Bridge The Gap (Harris) Ltd

Gestridge Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 1 August 2017 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.

We told Healthwatch that we were inspecting the practice. They did not provide any information.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Gestridge Dental Practice is in Kingsteignton and provides private treatment to patients of all ages.

There is level access for people who use wheelchairs and pushchairs. Car parking spaces are available near the practice.

The dental team includes one dentist, two dental nurses, one receptionist and one medically trained doctor who provides a conscious sedation service to patients on a sessional basis. The practice has one treatment room.

Summary of findings

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Gestridge Dental Practice was the dentist.

On the day of inspection we collected 50 CQC comment cards filled in by patients. This information gave us a positive view of the practice.

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

The practice is open:

- Tuesday 8am – 6pm.
- Wednesday and Thursday 9am – 6pm
- Friday 8am – 2pm.

Our key findings were:

- Staff treated patients with dignity and respect.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.
- Patient care records were not always completed fully.
- Recruitment records were not complete for all staff.
- Checks and maintenance on equipment used in the practice were not consistently performed.
- Policies informing procedures and practice were not always up to date.
- Policies and procedures for the delivery of conscious sedation were not robust.

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. For example, in the monitoring of medicines management in the practice.
- Ensure care and treatment is provided in a safe way to patients, in particular when treating patients for conscious sedation, completion of essential recruitment checks for all staff employed and provision of essential training for staff relevant to their roles.

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 rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Introduce protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requirements notice 

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

The practice had systems and processes to help them manage safe care. Following the inspection visit improvements have been made with respect to the management of Legionella and fire safety.

Not all staff had received appropriate training in safeguarding. However, the dentist knew how to recognise the signs of abuse and how to report concerns.

Recruitment records were not complete for all staff members.

Premises and equipment were clean.

Checks on equipment and medicines were not always completed. For example, electrical systems and medicines.

There were systems for following national guidance for cleaning, sterilising and storing dental instruments, but improvements could be made.

Are services effective?

No action

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

Patients described the treatment they received as attentive and reassuring. The dentist discussed treatment with patients so they could give informed consent. This was not always recorded in their records.

Improvements could be made to ensure the full and consistent completion of patient care records, in particular with respect to medical histories and oral examination checks.

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

The practice supported staff to complete training relevant to their roles but the systems to help them monitor this were ineffective as there were staff training gaps.

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 50 people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind

Summary of findings

and friendly. They said that they were given helpful explanations about dental treatment, and said the 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.

Are services responsive to people's needs?

No action ✓

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

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

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

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

Are services well-led?

Requirements notice ✗

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

There were ineffective systems and processes to ensure good governance in accordance with the fundamental standards of care. Particularly in relation to robust systems to audit clinical procedures and patient care records.

Conscious sedation for anxious patients was not managed in accordance with national guidelines. For example, in the arrangement for assessment, providing written consent for treatment and in record keeping whilst treatment was taking place. Not all staff assisting had completed training in conscious sedation.

Staff told us there was an open culture at the practice and were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service. Survey results showed that patients were satisfied with the service and had no suggestions for improvements.

Patient dental records were stored securely. Improvements could be made to ensure the full and accurate completion of records.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. The practice recorded, responded to and discussed all incidents to reduce risk and support future learning. We were told that there had not been any significant events at the practice.

At the time of the visit the dentist told us that the practice was not signed up to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). However, the dentist took immediate action to register with this service and said relevant alerts would be discussed with staff, acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

The 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. The dentist knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination. Improvements could be made with staff completing safeguarding training. Records showed that one staff member had not received any safeguarding training and two other staff had completed training in the safeguarding of adults only. We raised this with the dentist. They wrote to us confirming that outstanding training for staff in safeguarding would be completed by the end of August 2017.

We looked at the practice's arrangements for safe dental care and treatment. The practice followed relevant safety laws when using needles and matrix bands. Improvements could be made to follow current guidance when performing root canal treatments. The dentist did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. They used a parachute chain devise to secure the dental devise being used during the root canal treatment. We discussed the recommendation of using rubber dams with the dentist.

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

Medical emergencies

Staff told us that they completed training in emergency resuscitation and basic life support every year.

We looked at the emergency equipment and medicines available. Records of checks were complete for oxygen, the defibrillator and emergency medicines. We found some out of date syringes, some duplicate supplies of medicines that had expired and guidance flow charts within the emergency kit that did not reflect current guidance.

The practice carried out conscious sedation for patients who would benefit. This included patients who were very nervous of dental treatment and those who needed complex or lengthy treatment The dentist told us that the sessional sedationist brought medicines for the sedation and equipment, including emergency equipment, to the practice for each session. We were shown photographs of the equipment. There were no records of maintenance or calibration of the equipment to demonstrate its suitability for use. We raised this with the dentist, who wrote to us after the inspection and showed us evidence they had purchased their own blood pressure monitor and blood oxygen saturation machine for use during the sedations and they would ensure the equipment was maintained.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We looked at three staff recruitment files. In two files the practice followed their recruitment procedure. In one there was an absence of checks on training relevant to the role as part of on-going professional development, no references or Disclosure and Barring Service background check.

