Dr A.J. Amery And Associates Ltd

The Dentist

Inspection Report

63 High Street
Buntingford
Hertfordshire
SG9 9AE
Tel: 01763271695
Website: www.thedentistbuntingford.com

Date of inspection visit: 26 November 2019
Date of publication: 11/12/2019

Overall summary

We carried out this announced inspection on 26 November 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

The Dentist, Buntingford is a well-established practice that offers private treatment to about 3500 patients. The dental team consists of a dentist, a dental nurse, two hygienists and a receptionist. There are three treatment rooms. The practice opens on Mondays to Thursdays from 9 am to 6pm pm, and on Fridays from 9 am to 1 pm. There is portable ramp access for wheelchair users and a public car park 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.

Summary of findings

On the day of inspection, we collected 50 CQC comment cards filled in by patients and spoke with another two.

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

Our key findings were:

- Staff treated patients with care, dignity and respect. We received many positive comments from patients about the caring and empathetic nature of staff and the effectiveness of their treatment.
- The practice was small and friendly, something which patients appreciated.
- The dentist dealt with complaints empathetically and efficiently.
- The appointment system took account of patients' needs.
- The practice had cone beam computed tomography scanner, a Cerec machine, (to make ceramic dental restorations), an intra-oral camera and its own on-site milling machine to enhance the delivery of care to patients.
- 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 control measures to reduce potential hazards had not always been implemented.
- Audit systems within the practice were limited and had not been used effectively to drive improvement.

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 sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance.
- Review the practice's processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

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** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

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

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

The practice had some safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. However, the practice's child protection policy was limited in scope and did not provide comprehensive information about reporting procedures and protection agencies. Not all staff were aware of appropriate reporting procedures out with the practice, and evidence to show that some staff had received safeguarding training was not available.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination. One staff member gave us a practical example of the type of incident they would report to external agencies if they witnessed it occurring in the practice.

The dentist used dental dam in line with guidance from British Endodontic Society when providing root canal treatment, and latex free dams were available.

The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running.

The practice had a recruitment policy in place which reflected relevant legislation, although it was not being followed. We viewed the personnel file for the most recently recruited member of staff and found that references and a disclosure and barring check had not been obtained at the point of their employment. We were subsequently informed that they no longer worked at the practice and the principal dentist assured us that full and proper pre-employment checks would be conducted for future employees. On the day of our inspection a locum nurse was working, but no checks had been obtained to ensure their suitability for the role.

A fire risk assessment of the premises had been completed just prior to our inspection: none had been undertaken previously. Fire extinguishers, fire alarms and the emergency lighting were tested regularly, and staff told us they undertook fire evacuation drills. Fixed wire testing had not been undertaken every five years as recommended and there was no evidence to show that the gas boiler had been serviced each year. Portable appliance testing had last been completed in 2009 and had not been tested since.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. 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.

We noted that all areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked two treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. However, staff wore the same trousers for both work and home and one nurse had long painted finger nails which compromised infection control. We noted that nail scrubbing brushes were available for use by sinks which was not in line with national guidance.

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 2016 but its recommendations to lag the pipework and display drinking water signage had not been implemented. Nursing staff were not aware of recommended dental unit water line management systems.

The provider had risk assessments in place for the control of substances that were hazardous to health (COSHH), although safety data sheets were not available for some cleaning products used in the practice.

External clinical waste bins were locked but had not been secured adequately to prevent their unauthorised removal.

The practice had some arrangements to ensure the safety of the X-ray equipment and had the required information in

Are services safe?

their radiation protection file. Rectangular collimation was used on the X-ray unit to reduce patient exposure. We found recording of the justification on taking X-rays in the patient notes we viewed, but not their grading. Radiography audits were not completed every year as recommended in current guidance and legislation. There was no signage on treatment room doors to warn of X-ray usage.

The practice had a cone beam computed tomography X-ray machine. We noted that the dentist had not undertaken appropriate training in its use and had not completed monthly tests of the equipment. There was no quality assurance programme in place for the images produced, or patient dose audits.

