Enslin Limited

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Inspection Report

Enslin Dental Practice
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Overall summary

We carried out this announced inspection on 19 June 2018 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 that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Enslin Limited Dental Care is a small, well-established dental practice that provides NHS treatment to about 10,000 adults and children. The dental team includes two dentists, three dental nurses, one receptionist and a practice manager. The practice has two treatment rooms.

As the practice is not on ground level, there is no access for people who use wheelchairs. The practice does not have its own parking facilities, but there is pay and display parking nearby.

Summary of findings

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

On the day of inspection, we collected 38 CQC comment cards filled in by patients and spoke with three other patients.

During the inspection we spoke with two dentists, two dental nurses, and the practice manager.

The practice is open: Monday to Friday from 8:45 am to 5 pm each day.

Our key findings were:

- Information from completed Care Quality Commission comment cards gave us a positive view of a caring and professional service.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available, apart from portable suction.
- Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.
- Systems to ensure the safe recruitment of staff were insufficiently robust, as essential pre-employment checks had not been completed.
- Patients' needs were not always assessed or treatment delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.

We identified regulations the provider was not meeting. They must:

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

A full detail of the regulation the provider was not meeting is at the end of this report.

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

- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the practice's protocols for the selection criteria of radiographs taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the practice's responsibilities to the needs of people with a disability, including those with hearing difficulties within the requirements of the Equality Act 2010.

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?

No action

We found that this practice was providing safe care in accordance with the relevant regulations, although we noted that a number of improvements were required. Once these have been implemented the likelihood of them occurring in the future is low. We will be following up on our concerns to ensure they have been put right by the provider.

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

Premises and equipment were clean and properly maintained and the practice mostly followed national guidance for cleaning, sterilising and storing dental instruments.

There were sufficient numbers of suitably qualified staff working at the practice. Recruitment practices needed strengthening to ensure only suitable staff were employed to work with vulnerable adults and children.

Untoward events were not always reported appropriately and learning from them was not shared across the staff team.

Not all dentists routinely used rubber dams to protect patients' airways.

Are services effective?

No action

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

Patients described the treatment they received as effective and pain free. We dental clinicians were not following FGDP guidance in relation to clinical examinations and record keeping. Clinicians were not consistently recording patient's medical history updates, basic periodontal examination, caries, or oral cancer risks.

The practice had arrangements when patients needed to be referred to other dental or health care professionals, although patients' referrals were not actively tracked.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

No action

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

Summary of findings

We received feedback about the practice from 38 patients. They were complimentary about all aspects of the service provided. Patients spoke positively of the dental treatment they received and of the caring and supportive nature of the practice's staff. Staff gave us specific examples of where they had gone out their way to support patients.

Are services responsive to people's needs?

No action ✓

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

Routine dental appointments were readily available and time to treatment was good. Patients told us it was easy to get an appointment, especially in an emergency and the practice offered a telephone reminder service that patients valued.

Staff were aware of translations services for patients who did not speak English but information about the practice was not available in other formats or languages. There was no portable hearing loop to assist patients who wore hearing aids.

The practice took patients' views seriously. They valued compliments from patients and responded to complaints appropriately.

Are services well-led?

Requirements notice ✗

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 section at the end of this report).

The staff told us they enjoyed their work and felt supported by both the principal dentist and practice manager. The practice asked for and listened to the views of patients and staff.

We found a number of shortfalls indicating that the practice's governance procedures needed to be improved. This included the analyses of untoward events, recruitment procedures, auditing systems and the management of risk.

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, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We noted information about safeguarding reporting procedures in the reception diary, making it easily available to staff.

The practice had a whistleblowing policy and staff told us they felt confident they could raise concerns.

The routine use of rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment was not evidenced by the dentists. We were not able to assess if other methods were used to protect patients' airways from the records we viewed.

The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running. It was kept on site so it was not clear how it could be accessed in the event of an emergency.

Clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. The practice had a recruitment policy to help them employ suitable staff. We viewed recruitment files for staff and found that pre-employment checks had not been undertaken such as references and disclosure and barring checks. The practice did not keep a record of employment interviews to demonstrate they had been conducted fairly and in line with good employment practices.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire extinguishers and smoke alarms were regularly tested. The practice had not conducted a fire risk assessment, and we noted a number of hazards when we were on the premises such as oxygen storage and steep stairways. The practice manager told us that full fire risk assessment had been commissioned to take place on 2 July 2018, and quotes had been obtained for an integrated alarm system to improve safety.

The practice had arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and all required information was in the radiation protection file. Clinical staff had completed continuing professional development in respect of dental radiography. We noted that one X-ray unit was fitted with a rectangular collimator, but there were no beam aiming devices to hand. In the other treatment room there were beam aiming devices but the X-ray unit was not fitted with a rectangular collimator to reduce dosage.

We noted that the dentists did not always fully justify, accurately grade or report on the radiographs they took. FDGP guidelines were not always followed for their frequency, and we noted an unnecessary X-ray had been taken for the documented diagnosis. The practice carried out radiography audits, although results were not checked or validated.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not robust.

