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Townley Dental Centre

Inspection Report

Upwell Health Centre
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Overall summary

We carried out this announced inspection on 19 February 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

Townley Dental Care is based in Upwell and offers private treatment to about 1500 patients. The dental team is small, consisting of one dentist, two dental nurses and receptionist. There is one treatment room. The practice is sited within the local health centre and shares some of its facilities.

There is level access for people who use wheelchairs and those with pushchairs and a car park with specific spaces for patients with limited mobility.

Summary of findings

The practice opens Mondays, Tuesdays and Thursdays from 8am to 5pm; on Wednesdays from 8.30am to 4pm, and on Fridays from 8am to 12 noon.

The practice is owned by an individual who is the principal 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 24 CQC comment cards filled in by patients and spoke with another thee patients.

During the inspection we spoke with the dentist, both nurses 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 dignity and respect, and we received many positive comments from patients about the caring and empathetic nature of the dentist and nurses.
- There were suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Patients' complaints were dealt with positively and efficiently.
- Staff felt involved and supported and worked well as a team
- Recruitment procedures were not robust
- Dental care records were not maintained in line with guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Medicines were not managed or prescribed according to national guidance.
- Some of the practice's infection control procedures did not comply with national guidance
- Systems to ensure good governance were limited.

We identified regulations the provider was not meeting. He 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.

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?

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).

Staff had received safeguarding training and were aware of their responsibilities regarding the protection of children and vulnerable adults.

Premises were clean and properly maintained, although the practice did not follow national guidance for cleaning, sterilising and storing dental instruments.

The practice had suitable arrangements for dealing with medical and other emergencies, although did not have all the recommended equipment easily available. Medicines were not always managed or prescribed according to national guidance.

Recruitment procedures were not adequate to ensure that only suitable staff were employed at the practice.

Requirements notice ✖

Are services effective?

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

Patients told us they were happy with the quality of their dental treatment and the staff who provided it. Staff had a satisfactory understanding of the Mental Capacity Act 2005, and Gillick competence and how this might impact on treatment decisions.

Patients' dental records did not meet standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals, although non-NHS referrals were not actively monitored to ensure they had been received.

No action ✓

Are services caring?

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

We received feedback about the practice from 27 patients. Patients spoke highly of the practice's staff and had clearly built up strong relationships with them over the years. Staff were described as caring, patient and reassuring. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

Staff described to us the practical ways they helped nervous patients manage their treatment.

No action ✓

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 appointments were available from 8 am in the morning. Patients could get an appointment quickly if in pain and waiting times for treatment were good.

The practice shared its premises with a local health centre and therefore there was good accessibility for wheelchair users. There was a downstairs treatment room and fully accessible toilet. However, the practice did not provide a hearing loop to assist those patients with hearing aids and information was not available in any other languages or formats such as large print.

Complaints were managed in a timely and professional way.

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).

The staff told us they enjoyed their work and felt supported by the dentist. They received regular appraisal of their performance.

We found a number of shortfalls indicating that the practice was not well-led. Staff were not following current best practice guidance in several areas including the documented use of rubber dams, the management of medicines, the control of infection, the assessment of risk and the recruitment of staff. There were no systems in place to gather feedback from patients about the quality of the service.

Are services safe?

Our findings

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

Staff knew their responsibilities if they had concerns about the safety of children and vulnerable adults and the nurses had received appropriate training for their role. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Information about local protection agencies was on display in the staff area, making it easily accessible. The practice had a whistleblowing policy and staff felt confident they could raise concerns without fear of recrimination.

Staff told us that rubber dams were used in line with guidance from the British Endodontic Society when providing root canal treatment (RCT). However, the dentist told us he did not record the use of rubber dams or of any alternative methods used to protect patients' airways.

There was no formal written protocol in place to prevent wrong site surgery, although the dentist described to us the methodical process he used to ensure appropriate treatment was given.