Clinical staff were qualified and registered with the General Dental Council (GDC), or other professional body where relevant, and had professional indemnity cover.

Monitoring health & safety and responding to risks

Are services safe?

The practice had a range of health and safety policies and risk assessments to help manage potential risk. These covered general workplace and specific dental topics. Improvements could be made to review some of the policies and procedures, for example with respect to conscious sedation, as this policy was not up to date and suitable.

The practice had an integrated fire safety detection and alarm system. This was maintained on an annual service contract. Records showed that fire drills took place regularly; the latest took place in April 2017. Weekly testing of the fire alarm had not been taking place. Following the inspection the provider sent us records to show weekly testing was now on-going. We noted that designated fire escape routes were compromised by office equipment and the reception desk in the corridor to the front of the building. We noted that the latest fire risk assessment, dated June 2017, did not include an assessment of patients whose ability to leave the premises during an emergency may be compromised, due to being sedated. We raised these issues with the dentist. They wrote to us to tell us that a revised fire risk assessment had been completed by an outside fire specialist. They also sent us the revised risk assessment, which now included a fuller assessment of risk and control measures implemented at the practice.

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

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

Infection control

The practice had an infection prevention and control policy and procedures. Improvements could be made to follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments. There was a dedicated decontamination room for the cleaning, sterilising and processing of dental instruments. We noted that this room was cluttered, which may compromise the effectiveness of the dirty to clean flow in the room. Records showed equipment staff used for cleaning and sterilising instruments was maintained. Start of day checks for autoclaves were not performed to current practice guidance. We discussed this with the dentist, who made arrangements to change the practice policy and procedures to ensure start of day checks were robustly completed.

The practice had not been carrying out an infection prevention and control audit twice a year. The latest audit was dated April 2014. We raised this with the dentist, who said the audits would re-commence twice yearly. Following the inspection they wrote to us enclosing a completed audit dated completed during August 2017.

The practice had a procedure to reduce the possibility of Legionella or other bacteria developing in the water systems. For example, the dentist told us that they monitored water temperatures from outlets on a monthly basis (but did not record this). However, we were also told that there was no Legionella risk assessment for the premises to inform such control measures. We raised this with the dentist. They wrote to us to tell us that they had arranged for a contractor to complete a Legionella risk assessment of the dental practice on 13 August 2017. They said this assessment would then inform policy and subsequent Legionella control measures.

Equipment and medicines

We saw servicing documentation for the equipment used. Improvements could be made as some equipment servicing was overdue, for example, the five yearly electrical hard-wiring check. We raised this with the dentist. They wrote to us to tell us that this check would be carried out during September 2017.

The practice had systems for prescribing, dispensing and storing medicines but improvements could be made. The dentist was using the antibiotic Erythromycin as a treatment for all dental infection (unless allergy prevented this). Erythromycin is not recommended as a first line treatment. We discussed this with the dentist. They agreed to review their prescribing practice in line with NICE guidance and wrote to us to tell us that they had changed their prescribing regime at the practice.

There was no auditing of medicines prescribing to inform current practice. Following the inspection we were sent a copy of a self-audit completed in August 2017. The audit concluded that patients had received antibiotics based upon appropriate clinical screening and assessment. We

Are services safe?

found some out of date antibiotics stored in the medicines fridge and we brought this to the attention of the dentist, for them to arrange disposal. There were no systems in place for checking medicine stocks.

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

Radiography (X-rays)

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

We saw evidence that the dentists justified, graded and reported on the X-rays they took.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept written dental care records containing information about the patients' current dental needs, past treatment and medical histories. During the course of our inspection we checked dental care records to confirm the findings. Improvements could be made to ensure that assessments of oral examination and risk are consistently recorded.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health. The dentist was aware of the Delivering Better Oral Health toolkit guidance document.

The dentist 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 dentist told us 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 had a period of induction based on a structured induction programme tailored to their job role. However, we noted that the induction did not always cover mandatory training. For example, one staff member had not complete safeguarding training as part of their induction. We raised this with the dentist who arranged for this training to take place.

Clinical staff had not all completed the continuous professional development required for their registration with the General Dental Council. For example, the dental nurse assisting with conscious sedation had undertaken no training in this area.

Staff told us they discussed training needs at annual appraisals. We saw evidence of completed appraisals.

Working with other services

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

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment, although we saw that in patient care records that consent to treatment was not always recorded.

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 dentist was aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were welcoming and reassuring. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding.

Staff were aware of the importance of privacy and confidentiality. The layout of the waiting area provided privacy. The reception area was in a corridor. We saw the appointment book, on occasion, open and unattended. We raised this with the dentist. They told us that a revised system for maintaining the confidentiality of the appointments book would be introduced.

The practice benefitted from a dedicated consultation room, which the dentist used to speak in private with patients prior to and after their dental treatment.

Paper patient records were stored securely.

