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Haverhill Dental Centre

Inspection Report

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Overall summary

We carried out an announced focussed inspection on 21 April 2016 to ask the practice the following key questions; Are services effective, responsive and well-led?

Our findings were:

Are services effective?

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

Are services responsive?

We found that this practice was not 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

Haverhill Dental Centre is a mostly NHS dental practice which can be found near the centre of Haverhill, Suffolk. The practice offers general dentistry including fillings, dentures, crowns and bridges to adults and children. It is situated on the ground and first floor of a building, and can accommodate wheelchair access to the ground floor treatment rooms using temporary ramps.

The practice has two dentists, two dental nurses (one of whom works part time) and a receptionist. The ground floor of the building accommodated one treatment room, the reception and waiting areas, a dedicated decontamination room and patient toilet. The first floor houses another treatment room and a staff room, as well as further storage space.

The practice was registered with the Care Quality Commission (CQC) in August 2012.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received positive feedback from two patients about the services provided. This was through speaking with patients in the practice during our visit.

The inspection was carried out to address specific concerns and was therefore focussed in these areas.

Our key findings were:

- Patients we spoke with commented that the staff were friendly and helpful.
- We found one dental treatment room was well maintained and well equipped but found some shortfalls in the other treatment room where some equipment and practice infrastructure was in a poor state of repair.

Summary of findings

- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines
- Practice staff reported that the Automated External Defibrillator for use in the event of a cardiac arrest was not working due to the lack of a battery.
- The service was aware of the needs of the local population and took those these into account in how the practice was run.
- On the day of our visit the appointment diary for each dentist showed that patients could access treatment and urgent and emergency care if required. However we became aware that there had been a significant number of cancelled appointments in the months preceding our visit.
- On the day of our visit there were enough staff to support the dentists during patient treatment. Staff told us that the practice was often short staffed with respect to dental nurses at various times each week. During these times dentists were not appropriately supported when carrying out patient treatment.
- The practice carried out clinical audits in record keeping, dental radiography and infection control, but these did not always generate an action plan, or the issues raised addressed.

We identified regulations that were not being met and the provider must**:**

- Ensure availability equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure that all equipment used as part of patient care and practice infrastructure is maintained to an appropriate standard.
- Ensure that staffing levels enable dentists to be appropriately supported by a dental nurse at all times when patients are receiving dental care and treatment.
- Ensure that systems are in place to assess and respond to risk, quality and safety of provided services.

There were areas where the provider could make improvements and should:

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.

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 effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Patients were required to complete a comprehensive medical history form, and these were reviewed by the patient at appropriate intervals.

The practice was often short staffed in the respect of dental nurses, and as a result dentists were working without a nurse at certain times of the week. The practice had attempted to engage locum dental nurses but with limited success.

Are services responsive to people's needs?

We found that this practice was not providing responsive 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 at the end of this report).

Patients were experiencing increased numbers of cancelled appointments for one of the dentists due to a variety of reasons, and this had been an issue for several months. Staff did their best to mitigate the risks surrounding this by keeping emergency appointments available for patients in pain, as well as moving patients temporarily to the other dentist, and keeping a cancellation list of patients who could be available at short notice should a slot become available.

Out of hours cover was provided by the NHS 111 scheme, and patients were directed to this via a message on the practice's answerphone.

The practice had a complaints policy displayed in the reception area, and a leaflet directing patients to the patient advice and liaison service.

Are services well-led?

We found that 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 at the end of this report).

We found that changes could be made to improve the way in which the practice was run. For example, we found that the practice did not have systems in place to undertake routine governance such as clinical audits and risk assessments following the resignation of certain staff.

The lack of ongoing governance systems and communication across the team were making it difficult for the practice to identify risks, and respond to them in a timely manner.

The principal dentist was not providing effective leadership of the practice at the time of our visit, and communication across the dental team was limited.

Haverhill Dental Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 21 April 2016 and was led by a CQC inspector and a dental specialist advisor.

The focussed inspection of the practice was carried out to address specific concerns, and was arranged in response to information received from NHS England. We informed the NHS England area team that we were inspecting the practice.

During the inspection, we spoke with the principal dentist, an associate dentist, dental nurses, reception staff and patients. We reviewed policies, procedures and other documents.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Through speaking to one of the dentists and being shown a sample of the dental care records we found that the dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We spoke with a member of staff who confirmed each patient completed a written medical history at the beginning of treatment. We saw evidence in the dental care records that the medical history was updated at subsequent visits.

This was followed by an examination covering the condition of a patient's teeth, gums, soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products.

The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Records we saw showed that this was the case, with the standard NHS treatment planning forms for dentistry used where applicable. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

The dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).