The practice did not have a completed business continuity plan describing how it would deal with events that could disrupt its normal running.

The practice had a recruitment policy in place but records we viewed for a recently recruited member of staff showed that they had been employed without any references or a recent disclosure and barring check to ensure they were suitable for their role. No record of their interview had been kept showing it had been conducted fairly and in line with good employment practices.

We found that staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover in place.

Fire alarms were tested every week and fire evacuations were held twice a year which included patients. Fire extinguishers and emergency lighting were maintained and tested by staff from the health centre. We noted that there was no signage on the outside of the practice to warn that oxygen was stored on site.

The practice had some arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. However, a rectangular collimator had not been fitted to the X-ray unit to reduce patient exposure; radiographs were not always graded and there was no X-ray warning light or notice displayed outside the treatment room.

Risks to patients

A 'risk assessment check list' had been completed by the practice but this did not constitute a comprehensive assessment to identify potential hazards on the premises. We found a number of discrepancies in this risk assessment check list. For example, it stated that there was an appointed first aider at the practice, that there were records of staff immunisations and that display screen equipment assessments had been completed. This was not the case.

A specific sharps risk assessment had not been undertaken as recommended in the Sharps Regulations 2013, and the dentist did not use the safest forms of needles, or single use matrix bands as recommended. The sharps box was not sited securely in the decontamination room and its label had not been completed. There was no system in place to ensure clinical staff had received appropriate vaccinations. No staff immunisation records were available so that the principal dentist could not assure himself that staff were protected. One staff member told us they were a non-responder to the Hep B vaccination, but no risk assessment had been undertaken for this and there was no record of this on their personnel file.

The practice worked with staff at the health centre to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The dentist undertook regular water temperature testing.

Most staff had completed training in resuscitation and basic life support, although the receptionist had not despite working at the practice for over four months. Staff did not regularly rehearse emergency medical simulations so that they had a chance to practise their skills. Most emergency equipment and medicines were available as described in recognised guidance, although portable suction and a spacer device could not be located. The emergency drugs kit did not contain the recommended amount of adrenalin and we found glucose tablets that had

Are services safe?

expired in 2017. A defibrillator was held on site, in one of the GP nurse's offices, but staff had not practiced accessing this in an emergency. Weekly checks of the emergency drugs and equipment had been undertaken by the dentist, but these had failed to identify the shortfalls we found.

An eye wash kit was available but we noted the mercury spills kit had expired in 2001.

We noted that areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However, the clinical waste bin was very full and overflowing. We noted a number of loose and uncovered instruments in drawers, that risked aerosol contamination and there was considerable lime scale build up round a tap. There was no feminine hygiene waste bin in the staff toilet. The practice did not have appropriate cleaning equipment and the same mop was used to clean the treatment room and toilet. The mop was stored wet and head down, risking the accumulation of bacteria. We were told mop heads were changed only about once a month.

Risk assessments and safety data sheets were in place for some hazardous materials used in the practice, but there were none available for the cleaning products used.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments. However, these were not always in line with national guidance. For example,

- Staff were not aware of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. No annual statement had been completed.
- Dirty instruments were not transported in lidded, lockable, leak proof boxes.
- The practice's ultrasonic bath was not validated and had never been serviced.
- Test cycles at the beginning of the day were not completed for the autoclave and no TST strips were used to ensure it operated effectively.
- There was only one sink available in the decontamination room for washing and rinsing dirty instruments. We noted the nurse rinsed instruments under running water, causing splashes.
- Temperature checks were not completed to ensure dirty instruments were cleaned in water below 45 degrees Celsius.
- There was no illuminated magnifying glass available to check instruments were cement free and clean.
- One nurse's finger nails were long, compromising hand hygiene.
- Staff conducted infection prevention and control audits, but not as frequently as recommended by guidance. We noted some outstanding actions had still to be completed from the latest audit. We requested previous audits to check if these issues had been identified then, but were told they were not available.