The practice provided drinking water.

Information folders, patient survey results and thank you cards were available for patients to read.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The 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 dental treatment under sedation.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

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

Staff told us that they currently had no patients for whom they needed to make adjustments to enable them to receive treatment. Staff told us that they telephoned some older patients on the morning of their appointment to make sure they could get to the practice. We were told that phone/text/email reminders for appointments were available to all patients.

Promoting equality

The practice made reasonable adjustments for patients with disabilities. These included step free access and accessible toilet. Staff said they had access to interpreter/ translation services.

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. There were arrangements with other local practices to cover emergencies when the dentist was away on leave. The website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

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

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

We looked at comments, compliments and complaints the practice received in the last 12 months. These showed the practice responded to concerns appropriately.

Are services well-led?

Our findings

Governance arrangements

The dentist had overall responsibility for the management and clinical leadership of the practice. Their systems or processes in place were operating ineffectively, in that they failed to enable them as a registered person to evaluate and improve their practice, in respect of the processing of the information obtained throughout the governance process. At the time of the visit we found improvements were needed with respect to completion of environmental risk assessments and control measures with respect to Legionella and fire safety. The dentist was carrying out audits of patients' dental care records to check that the necessary information was present. However, the audits seen only provided an overall score of the audit result. There were neither details of how many records were included in the audits nor details of what audits had assessed in the care records to use as meaningful comparisons for future audits. The dentist told us they would review their audits procedures and complete another patient record audit and this was completed and sent to us.

The practice's systems and processes for carrying out conscious sedation were not in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015. The practice's systems were not robust and did not fully follow the criteria in the Society for the Advancement of Anaesthesia in Dentistry (SAAD) 2015 checklist. Records showed that the patient requesting sedation was assessed shortly prior to the procedure. This included checking the patients' medical history but did not include base line checks, for example on blood pressure and blood oxygen saturation levels. We raised this with the dentist, who told us that these checks would be included in future pre-sedation assessments. Following the inspection they sent us records to show that the procedure for assessments had been revised.

We saw that consent for the sedation was recorded; these were on the day of the planned dental treatment under sedation. Consent on the day of the treatment is not appropriate except with immediate treatment. We raised this with the dentist, who said they would amend their procedures to seek consent prior to the day and on the day of treatment to follow national guidelines.

The practice had a policy on the use of medicines used in conscious sedation. This policy was dated May 2012 and had not been reviewed since. In discussion with the dentist the policy did not reflect the type of conscious sedation being offered to patients. Therefore the document was not kept current and appropriate.

During the course of our inspection we checked dental care records to confirm the findings. We noted that when sedation had taken place that the documents were set out to enable the dentist and sedationist to capture the necessary information when monitoring the patients. However, we saw there was no record of action taken when patients' blood oxygen saturations decreased during the procedures and no record that the patient recovered their blood oxygen saturation levels. Therefore it was not possible to determine from the records that the patient was fit for discharge.

At the point of discharge patients records showed that patients were supplied with post-operative instructions and emergency contact numbers.

The sedationist was supported by the dentist and a dental nurse. The dental nurse told us they were present during the procedures under conscious sedation. Records did not record that the nurse was present.

Following the inspection the dentist wrote to us telling us their plans to make improvements at the practice. We will return to the practice to check that these improvements have been made and that improvements are sustained.

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 culture at the practice. They said the 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 dentist was approachable, would listen to their concerns and act appropriately.

The practice held meetings where staff could raise any concerns and discuss clinical and non-clinical updates.

Learning and improvement

The dentist was conducting audits of dental care records and X-rays. The audits lacked detail to appraise how effective the auditing processes were and contained no

Are services well-led?

learning outcomes recorded, to inform future auditing cycles. Following the inspection the dentist sent us copies of a number of clinical audits completed in August 2017. These audits contained sufficient detail to use as meaningful and comparative audits for the auditing cycle.

Staff told us that the dentist supported them in receiving training. However, we found there was no team training development plan in place and a lack of adequate training in safeguarding and conscious sedation training within the team. There was also no evidence of training records for the sedationist to demonstrate their on-going clinical competency in conscious sedation. The dentist told us they would arrange training for the dental nurse and ask the sedationist for copies of their training records. The whole staff team had annual appraisals. We saw evidence of completed appraisals in the staff folders.

Staff told us they completed training in medical emergencies and basic life support, each year. However, this did not include scenario training for conscious sedation, which is recommended.

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

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service. Survey results showed that patients were satisfied with the service and had no suggestions for 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 **How the regulation was not being met.** The registered person had failed to ensure care and treatment is provided in a safe way to patients; adequately assess the risks to the health and safety of service users of receiving the care or treatment; act to do all that is reasonably practicable to mitigate any such risks; ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. In particular: • Conscious sedation procedures and processes were not managed safely; • Essential recruitment checks for all staff had not been completed; • Not all staff had completed essential training.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **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 evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

This section is primarily information for the provider

Requirement notices

- Not all essential equipment had been adequately maintained.