Bassingbourn Dental Practice Limited

Bassingbourn Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection of Bassingborn Dental Practice 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. A CQC inspector, who was supported by two specialist dental advisers, led the inspection.

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

Bassingborn Dental Practice is a well-established practice based in the village of Bassingbourn that provides mostly NHS treatment to patients of all ages, although has a predominance of older patients.

The dental team includes two dentists, two dental nurses, one dental hygienist and a receptionist. A clinical co-ordinator, who is a registered dentist from another practice, helps with administration when needed. The practice has two treatment rooms and is open on Mondays and Tuesdays from 8.30am to 5pm; on Wednesdays from 8am to 6pm, on Thursdays from 8am to 5pm, and on Fridays from 8am to 1pm.

There is level access for people who use wheelchairs and those with pushchairs, but no disabled toilet facilities.

The practice must have a person registered with the Care Quality Commission as the registered manager.

Summary of findings

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 Bassingbourn Dental Practice is the principal dentist and owner.

On the day of our inspection we collected 14 comment cards filled in by patients and spoke with two other patients. This information gave us a very positive view of the practice.

During the inspection we spoke with the principal dentist, the clinical co-ordinator and two dental nurses. We looked at the practice's policies and procedures, and other records about how the service was managed.

Our key findings were:

- We received consistently good feedback from patients about the quality of the practice's staff and the effectiveness of their treatment.
- Appointments were easy to book and patients requiring urgent treatment were always seen on the same day.
- The practice had suitable safeguarding processes and staff knew their responsibilities for protecting adults and children.
- Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- Staff we spoke to felt well supported by the practice owner, and there were regular practice meetings involving all staff. The practice listened to its patients and staff and acted upon their feedback.
- Risk assessments were not robust enough to ensure that patients and staff were adequately protected
- The practice's sharps handling procedures and protocols did not comply with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Essential information and evidence of some dental examinations and risk assessments was missing from patient dental care records.

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

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This includes the recording and monitoring significant events; ensuring appropriate medical emergency equipment is available, ensuring staff recruitment is effective, implementing robust risk assessment, and improving the management of sharps. The practice must also ensure dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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

- Review the storage of medicines to ensure they are kept according to guidance.

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.

Staff received training in safeguarding vulnerable adults and children and knew how to recognise the signs of abuse and how to report concerns. The practice followed national guidance for cleaning, sterilising and storing dental instruments, although some equipment used in the decontamination of instruments had not been maintained adequately.

Significant events were not always reported appropriately and learning from them was not shared across the staff team. Emergency equipment did not meet national recommended guidelines

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. They told us that their dentist listened to them and gave them clear information about their treatment.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this. However, it was not possible for us to ascertain from the dental care records if patients' needs were fully assessed, and if care and treatment was delivered in line with current standards and evidence based guidance, as there appeared to be some essential information about patients' treatment and examinations missing.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

Are services caring?

No action

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

We received feedback about the practice from 14 patients. Patients were positive about all aspects of the service the practice provided and spoke highly of the treatment they received and of the staff who delivered it. Staff gave us specific examples of where they had gone out their way to support patients. We saw that staff protected patients' privacy and were aware of the importance of handling information about them confidentially.

Are services responsive to people's needs?

No action

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

Summary of findings

Routine dental appointments were readily available and patients experiencing dental pain were always seen on the same day. Patients commented that it was easy to get through on the phone to the practice, and they rarely waited once they had arrived. The practice had amended its opening hours in order to better meet patients' needs.

Information was available to patients about how to raise concerns.

Are services well-led?

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

Staff told us they enjoyed their work and felt supported and listened to by the principal dentist. However, we found a significant number of shortfalls in three of the five key questions we inspected, indicating that the practice was not well-led. This included the analyses of untoward events, the quality of dental care records, the provision of medical emergency equipment and the quality of audit systems. Some risk assessments had only just been completed prior to our inspection and not all control measures had been implemented.

Requirements notice 

Bassingbourn Dental Practice

Detailed findings

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have any policies regarding the reporting of untoward events, or any process in place to ensure learning from them was shared formally. Staff had a limited understanding of what might constitute a significant event. For example, staff told us there had not been any unusual incidents in the practice for a number of years; however, we were made aware of three such incidents including extensive IT failure, a serious complaint in relation to communication from the practice and a failed trainee dental nurse placement. There was no recorded evidence that these events had been fully investigated, or of any action taken to prevent their reoccurrence.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) from the local area NHS team, and staff were aware of recent alerts affecting dental practice. The principal dentist assured us she would sign up to receive these alerts directly from the MHRA website.

Reliable safety systems and processes (including safeguarding)

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 saw evidence that staff received safeguarding training and information was available around the practice with contact details of local protection agencies.

Only the dentists handled sharps and staff spoke knowledgeably about action they would take following a sharps' injury. However, the practice had not completed a specific sharps' risk assessment and dentists did not use a syringe needle safety system, as recommended in Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Following our inspection, the principal dentist informed us she was now using a safer sharps' system.

The practice had a business continuity plan describing how it would deal events that could disrupt the normal running of the practice. However, this was a generic plan that bore little relation to the actual practice. For example, it stated that a sprinkler system was in place; that there were sand bags, window shutters and remote access to a business telephone line; none of which the practice had.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year. We noted the practice did not have some essential medical emergency equipment including a full set of airways equipment, a child's ambubag or portable suction.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice and those we checked were in date for safe use. We noted that Glucagon was stored in the practice's drugs kit, rather than the fridge, but that its expiry date had not been reduced to allow for this.