We asked one dentist about the safety procedures in place when they carried out root canal treatment and if a rubber dam was used. They explained that they did not use a rubber dam when root canal treatment was carried out. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). We asked if they used alternative safety procedures such as a parachute safety chain for holding root canal files. The dentist we spoke to explained that they did not use other safety procedures but relied on being 'very careful' when using root canal instruments.

Health promotion & prevention

We spoke to one dentist about their approach to dental health promotion and prevention. They explained that adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth.

Tooth brushing techniques were explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. The dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or appropriate high concentration fluoride tooth paste to keep their teeth in a healthy condition. They also placed special plastic coatings (fissure sealants) on the biting surfaces of adult back teeth in children who were particularly vulnerable to dental decay. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Staffing

On the day of our visit there were enough staff to support the dentists during patient treatment. But staff told us that the practice was short staffed with respect to dental nurses at various times each week. During these times dentists were either not appropriately supported when carrying out patient treatment and working alone, or one dental nurse was supporting two dentists at the same time by going between their treatment rooms which were on different floors of the premises.

Are services effective?

(for example, treatment is effective)

As a result of dentists working alone, there was a risk that proper chaperoning or dealing with a patient who was developing a medical emergency and the carrying out of effective infection prevention control measures could be compromised. In situations where the one dental nurse was supporting two dentists at the same time, the nurse was placed under stress and carrying out effective dental nursing support could be compromised.

In mitigation the principal dentist explained that the recruitment of suitable candidates was a problem in this particular area of the country.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves. Referrals to specialist services such as orthodontics were made locally, however for certain specialist treatment for which there was no provision locally the practice would refer to teaching hospitals in London.

If referrals were made urgently for suspicious lesions, the practice would follow up the letter with a phone call to the hospital to ensure that the referral had been received.

The practice kept a copy of the referral made in the patients' records, but did not offer a copy of the referral to the patients for their own records.

Consent to care and treatment

The dentist we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

Patients we spoke with on the day confirmed that treatment options were explained to them in full.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered. We spoke with the reception staff, and looked at the appointments book.

We looked at the booked appointments for the three weeks preceding the inspection and found that there had been significant cancellations by the practice in each week. Between a quarter and two-thirds of all booked appointments for the principal dentist were cancelled in each of those weeks for a variety of reasons.

We spoke to staff who confirmed this was a current trend and some patients were having their appointments cancelled multiple times. A patient we spoke with during our visit confirmed they had experienced multiple cancellations.

Reception staff attempted to minimise the impact of the repeated cancellations by keeping a record of patients who could be available at short notice should a gap open up and would contact them in that scenario.

Tackling inequity and promoting equality

The practice welcomed all patients to the practice, and each would be treated according to their needs.

The practice had procedures in place to assist patients with limited mobility. In order to access the ground floor treatment room the practice had temporary ramps that could be placed to allow wheelchair access to the treatment room. We saw these in use at the practice and staff assisting patients with this.

Access to the service

At the time of our visit patients had to wait up to a month for a routine appointment, although emergency slots were put aside on a daily basis to accommodate patients in pain, and the reception staff indicated that most patients in pain were seen within 24 hours of contacting the practice. Patients we spoke with verified that they were seen promptly in the event of an emergency.

In addition, where possible the associate dentist would see any patients that were unable to wait until their new appointment date, and they would also see emergency patients irrespective of who their regular dentist was to ensure that patients' needs were put first.

Out of hours patients were directed to the NHS 111 service by way of a message on the answerphone.

Concerns & complaints

The practice had systems in place to deal with complaints to the service although it was unclear how effective they were during our visit, as we were not shown any recent examples of the process.

The practice had a complaints policy which was dated 28 September 2013; this was displayed in the waiting area. As well as detailing how complaints could be made to the practice, it also detailed external organisations to which complaints could be escalated if not dealt with satisfactorily by the practice. These included the General Dental Council.

In addition leaflets were available in the reception area from the patient advice and liaison service, which if contacted would be able to support and direct patients in making a complaint. This leaflet also detailed the contact details for the Parliamentary and Health Service Ombudsman, who were available to review the way in which a complaint was handled.

Staff told us that there had been complaints made to the practice, however the complaints file detailed only historic complaints. We raised this with the principal dentist who said that he was dealing with more recent complaints, but couldn't show us details during our visit.

Are services well-led?

Our findings

Governance arrangements

On the day of our visit, we saw policies and procedures including infection prevention, complaints handling, safeguarding, health and safety, and general maintenance of the practice.

We found that up until fairly recently the governance systems had been maintained reasonably well. But the loss of a number of staff and the lack of effective leadership had contributed to lapses in areas such as required clinical audit being carried out on time. The last infection control audit was completed on 6 October 2015; however national guidance indicated that this should be carried out every six months.