We were shown the practice's 'Risk Assessment 2016'. This recommended that a fire alarm be fitted, that reception staff receive eye tests, that work station assessments should be undertaken and that visual checks of all electrical equipment should be undertaken every six months. We were not provided with evidence to support that any of these issues had been addressed during the inspection. A number of potential hazards around the practice such as steep stairs and low ceilings had not been assessed. We noted spent mercury capsules stored in an open container, and an amalgamator without a lid, potentially exposing patients and staff at unnecessary risk.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year. Emergency equipment and

medicines were available as described in recognised guidance, with the exception of a portable suction unit. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team.

The provider had suitable risk assessments to minimise potential risks from most substances that were hazardous to health in the practice. We noted there were safety data sheets for some cleaning products such as floor cleaner and bleach.

The practice 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 (HTM01-05) published by the Department of Health and Social Care.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A risk assessment had been completed in June 2017 and its recommendations to improve signage around taps and monitor water temperatures had been implemented.

We noted that all areas of the practice were visibly clean, including treatment rooms, the waiting area, toilets and staff areas. Loose and uncovered instruments were found in drawers close to the operating area, and uncovered burs and cotton wool rolls stored on the bracket table. These risked becoming contaminated in the long-term.

The practice's arrangements for segregating, storing and disposing of dental waste reflected current guidelines from the Department of Health and the practice used an appropriate contractor to remove dental waste. Dental clinicians did not follow the relevant safety guidelines when using needles and other sharp dental items. A specific sharps risk assessment had not been undertaken in line with Sharps Regulations 2013. Labels on sharps' bins had not been completed so it was not possible to tell how long they had been in use.

The practice carried out infection prevention and control audits. The most recent audit conducted in 2016 showed the practice was meeting the required standards. There was no system to identify this had not been completed six monthly as recommended.

Information to deliver safe care and treatment

Patients' paper records were kept securely and staff were aware of new regulations affecting the management and security of patient information.

Safe and appropriate use of medicines

The practice had a specific fridge in which medicines requiring cool storage were kept. Its temperature was not monitored to ensure it operated effectively so it was not clear if the glucagon it contained was still effective for use. Prescription pads in treatment rooms were not held securely and there was no tracking in place to monitor individual prescriptions to identify any theft or loss.

An antimicrobial audit had been conducted to ensure dentists were following current guidelines. This had indicated that prescribing rates were high within the practice. The practice manager told us that the results had been discussed between dentists, but there was no evidence to show that improvements had been made as a result of the audit and no follow up audit had been planned.

Lessons learned and improvements

The practice had a significant events policy that provided guidance on RIDDOR requirements but there was no guidance for staff on how to manage other types of events**.** We found that staff had a limited understanding of what might constitute an untoward event and they were not recording all incidents to support future learning. For example, we were aware of several untoward incidents including a sharp's injury, and staff and patient trips. There was no evidence to demonstrate how learning from these incidents had been used to prevent their recurrence.

The practice had signed up to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). These were monitored by the practice manager who actioned them if necessary.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Our review of dental care records and discussion with the dentists demonstrated that patients' dental assessments and treatments were not always carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC). For example, patients' risk of caries, periodontal disease and oral cancer had not been assessed and recorded consistently. The practice lacked the appropriate dental probes to accurately measure patients' BPE scores. Medical histories had not been updated and signed by the patient as frequently as recommended.

Helping patients to live healthier lives

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. Nurses told us that the dentists discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health. Smoking cessation leaflets were available in treatment rooms.

The practice was participating in a government scheme to reduce the sugar intake amongst children. One young patient told us that they had enjoyed reading the posters about healthy teeth on display in the waiting room.

Consent to care and treatment

The practice 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 told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

Patients told us that they were provided with good information during their consultation and they had the opportunity to ask questions before agreeing to a treatment. Patients were provided with plans that outlined their treatment and additional written consent forms were used for some procedures.

Staff understood their responsibilities under the act when treating adults who might not be able to make informed decisions. Staff were aware of the need to consider Gillick competence when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice audited patients' dental care records to check that the dentists recorded the necessary information.

Effective staffing

Although the practice team was small, staff told us there were enough of them for the smooth running of the practice and to meet patients' needs. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at their annual appraisals.

Co-ordinating care and treatment

Staff confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems and processes for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice did not actively monitor to check that non NHS referrals had been received and patients were not routinely offered a copy of their referral for their information.

Are services caring?

Our findings

Kindness, respect and compassion

We received positive comments from patients about the caring and empathetic nature of the practice's staff. One patient told us staff made their young son feel very comfortable about going to the dentist. Another patient reported that staff always took the time to allow for, and understand, their great fear of the dentist.

Staff gave us examples where they had gone out of their way to assist patients. For example, when the local post office closed down for three months staff drove to other post offices in their own time to post denture and crown work. One dentist gave their lunch to a diabetic patient following a hypoglycaemic episode. One staff member hand delivered repaired dentures to a patient who was too ill to attend the practice.

We spent time in the reception area and observed a number of interactions between the receptionist and patients coming into the practice. The interaction was positive, and the receptionist was helpful and professional to patients both on the phone and face to face.

