as described in recognised guidance, however we noted the following shortfalls:

- Some airways were very out of date for safe use.
- One oxygen cylinder had become out of date for safe use. The other oxygen cylinder was not fit for purpose as it was undated. We noted that the clear plastic mask that accompanied it was yellow with age and its elastic was perished.
- The practice's AED was only checked once a month, and not weekly as recommended in national guidelines. These checks were not logged. There were no scissors or razor available with it.
- Glucagon was not easily accessible in the event of an emergency as it was stored in a locked garage outside the premises.

Are services safe?

- Aspirin was available but not dispersible as recommended
- Buccal Midazolam was not available in the recommended format or dosage.

A first aid, eye wash kit and mercury spillage kit was available, although we noted the mercury spillage kit had become out of date in 2006. The eye wash solution was about to become out of date: there was no way of staff to identify this as they did not regularly check its contents.

We noted that all areas of the practice were visibly clean, including the waiting area, toilet and staff area. Hand sanitiser was available on the reception desk for patients to use. We checked both treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. We found uncovered instruments and local anaesthetics in treatment room drawers that risked aerosol contamination.

Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. However, one dentist told us he wore the same trousers for both work and home, compromising infection control.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments which were mostly in line with national guidance. However, we noted the following shortfalls:

- Infection control audits were carried out, but not as frequently as recommended in national guidance.
- The practice had not produced an annual infection control statement.
- Staff were not measuring the amount of solution they used to clean water lines.
- Staff were not measuring the amount of solution they used when manually cleaning instruments.
- Staff were not testing the water temperature when manually cleaning instruments.
- Clean and dirty areas had not been identified in decontamination and treatment rooms.
- Staff were not using a lint free cloth to dry instruments.
- Staff were not checking hot and cold-water temperatures each month.
- We noted a nail scrubbing brush by the hand wash sink.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A full legionella risk assessment had been undertaken in 2012 but had not been reviewed since this time. Its recommendations to lag the pipework and undertake monthly water testing had not been implemented.

Safe and appropriate use of medicines

The fridge's temperature, in which Glucagon was kept, was not monitored to ensure it operated effectively. Prescription pads were not held securely and there was no tracking in place to monitor individual prescriptions to identify their theft or loss. An antimicrobial audit had not been undertaken to assess if staff were prescribing according to national protocols.

Staff were not aware of the yellow card scheme for reporting adverse reactions to drugs or defective medicines.

Lessons learned and improvements –

We found that staff had a limited understanding of what might constitute an untoward event and were unclear about national reporting requirements. One clinician told us they had never heard of the term 'Never Event'. We noted that three sharps injuries had been recorded in the accident book, but there was no evidence to show how learning from them had been shared to prevent a recurrence.

We were told that one dentist received MHRA and national patient safety alerts but there was no clear system for disseminating them to ensure all staff had seen and read them.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 47 comments cards that had been completed by patients prior to our inspection. The comments received reflected that patients were very satisfied with their treatment and the staff who provided it. One patient commented, 'the treatment is first class, even the unpleasant parts are made less uncomfortable by the staff's attitude'. Another patient stated, 'My broken tooth was seen to quickly and repaired effectively'.

Our review of dental care records indicated that patients' dental assessments and treatments were not always carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC). For example, the findings from intra and extra oral assessments were not always recorded. Patients' risk of caries, periodontal disease, oral cancer and non-carious tooth loss had not been recorded consistently to inform patient recall intervals.

Audits of the quality of dental care records were undertaken but they had not been effective in identifying the shortfalls we found during our records' review.

Helping patients to live healthier lives

We noted some information in the waiting area for patients in relation to oral health, and free samples of toothpaste were available. One nurse had visited a local primary school to deliver a session on oral health to the pupils there. Children were encouraged to colour in age appropriate posters in relation to their oral health.

We found clinicians had a limited understanding and awareness of the Department of Health's guidance, Delivering Better Oral Health toolkit. The dentists told us they gave oral health advice to patients, but dental care records we reviewed did not always demonstrate this. It was not clear from the notes if they used fluoride varnish for children and adults based on an assessment of the risk of tooth decay.

Consent to care and treatment

Patients confirmed their dentist listened to them and gave them clear information about their treatment. One stated, 'Treatment at all times explained, taking into account my on-going medical treatment'.

We found that staff did not have an adequate understanding of the Mental Capacity Act and its implications when treating patients who might not able to make decision for themselves. Staff were also unaware of Gillick competence guidance and its implications when treating young people.

Effective staffing

Staff told us there were enough of them for the smooth running of the practice and to allow for annual leave. The nurses told us they never felt rushed in their work.

Staff new to the practice had a period of induction based on a structured programme. Staff training records we viewed showed that not all had undertaken essential training in safeguarding vulnerable adults, information governance, patient consent and fire safety.

Co-ordinating care and treatment

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

The practice did not actively monitor non-NHS referrals to make sure they were dealt with promptly. Patients were not routinely offered a copy of their referral for their information.

Are services caring?

Our findings

Kindness, respect and compassion

We received many positive comments from patients about the caring nature of the practice's staff. Patients described staff as friendly, attentive and reassuring. One patient told us, 'I'm impressed by the positivity of staff and their non-judgemental attitude towards people who should have taken more care of their teeth in the past'. Another commented, 'Brilliant with the children, helped them to feel so at ease'.