Risks to patients

A general risk assessment had been completed for the practice, but its recommendations to check medicine stock, service the gas boiler and inspect portable electrical appliances had not been implemented by staff.

The dentist was not using the safest types of needles to prevent injury. A specific sharps risk assessment had been undertaken but was limited in scope as it only identified risks in relation to the use of needles and did not include other instruments such as matrix bands, scalpels and scissors. Some used sharps bins had not been disposed off correctly and had been stored in the practice's basement for several years.

Staff had completed training in resuscitation and basic life support the week before our inspection but had not completed the training yearly prior to this, as recommended in national guidance. Most emergency equipment and medicines were available as described in recognised guidance, although there was no dispersible aspirin, no children's self-inflating bag and only one size of adult face mask. The oxygen cylinder had become out of date in 2008 and some items in the first aid kit were also out of date for safe use. Following our inspection, we were sent evidence that missing and out of date equipment had been ordered.

Safe and appropriate use of medicines

The dentist was aware of current guidance with regards to prescribing medicines. However, a log to monitor and record medicines dispensed to patients had only been introduced immediately prior to our inspection. The fridge's temperature, in which Glucagon was kept, was not monitored to ensure it operated effectively and kept the medicine at the correct temperature.

An antimicrobial audit had not been undertaken to assess if staff were prescribing according to national guidelines.

Lessons learned and improvements

The practice had procedures in place to investigate, respond to, and learn from significant events and complaints, and staff were aware of formal reporting procedures**.** We viewed two significant event logs that had been completed following a false fire alarm in the practice and an IT failure.

The dentist told us he 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 50 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 dentist is excellent, and his work is of a high standard'.

The practice had a cone beam computed tomography scanner, a CEREC machine, an intra oral camera, and its own dental milling machine to enhance the delivery of care to patients.

Our review of dental care records indicated that patients' dental assessments were not always recorded 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, and oral cancer had not been recorded consistently to inform patient recall intervals. Patients' medical histories had not always been updated as frequently as recommended.

An audit of the quality of the dental care records had been undertaken for the first time just prior to our inspection, and not every year as recommended in national guidance. This audit had highlighted the same shortfalls we had identified in the records and action plan to improve was in place.

The practice offered dental implants which were placed by the dentist. Patients did not sign a specific formal consent form in relation to their implants.

Helping patients to live healthier lives

Two part-time dental hygienists were employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease. One patient commented, 'regular hygiene checks and oral health checks have meant no problems in the past 10 years'. There was a selection of dental products for sale to patients including interdental brushes, mouthwash, toothbrushes and floss.

We noted some information in the waiting area for patients in relation to oral health, and free samples of toothpaste were available on the reception desk.

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them. However, we found he had a limited awareness of the Department of Health's guidance, Delivering Better Oral Health toolkit. The dentist told us he gave oral health advice to patients, although dental care records we reviewed did not always demonstrate that smoking, alcohol and diet advice had been provided.

Consent to care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment, although dental care records we viewed did not always demonstrate that a meaningful consent process had occurred.

We found that staff had 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 aware of Gillick competence guidance and its implications when treating young people.

Effective staffing

The staff team was very small consisting of one dentist, one nurse, two hygienists and a receptionist. Despite this, staff told us there were enough of them to run the practice and that they did not feel rushed in their work. Locum dental nurses from an agency were used if needed.

Co-ordinating care and treatment

The dentist 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.

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 consistently caring, helpful and warm. One patient told us 'I love, love, love this surgery. I am such a nervous patient, but the dentist always put me at ease, and even make me laugh.' Another commented, 'staff go out their way to support me and make me feel more comfortable'.

We received several comments from patients stating how helpful and friendly the receptionist was. During our inspection, we noted they took time to talk to an older patient who had popped into the practice just for a chat.

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 such as telephoning patients when the waiting room was empty and offering a separate room for patients to discuss confidential matters.

All consultations were carried out in the privacy of the treatment rooms and we noted that the door was closed during procedures to protect patients' privacy. We noted blinds were on the downstairs window to prevent passers-by looking in. Staff password protected patients' electronic care records and backed these up to secure storage.