Clinical waste was stored externally in bins shared with the health centre. We found that one of the yellow bins was unlocked and was not secured from public access. Amalgam was disposed of correctly but we staff were not aware of the most recent guidance in relation to its use.

Safe and appropriate use of medicines

We noted that Glucagon was stored in the fridge, but the fridge's temperature was not monitored to ensure it operated effectively.

Antimicrobial audits had been conducted to ensure the dentist was following current prescribing guidelines. We found that the dentist's prescribing protocols were not always in line with NICE guidance.

Private prescription paper was stored securely, however the practice's name and address was not included on the label of dispensed medicines. The practice did not monitor the expiry dates of dispensed medicines stock to ensure it was fit for safe use.

Lessons learned and improvements

The practice had an accident and incident policy, although not all staff we spoke with were aware of it**.** We found that staff had a limited understanding of what might constitute an untoward event and told us there had not been any. However, we were told of a patient who had fainted and of a patient referral that had gone missing. Neither of these incidents had been documented as unusual events, and there was no evidence of learning from them. The practice's accident book could not be found on the day of our inspection

The principal dentist had signed up to receive national patient safety and medicines alerts from the Medicines and

Are services safe?

Healthcare Products Regulatory Authority (MHRA). However, there was no formal system in place to disseminate the information and ensure staff were aware of relevant alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 24 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.

Dental care records we viewed showed that patients' medical histories were checked and that both extra and intra oral examinations had been completed. However, it was not possible to tell if patients' caries and oral cancer risk, recall frequencies, and oral health instruction had been recorded as the dental records were hand written and often difficult to read. They did not meet standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Helping patients to live healthier lives

Staff told us they were aware of, and took part in, national oral health campaigns such oral cancer awareness week and national smile month. We noted good information about oral cancer awareness in the waiting room, along with leaflets in relation to healthy gums, tooth decay and sensitive teeth. Free samples of high fluoride toothpaste were also available to patients.

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. All patients received a treatment plan, but they were not asked to sign it to demonstrate they understood the nature of the proposed treatment and its associate fees.

The practice had a patient consent policy which included information and guidelines in relation to the Mental Capacity Act and Gillick competence. We found staff had a satisfactory knowledge of the MCA and Gillick competence guidelines and how this might affect treatment options.

Effective staffing

The staff team was very small consisting of one dentist, two nurses and a receptionist. Staff told us there were enough of them to run the practice, cover each other's annual leave and meet patients' needs. We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

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 had been received and dealt with promptly. One staff member told us of an occasion where a referral had 'gone missing''.

Are services caring?

Our findings

Kindness, respect and compassion

We received positive comments from patients about the caring nature of the practice's staff. One patient reported that the dentist was 'excellent' with their two young children, and another that he worked well with their autistic son. One patient described reception staff as 'always very helpful and friendly'. It was clear staff had built up very strong relationships with patients over the years, and patients spoke very highly of them. We observed many warm and positive interactions between staff and patients throughout our inspection. Staff gave us examples of where they had supported patients such as giving them a lift home after complex treatment and working through their lunch hour to accommodate dental work prior to patients' special occasions.

The nurses told us some of the practical ways they supported nervous patients during their treatment.

Privacy and dignity

All consultations were carried out in the privacy of the treatment room and we noted that the door was closed during procedures to protect patients' privacy. Blinds had been placed on the window to prevent passers-by looking in.

The reception computer screen was not visible to patients and staff did not leave patients' personal information where other patients might see it.

Involving people in decisions about care and treatment

Patients told us the dentist listened to them and gave them clear information about their treatment, and staff used dental models to help patients understand their treatment. We found there was limited use of treatment information leaflets to help patients better understand what was involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 level access to the building, a ground floor treatment room and an accessible toilet on site. We noted there was no portable hearing loop to assist those who wore hearing aids. There was no information about translation services for patients who did not speak or understand English, and information about the practice was not produced in any other formats or languages.