Throughout our inspection we found that the receptionist was consistently helpful, polite and friendly to patients both on the phone, and face to face.

Privacy and dignity

The reception area was not particularly private, but the receptionist told us some of the practical ways they helped maintain patient confidentiality. We noted a poster on display advising patients they could request to speak in a private room if needed. All consultations were carried out in the privacy of the treatment rooms and we noted that the doors were closed during procedures to protect patients' privacy. We noted blinds were on the window to prevent passers-by looking in.

Patients' records were stored in fire proof filing cabinets which were locked each night.

Involving people in decisions about care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment. One commented, 'Staff always listen to what I have to say and act accordingly. Another told us, 'He explains things to me and any treatment needed. Very reassuring'. However, dental records we reviewed did not always show what treatment options had been discussed with patients, or document the consent process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The waiting room contained magazines for patients to read and a specific children's area with books and colouring in materials to keep them occupied whilst waiting.

The practice had made some adjustments for patients with disabilities. There was portable ramp access to the entrance and ground floor treatment rooms. However, the toilet was not fully accessible and there was no hearing loop to assist patients with hearing aids. Information about the practice was not produced in any other formats or languages.

Timely access to services

Reception staff told us that the dentists were good at running to time and patients rarely waited, having arrived for their appointment. Patients' comments cards we received also reflected this. 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.

At the time of our inspection the practice was not able to take on any new NHS patients. The waiting time for a routine appointment was about two weeks, as was the time for treatment. The practice did not have any system in place to remind patients of their appointments and the receptionist told us that patients had failed to attend 16.5 hours' worth of appointments in the last month.

Emergency appointments were available daily and each dentist had one slot available in the morning and in the afternoon.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales and other agencies that could be contacted. Information about how patients could raise their concerns was available in the waiting room, making it easily accessible.

It was not possible for us to assess how the practice dealt with patients' complaints, as we were told none had been received by either dentist in the previous few years.

Are services well-led?

Our findings

Leadership capacity and capability

Staff told us the dentists were approachable and responsive, and described close working relations with them.

Although two dentists worked at the practice providing one service, each was registered with us separately in their own right. Each had overall responsibility for both the management and clinical leadership of the practice. As there was not a dedicated practice manager, they had taken on most managerial tasks themselves and it was clear they had struggled to keep on top of administrative and governance procedures.

Culture

The practice was small and friendly and had built up a loyal and established patient base over the years. Staff told us they enjoyed their job and felt valued in their work.

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

Governance and management

The practice did not have robust governance procedures in place. We found that staff worked in relative isolation and had not kept up to date with current dental practices and guidelines. We identified a number of shortfalls during our inspection including the recruitment of staff, the quality of dental care records, infection control procedures and the availability of medical emergency equipment, which demonstrated that governance procedures in the practice were ineffective.

Although the practice had policies in place, these were very generic, and many had not been reviewed since 2011. Some referred to health organisations that no longer existed. There was no evidence to show that staff had read and understood the polices. Risk assessment was limited, and we noted a few identified hazards within the practice that had not been addressed.

Communication systems between staff were very informal and there were no regular practice meetings to share key messages or discuss the practice's procedures and policies. Staff told us they would value regular meetings to ensure consistent communication across the team.

Engagement with patients, the public and external partners.

Prior to our inspection we asked the practice to gather examples of where they had implemented staff and patients' suggestions, however we were not provided with any.

Although the practice did not complete its own survey, patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. It was not clear how the results were used to drive improvement as they were not actively shared with the patients or staff.

Continuous improvement and innovation

The practice paid for staff's on-line training with an accredited training provider. However, none of the staff received a regular appraisal so it was not clear how their performance was assessed, or their training needs identified.

The practice did not have robust quality assurance processes to encourage learning and continuous improvement. Audits did not follow national guidance and their results were not effectively analysed and used to drive improvement. The dental records and infection control audits had failed to identify many of the shortfalls we noted and were not consistent with our findings. There was no evidence of resulting action plans and improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12- Safe Care and Treatment.** **Care and treatment must be provided in a safe way for service users** **How the regulation was not being met** **The practice did not have policies in place in relation to the protection of vulnerable adults. Not all staff had received relevant safeguarding training.** • Some emergency medical equipment was not fit for purpose and checks of it were not undertaken as frequently as recommended in national guidance. • Some of the practice's infection control procedures did not meet the Department of Health's Technical Memorandum 01-05: Decontamination in primary care dental practices • NHS prescription pads were not held securely, and no system was in place to monitor and track their use. • Fixed wire testing had not been completed every five years. • Recommendations from the practice's Legionella assessment had not been implemented. **Regulation 12 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

In particular:

· There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.

- There were no robust recruitment systems in place to ensure that only fit and proper staff were employed by the practice.
- There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice.

· Audits of dental care records, antibiotic prescribing and radiography were not effective in identifying shortfalls and areas for improvement.

- Risk assessment was not robust and identified hazards within the practice had not been addressed.
- There was no effective system to ensure the practice's policies and procedures were regularly reviewed and updated.
- There was no system in place to ensure staff received regular appraisal of their performance and to identify any learning and development needs.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1)