Dr. Paul Ready

Antrobus Dental Surgery

Inspection report

144 Boldmere Road
Sutton Coldfield
Birmingham
B73 5UD
Tel: 01213542425

Date of inspection visit: 15 June 2021
Date of publication: 24/08/2021

Overall summary

We carried out this announced inspection on 15 June 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

As part of this inspection we asked the following questions:

• Is it safe?

• Is it effective?

• 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 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 well-led?

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

Summary of findings

Background

Antrobus Dental Practice is in Sutton Coldfield, West Midlands and provides NHS and private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available in the practice car park and on local side roads.

The dental team includes one dentist (the provider), one dental hygienist and four dental nurses, (one dental nurse is the practice manager; all dental nurses work on reception as needed). The practice has two treatment rooms.

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

During the inspection we spoke with the provider, the dental hygienist, the practice manager and a dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday, Tuesday and Thursday 9am – 5pm

Wednesday and Friday 9am - 2.30pm

Saturday - Closed

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- A Legionella risk assessment had been completed by a competent professional, but the provider did not have access to this information.
- Staff knew how to deal with emergencies, training in basic life support was overdue but was booked for July. Appropriate medicines and life-saving equipment were available.
- The provider's systems to help them manage risk to patients and staff could be strengthened and improved.
- There was no five-year fixed wire electrical safety certificate.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had systems for dealing with complaints positively and efficiently.
- The provider had information governance arrangements.

We identified regulations the provider was not complying with. They must:

Summary of findings

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

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

- Implement an effective system for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records and improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** ✓
Are services effective?	**No action** ✓
Are services well-led?	**Requirements notice** ✗

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances.

The provider had a policy for safeguarding children and safeguarding was discussed during practice meetings. Staff had completed continuous professional development regarding safeguarding. Following this inspection, the provider sent evidence to demonstrate the level of training completed. They also forwarded an updated safeguarding vulnerable adults and children policy, and an action plan which included review and update of all safeguarding related policies and information in staff induction and training. We were told that the provider and practice manager would be completing training at a higher level.

Staff had downloaded the NHSE safeguarding application on to their phones which gave contact details and other relevant information and updates regarding safeguarding.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider 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, (HTM 01-05), published by the Department of Health and Social Care. There was no documented evidence of annual review or update of this policy, although the practice manager confirmed that all policies received an annual review. Evidence was available in the four staff training files that we reviewed to demonstrate that infection prevention and control training had been completed.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

The risks relating to Legionella had not been adequately assessed by the provider. We were told that an external legionella expert had conducted a legionella risk assessment on behalf of the landlord of the premises. The provider did not have access to the risk assessment and had therefore included information regarding legionella within the practice risk assessment. Following the inspection, the provider confirmed they had obtained quotes from external experts and would have a full legionella risk assessment completed.

Documentary evidence was available to demonstrate that dental unit water line management systems were in place and these were maintained.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean.

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

Are services safe?

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

The provider had guidance information regarding whistle blowing but did not have a formalised policy. Staff said they could raise concerns without fear of recrimination. The provider confirmed that a speak up policy would be developed as part of the overall review of safeguarding procedures.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider did not have a recruitment policy and procedure, all members of the staff team were employed between 1996 and 2012. The practice was fully staffed, and the provider confirmed should they need to recruit any new staff the relevant policies and procedures would be developed. We were provided with some staff recruitment information including a disclosure and barring service check, registration with the professional body and immunisation status records. Further information would be required for any new staff employed in compliance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. The provider told us they had a contract for service of gas appliances which renewed in November 2020, but they were unable to find a gas safety certificate. The next service and safety check was booked for 30 June 2021. The provider was unable to demonstrate that a five-year fixed wiring check had been completed. Portable electrical appliances were last checked in June 2021.

We were told that an external expert had conducted a fire risk assessment on behalf of the landlord of the premises. The provider did not have access to a copy of this risk assessment but had a copy of the recommendations for action which we were told had all been addressed. Following this inspection, the provider detailed the actions taken to address these issues.

Information regarding fire was included in the practice risk assessment. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. Invoices were available, dated October and December 2020 to demonstrate that checks had been made on fire safety equipment such as fire extinguishers. Details of staff attendance at fire drills was recorded in a log and in the minutes of practice meetings. There was no evidence to demonstrate that staff had completed fire safety training.

We did not see evidence that the dentist justified, graded and reported on the radiographs they took on each occasion. However, the provider confirmed that they had updated their current dental software to allow for justification to be easily added to the clinical notes. A rectangular collimator was available but was not attached to the X-ray unit. The provider confirmed they would ensure this was kept by or attached to the X-ray and used on each occasion. The provider carried out radiography audits every year following current guidance and legislation. Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider did not have oversight of all systems to assess, monitor and manage risks to patient safety.

Documentary evidence was not available to demonstrate that the practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance which was renewed in July 2020.

Are services safe?

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually. Further information should be included in the risk assessment, for example to include the use of scalpels, matrix bands and endodontic files.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We were told that a member of staff was a non-responder to the vaccination, however there was no risk assessment in place. The provider did not hold records to support the seroconversion levels for one member of staff and no risk assessment was in place. Records for all other staff were available and up to date.