We noted information in the waiting area for a number of support organisations such as Norfolk Dementia and Sure Start.

Privacy and dignity

The practice's reception area was based in a corridor at the top of the stairs. It was not particularly private but staff were aware of the importance of privacy and confidentiality. They had placed a sign on the desk asking patients not to come around the side of the desk so that the screen could not be seen. Staff did not leave patients' personal information where others might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. Paper records were kep securely in a locked area upstairs.

All consultations were carried out in the privacy of the treatment rooms and we noted that doors were closed during procedures to protect patients' privacy

Involving people in decisions about care and treatment

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

The practice's information leaflet provided patients with information about the range of treatments available at the practice. We noted leaflets describing various dental conditions and treatments in the waiting area making them easily accessible to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was located up some step stairs and therefore was not accessible to wheelchair users. The toilet had been adapted to help those with limited mobility and staff were aware of translation services. We noted however that there was no portable hearing loop to assist those who wore hearing aids and information about the practice was not available in any other languages or formats such as large print.

Timely access to services

The practice displayed its opening hours in the premises, and included it in their practice information leaflet and on their website. We received several positive comments from patients about the ease of getting an appointment. One patient reported they had needed emergency treatment several times and staff had arranged an appointment quickly for them. Another patient greatly appreciated that the practice saw them when they had been holidaying in the area, saving them 'days of misery'.

Patients told us that waiting times for treatment were good and the dentists ran to time. They stated that getting through on the telephone was easy and they were rarely kept waiting once they had arrived for their appointment. Patients told us they had enough time during their appointment and did not feel rushed.

Two emergency slots were available each morning and each afternoon for patients experiencing dental pain.

Listening and learning from concerns and complaints

The practice had a complaints' policy providing guidance to staff on how to handle a complaint. Information about how patients could raise their concerns was available in the waiting room. Reception staff showed a good awareness of how to deal with patients' concerns and showed us a specific form that could be given to patients to complete.

The practice manager was responsible for dealing with complaints. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so that patients received a quick response. One patient told us they had had made a complaint about charges and it had been quickly and efficiently dealt with.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. He was supported by the practice manager who had worked at the practice for many years. Staff told us that both the principal dentist and practice manager were approachable and responsive.

Due to staff illness, the practice manager told us they had been under additional pressure. They told us this had caused them considerable stress and had adversely affected aspects of the practice's governance procedures. We were told that they were going to review their responsibilities and delegate their tasks amongst the staff team more effectively.

Vision and strategy

The practice did not have a specific vision or strategy, other than to continue providing NHS dental treatment, delivered by a small and friendly staff team.

Culture

The practice was small and friendly, something which both patients and staff particularly appreciated. Staff told us they enjoyed their job and felt valued in their work. They told us their morale was good and likened the staff team to a family. Staff reported they would be able to raise any concerns they had and felt they would be responded to.

The practice had a Duty of Candour policy in place, outlining staff's responsibilities to be open and candid if things went wrong.

Governance and management

Communication across the practice was structured around regular meetings which staff told us they found useful. There was a meeting each morning before the practice opened to discuss any stock deliveries, staff illness or events that day. In addition to this was a six weekly practice-wide meeting to discuss more formal matters.

The practice manager told us the dentists met regularly to discuss clinical matters, although these meetings were not minuted.

We identified a number of shortfalls in the practice's governance arrangements including the analysis of untoward events, the recruitment of staff and the detail recorded within dental care records that showed improvement was required. The assessment of risk within the practice was limited, and even when assessments had been completed, their recommendations to protect patients and staff had not always been implemented. The management of amalgam was not safe.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback about the NHS services they have used. Recent results showed that patients would recommend the practice. Patients' suggestions for the practice to implement a card payment scheme, and provide a clock and children's toys in the waiting room had been implemented.

The practice gathered feedback from staff through meetings, and informal discussions. Staff were encouraged to suggest improvements to the service and told us these were listened to and acted upon. For example, their suggestions to introduce a daily check list in surgeries, the wearing of clogs and visors had been actioned by the practice manager.

Continuous improvement and innovation

The practice paid for all training for its staff and subscribed to the Dental Nursing Journal. It was also a member of the British Dental Association to help staff keep up to date with current dental issues.

The practice manager, nursing and reception staff received annual appraisals from the principal dentist. The associate dentist did not, so it was not clear how their performance was monitored and assessed.

The practice conducted some audits but not all their results were fully analysed and there was no evidence of resulting action plans and improvements. The dental records audit had failed to identify the shortfalls we noted.

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 **Regulation 17 (1) Good Governance** The registered person did not have effective systems in place to ensure that the regulated activities at Enslin Dental Surgery were compliant with the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example: · There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence. • There were no robust recruitment systems in place to ensure that only fit and proper staff were employed by the practice. · A sharps risk assessment had not been completed and clinicians did not follow national guidance in relation to sharps' management and the use of rubber dams. · There was no system in place to ensure that regular audits of infection control were undertaken. . · Patient dental care records did not reflect standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

This section is primarily information for the provider

Requirement notices

- Actions and recommendations from risk assessments were not always implemented.

- Amalgam safety was not robust.

Regulation 17 (1)