The dentist had installed closed-circuit television (CCTV) around the practice, to improve security for patients and staff. Signage was in place warning patients of its use.

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, 'I was listened to, options were explained, all procedures were done after discussion and financial options explored'.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included dental models, X-ray images and an intra-oral camera. However, dental records we reviewed did not always show which treatment options had been discussed with patients or fully 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 practice had its own website which gave patients information about the services it offered and its staff. The waiting room contained interesting magazines for patients to read, and books for children to keep them occupied whilst waiting.

The practice had made some adjustments for patients with disabilities. There was portable ramp access to the main entrance, a ground floor treatment room, a hearing loop and accessible toilet. However, information about the practice was not produced in any other formats and staff were not aware of translation services to support a patient who did not speak or understand English.

Patients described high levels of satisfaction with the responsive service provided by the practice. Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service. 50 cards were completed, giving a patient response rate of 100%. All views expressed by patients were very positive about the care and treatment provided by the practice.

Timely access to services

Reception staff told us that clinicians 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.

At the time of our inspection the practice was able to register new patients. Reception staff told us there was about a week's wait for a non-urgent appointment, but about a two to three month waiting time for an appointment with a hygienist.

The practice offered a text or telephone appointment reminder service, which patients told us they particularly valued. Although there were no specific emergency slots put aside each day, the receptionist told us that any patient in pain would be seen within 24 hours.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Two other local practices covered any patient emergency appointments whilst the dentist was on annual leave or unavailable.

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 and on the practice's website making it easily accessible.

We viewed paperwork in relation to two complaints and found that the patients' concerns had been investigated and responded to in a candid, empathetic, timely and professional manner.

Are services well-led?

Our findings

Leadership capacity and capability

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.

The dentist had overall responsibility for both the management and clinical leadership of the practice. As there was not a dedicated practice manager, he had taken on most administrative tasks himself. It was clear this additional workload had been overly challenging for him and he told us he would benefit from allocating some of them to his staff. He told us our inspection had highlighted many areas for improvement and it was clear he was keen to implement changes as a result.

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 most felt valued in their work.

The practice had a duty of candour policy in place, and staff had a satisfactory knowledge of its requirements. Openness, honesty and transparency were demonstrated when responding to incidents and complaints

Governance and management

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

The practice's policies were generic and were not always followed by staff. Risk management was limited, and recommendations from various risk assessments had not always been implemented.

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.

Engagement with patients, the public and external partners.

The dentist told us as a result of patient feedback he had introduced music and additional heating in the waiting room.

Ways that patients could feed back about the service were limited. There were comments cards available in the waiting room; however, patients were not actively encouraged to complete them and only four responses had been received since 2013.

Continuous improvement and innovation

Staff received an annual appraisal of their performance and had personal development plans in place. However, the practice did not keep an overview of the training staff had undertaken and there was no evidence available to demonstrate that all staff had received essential training in areas such as infection control, equalities and diversity, information governance and mental capacity training as recommended by General Dental Council professional standards.

We found that the dentist was unaware of nationally recommended audit guidelines. For example, an audit for dental care records had only just been completed prior to our inspection and audits for radiography and antimicrobial prescribing had not been undertaken in line with guidance. Although infection control audits had been completed, their recommendations had not always been actioned.

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.** • 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 • There was no system in place to monitor and track the use of prescriptions issued to patients. Medicines were not stored safely. • Fixed wire testing had not been completed every five years, and the practice's gas boiler had not been serviced regularly. Portable appliance testing had last been undertaken in 2009. • Recommendations from the practice's Legionella assessment had not been implemented and staff were unaware of recommended dental until water line management systems. • Protocols and procedures for the use of X-ray equipment was not in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and HPA-CRCE-010 Guidance on the Safe Use of Dental Cone Beam (Computed Tomography). 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 **Regulation 17 (1) 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:

- There were no robust recruitment systems in place to ensure that only fit and proper staff were employed.
- 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 undertaken in line with nationally recognised guidelines

- The practice's systems for monitoring and mitigating the various risks arising from the undertaking of the regulated activities were limited and control measures had not always been implemented.

Regulation 17 (1)