Timely access to services

At the time of our inspection the practice was able to register new patients. Patients could access care and treatment within an acceptable timescale for their needs and reception staff told us there was about a two week wait for a non-urgent appointment. The practice did not offer a text or email appointment reminder service but did telephone some patients who requested this service.

In response to patients' demand the practice had reviewed its opening hours and now opened at 8am each morning to meet the needs of its working patients.

Patients told us they were satisfied with the appointments system and that getting through on the phone was easy. The practice did not have specific emergency slots held aside each day, but staff told us that any patient experiencing dental pain would always be seen same day. The practice offered an out of hours service on a rota system with two other local practices.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales for responding to them. A poster detailing how patients could raise their concerns was in the waiting room, making it accessible to patients.

We were shown the paperwork in relation to one complaint the practice had received and saw it had been managed in a timely, candid and professional way.

Are services well-led?

Our findings

Leadership capacity and capability

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 he had struggled to keep on top of administrative tasks and would benefit from allocating some of them to his staff.

Staff spoke highly of the dentist, telling us he was approachable and responsive to their ideas. For example, their suggestions to change the type of uniform they wore and to declutter the treatment room had been implemented. Although the staff team was small, it was clear they worked and communicated well together. Staff told us they enjoyed their work and both nurses had worked there for many years.

Culture

The practice was small and friendly and had built up a very loyal and established patient base over the years.

The practice had a duty of candour policy in place, and we found staff understood its requirements and had implemented them in relation to a patient complaint we reviewed.

Governance and management

Communication across the practice was structured around regular meetings. Staff told us the meetings provided a good forum to discuss issues and they felt able and willing to raise their concerns in them.

The practice did not have robust governance procedures in place. Its policies were generic and not specific to the practice itself. There was no evidence to show that staff had read, understood and agreed to abide by the policies.

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.

Engagement with patients, the public and external partners.

Staff told us that patients rated the surgery highly but could not provide any evidence to demonstrate this. The practice did not conduct any of its own patients' surveys and there was no information or means for patients to leave feedback about their experience and help drive improvement.

Continuous improvement and innovation

The practice did not have robust quality assurance processes to encourage learning and continuous improvement. For example, audits were undertaken but learning from them was not shared with the staff team or undertaken as frequently as recommended in national guidance. We reviewed the two latest dental care records audits and noted that the same weaknesses had been identified in both, indicating they had not been effective in driving improvement.

Staff told us the dentist regularly observed them undertaking decontamination procedures, but we found these observations had not been successful in identifying the shortfalls we found.

Training records provided to us by the dentist showed that none of the staff had received training in information governance, patient consent, or equalities and diversity. Only the dentist had undertaken training in fire safety and The Mental Capacity Act.

All staff received annual appraisals, which they told us they found useful. We found they were meaningful and assessed staff's knowledge, team work, communication and safety awareness.

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 (1) 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 was not in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • Medical emergency equipment did not comply with guidelines issued by the Resuscitation Council (UK) and the General Dental Council. · The practice did not follow guidelines issued by the British Endodontic Society in its use of rubber dams • Dental care records were not maintained in line with guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping. • Staff immunisation records were not available to demonstrate they had adequate immunity for vaccine preventable infectious diseases. • Not all equipment had been validated or maintained to ensure it operated effectively and safely. The ultrasonic bath, autoclave and air conditioning unit.

This section is primarily information for the provider

Requirement notices

- Medicines were not managed or prescribed according to national guidance.

- Infection control procedures did not comply the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practice.

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** **How the regulation was not being met** **There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • Auditing systems were limited and had been ineffective in identifying a number of shortfalls we found during our inspection. • There were no systems in place for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service. **The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:** • Appropriate pre-employment checks, including references and a DBS check had not been obtained for a recently recruited member of staff.

This section is primarily information for the provider

Requirement notices