Without a system in place to continue the governance arrangements within the practice, the practice could not be satisfied that staff, patients and visitors were safeguarded from harm. The practice principal indicated that following the departure of a key member of staff a system had not been put into place to continue the governance procedures. In addition newer members of staff were not able to identify where policies and risk assessments were located in the practice.

The lack of ongoing governance systems would make it difficult for the practice to identify risks, and respond to them in a timely manner, and this could put patients at risk of injury. For example, the autoclave used for sterilising instruments and the compressor (the air motor that runs the dental drills) had exceeded the normal maintenance interval of no longer than 14 months between servicing, and although the principal dentist thought that this had been recently carried out, no evidence was provided to this effect either during or following the inspection.

The practice was often short staffed in respect to dental nurses. This raised risk concerns regarding chaperoning, the ability to handle a medical emergency in the dental chair, and the ability of a single handed dental nurse to effectively complete infection control procedures for two treatment rooms, on different floors of the building. The practice had not completed a risk assessment to determine the risks involved in practicing without adequate nursing support.

A complaints policy was in place, and staff told us that recent complaints had been made to the practice. However we were not shown any evidence of these complaints, or how they had been dealt with. The principal dentist said he did not have that information with him.

Although the practice had arrangements in place to deal with medical emergencies that mainly followed published guidance, there were several shortfalls. For example we were informed that the practice had an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm, but we were told by staff that it was not working because it required a replacement battery which had not been provided. In addition the practice were carrying medicines that were no longer required in the current published guidance.

We observed that certain elements of the equipment and infrastructure in a dental treatment room was poorly maintained. This included a section of the dental chair with the stuffing exposed. This defect measured around 30cm by 10cm. We also noted that a section of the flooring was coming away from the one wall leaving a large gap that could accumulate dirt and debris. This measured several metres in length.

Leadership, openness and transparency

The current principal dentist had taken over the practice about four years ago. We found that over the last two years or so a number of ongoing concerns had affected the efficient running of the practice.

Because of this range of issues, we found that the principal dentist was struggling to provide effective leadership necessary for the smooth running of the practice. We did find that the staff we spoke with were hard working, caring towards the patients and committed to the work they did.

The practice had a whistleblowing policy on file. This indicated staffs' responsibility to report a colleague if they had concerns regarding their actions or behaviours. This policy was available for staff to reference in a file with other practice policies. Staff we spoke with were not always able to identify where they would locate the policy, but had a clear understanding of their professional responsibility in this regard, and knew how to raise such a concern should the need arise.

Are services well-led?

There was not effective communication across the team, and although the staff we spoke with were keen to support each other, there lacked an openness to discuss ongoing concerns.

The principal dentist wanted to run an efficient practice but we felt that they would benefit from obtaining peer support to deliver on these aspirations.

Learning and improvement

Clinical audit was used to highlight areas of clinical practice that could be improved, although the processes were not as robust as they might be, and therefore could not demonstrate any improvements had taken place.

An infection control audit was completed on 6 October 2015. The action plan generated from this audit made reference to the exposed stuffing of the dental chair, and the flooring in treatment room two, which was coming away from the wall. Although the practice principal was aware of the concerns; at the time of our inspection they were still outstanding.

A radiology audit was completed in March 2016. This was specific for each operator, so that inconsistencies between operators would be evident, but there was no written action plan generated following the completion of the audit. This meant that areas for improvement had not been identified, and opportunities for learning had not been taken up.

Some staff had completed basic life support training in the last year; however not all staff were able to attend the training, and no alternative training was arranged.

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

The practice sought feedback from patients through the NHS friends and family scheme, although we did not see any recent results of this.

Staff we spoke with gave conflicting information regarding how well feedback from staff was received. Some stated they felt their feedback was well received and they felt supported by the practice leadership whilst others had a less positive experience.

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 How the regulation was not being met: · The provider did not have systems and processes in place to identify risk, or where quality and safety were being compromised. Processes for completing audit and risk assessment had not been arranged following the resignation of a member of staff who was previously responsible for this. The replacement battery had not been provided for the automated external defibrillator. · Where risks to health, safety and / or welfare were identified, providers must have introduced measures to reduce or remove the risk. Infection control audit had highlighted exposed stuffing in a dental chair, and flooring coming away from the wall, but action had not been taken to remedy this. · The provider had not assessed the impact of the insufficient staffing levels, and had not taken adequate steps to mitigate the risk that insufficient staff could have on the health, safety and / or welfare of people who use the service. **Regulation 17 (1) (2) (a) (b)**