Staff had knowledge regarding the recognition, diagnosis and early management of sepsis. We were not shown evidence that staff had completed sepsis awareness training. The provider confirmed that they would ensure this was completed. Sepsis prompts for staff and patient information posters were previously displayed throughout the practice but these had recently been removed to maintain infection prevention and control arrangements during the Covid 19 pandemic. This information could be used to help ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Evidence was available in the staff training files that we saw to demonstrate that some on-line update training had been completed. The provider confirmed that the external training provider had not been conducting this training during the Covid 19 pandemic but had recently recommenced and training was booked for 13 July 2021.

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. We found these checks were not completed at the frequency as suggested in the resuscitation council guidance. One medicine to be used in a medical emergency was being kept in the refrigerator, staff were not monitoring the temperature of the refrigerator to demonstrate that this medicine was being stored correctly. Following this inspection, the provider confirmed that a new digital thermometer had been purchased which sounded an alarm and recorded temperatures outside of the suggested temperature range and staff would log daily fridge temperatures.

A dental nurse worked with the dentist and the dental hygienist when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

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. We looked at dental care records with clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

Are services safe?

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored NHS prescriptions as described in current guidance. A prescription log was available; the provider updated this log to include details of the prescription number. Following this inspection, a log was also developed recording the individual number for all prescriptions on the premises.

The dentists were aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits were carried out annually. The most recent audit indicated the dentist was following current guidelines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been no safety incidents. Staff told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We were told that the provider reviewed these and would act upon them if required Further improvements could be made if the alerts were shared with the team.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice. We saw clinicians assessed patients' 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 practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records.

The practice did not have a policy regarding consent to treatment.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories, although dental care records seen did not all demonstrate that radiographs were always justified or graded. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. Staff had been working at the practice for many years, with the newest member of staff being employed in 2012. Staff told us that as they worked part-time, they were flexible and would cover staff vacancies as required.

An induction programme was available should any new staff be employed. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

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 will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found the provider had the capacity, values and skills to deliver high-quality, sustainable care and was knowledgeable about issues and priorities relating to the quality and future of the service. Some issues were identified which were discussed with the provider during this inspection. The provider was keen to make any necessary improvements and took some action on the day of inspection to address issues identified and took further action and provided evidence of action taken.

Staff told us they worked closely with the provider who they said was approachable and supportive.

Culture

The practice had a culture of high-quality sustainable care.

Staff had worked at the practice for many years and stated they felt respected, supported and valued. They were proud to work in the practice and said that they worked well as a team.

We were told that staff discussed their training needs at informal appraisal meetings. The practice manager confirmed that meetings were held with staff to discuss training and development, and issues or concerns but appraisal conversations were not being documented and a formalised system was not in place.

Systems were in place to investigate and respond to any complaints made whether verbal or written. We were told that verbal complaints were dealt with immediately and written complaints forwarded to the complaint lead for investigation.

The provider was aware of Duty of Candour, although there was no information for staff to ensure compliance with the requirements of Duty of Candour.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The provider had overall responsibility for the management and clinical leadership of the practice. The provider and practice manager were responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities. The provider held the majority of lead roles at the practice with support provided by the practice manager.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. We were told that the practice manager had a computerised reminder system and policies were reviewed annually and discussed at team meetings but there was no documentary evidence to demonstrate this. Some important policies had not been developed, for example there were no consent, duty of candour or speak up policies.

Processes for managing risks, issues and performance could be improved. We identified risks in relation to:

- Checks made on medical emergency equipment were not completed at the required frequency and one medicine was not being stored correctly.

Are services well-led?

- The provider did not have oversight of legionella risk. The landlord of the premises had a copy of a legionella risk assessment which had been completed by a competent person, however the provider had not seen a copy of this document.
- The provider did not have a five-year fixed wire electricity certificate.
- The provider did not have oversight of the immunisation status of all staff. There were no supporting risk assessments to mitigate the risk for staff were seroconversion information was not available or for staff who were non-responders to the vaccination.
- The sharps risk assessment did not include all sharp objects in use at the practice.
- Although patient safety alerts, recalls and rapid response reports were received by the provider, these were not being shared with staff and there was no system for responding to these.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example NHS Business Services Authority performance information, and audits were used to ensure and improve performance. Performance information was combined with the views of patients.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Surveys and comment cards were used to gain feedback about the service; however, these had been paused temporarily due to the Covid-19 pandemic.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were in place.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of radiographs and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements. The provider was not completing an audit of dental care records.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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 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. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The provider had an ineffective system to ensure checks made on medical emergency equipment were completed at the required frequency and were stored correctly. The provider did not have Legionella risk oversight and effective management was not established. The provider did not have full oversight of staff training and development. Staff had not completed fire safety and training. The provider did not have an effective system to ensure a five-year fixed wiring test had been completed. The sharps risk assessment did not include all sharp objects in use at the practice. There was additional evidence of poor governance in particular: The provider did not have oversight of all immunisation status of staff and there were no supporting risk assessments to mitigate the risk.

This section is primarily information for the provider

Requirement notices

The provider did not have an effective system established for the on-going assessment, supervision and appraisal of staff.

There was no oversight of policies and procedures to ensure they had been reviewed on an annual basis or as needed if updates were required.

Regulation 17 (1)