Staff recruitment

Staff files we reviewed showed that some pre-employment checks had been undertaken for staff including proof of their identity and DBS checks. However, references were missing for two staff, there were no records of the interviews held and no evidence that staff had received a full induction to their role.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had appropriate professional indemnity cover.

Monitoring health & safety and responding to risks

We viewed a number of risk assessments undertaken by the practice. These were very basic and sometimes were not actually relevant to the practice. Not all control measures to reduce identified hazards following the assessments had been actioned. For example, recommendations that fire drills were held twice a year, that staff receive individual workstation assessments, and that visual portable appliance testing checks were undertaken, had been not implemented.

Staff were monitoring hot and cold water temperatures every month, but were unaware of some of the guidance in relation to dental unit water line management.

Are services safe?

Firefighting equipment was serviced regularly. However staff did not practice full evacuation from the building and there was no evidence that they had received any fire training.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for most materials used within the practice.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice's waiting area, toilet and staff areas were clean and uncluttered. Cleaning equipment used for different areas of the practice was colour coded to reduce the risk of cross infection. We checked the treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed work surfaces so they could be cleaned easily. However, we noted one radiator was very dusty and it was not clear when, or how often, window blinds were cleaned. The nurses carried out all cleaning but there were no cleaning schedules or accountability sheets in place.

We noted that staff's uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. Records showed that dental staff had been immunised against Hepatitis B.

The practice had infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. The practice conducted infection prevention and control audits but these were not undertaken as frequently as recommended by national guidance. Results from the latest audit had recommended that sharps boxes be wall mounted and that dentists use disposable syringes: neither of these recommendations had been implemented.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed that most equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance. However, there was no annual validation or quarterly foil testing for the practice's ultrasonic bath and one of the autoclaves was overdue its annual service.

The practice's arrangements for segregating, storing and disposing of dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice. Clinical waste was stored externally, although we noted the bin was not locked to ensure its safety.

Equipment and medicines

Staff told us they had the equipment needed for their role and that repairs to premises and fixtures were actioned in a timely way. Stock control was good and medical consumables we checked in cupboards and drawers were within date for safe use.

Dentists we spoke with were aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines. The practice stored prescription pads safely to prevent loss due to theft and a logging system was in place to account for any issued to patients. We noted that the name and address of the practice was not written on medicines directly issued to patients and need to be added.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. These met current radiation regulations and the practice had most of the required information in their radiation protection file. Rectangular collimation was used to help reduce patient dosage. It was not clear whether the Health and Safety executive had been notified that the practice undertook radiography.

Clinical staff completed continuous professional development in respect of dental radiography. Not all of the certificates were available on the day of our visit but these were forwarded to us after the inspection.

Not all dental care records contained evidence that the dentists had justified, graded and reported on the X-rays they took.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two patients during our inspection and received 14 comments cards that had been completed by patients prior to our inspection. All the comments received reflected that patients were very satisfied with the quality of their dental treatment, describing it as pain free and effective.

We saw a number of records that showed a number of shortfalls. The dentist told us that repeated IT failures had caused some patient records not to have been completed contemporaneously, and a lack of time meant they had not been updated retrospectively. She told us that the BPE discrepancies were due to differences in BPE taking between herself and the dental hygienist.

Health promotion & prevention

There was a selection of dental products for sale to patients including interdental brushes, mouth wash and toothpaste.

A hygienist was employed by the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease. She was also able to provide fluoride varnishes if needed. The principal dentist told us she regularly provided oral health education sessions to pupils at a local school and a pre-school group. The practice participated in National Smile Month and gave out stickers and balloons to children attending the practice during it.

Dental nurses told us the dentists regularly discussed smoking, alcohol consumption and diet with patients during appointments, and dental care records we viewed demonstrated that oral health advice was given to patients.

Staffing

Although a busy practice, both staff and patients told us they did not feel rushed during appointments. At the time of inspection, the practice was relying on agency nurses to cover set days in the week, whilst one of the nurses undertook her training course. Staff told us the dentists never work unchaperoned, although the hygienist did.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role. Staff told us they discussed their training needs at their annual appraisals and that the principal dentist was supportive of their training requests.

Working with other services

Staff confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure a specialist saw patients quickly. The practice kept a central log of all referrals, however this was not actively monitored to ensure that all referrals had been received once sent. This meant that the practice was not able to follow up these referrals until the patient themselves raised a concern that they had not heard anything. Patients were not routinely offered a copy of their referral for their information.

Consent to care and treatment

Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice team understood the importance of obtaining and recording patients' consent to treatment. Staff described to us some of the additional measure they implemented to ensure patients with Alzheimer's might be supported in line with the principals of the Mental Capacity Act. Staff described how they involved patients' relatives or carers where appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as caring and empathetic to their needs. One patient told us they had never felt judged by their dentist, despite failing to look after their teeth well.

Staff gave us specific examples of where they had supported patients such as ringing them after complex treatment to check on their welfare and coming in on Christmas eve specifically to see a patient in dental pain. We observed one dentist while they practiced clinical dentistry on six patients. Throughout all the treatments provided the dentist was professional and caring and provided effective care. This was particularly evident during the dental extraction where they dealt with a very nervous patient compassionately. They also dealt effectively with three quite challenging young siblings.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients, although staff assured us that they were careful not to give out patients' personal details when speaking on the phone. We saw that staff treated patients respectfully and were friendly towards patients at the reception desk and over the telephone. Computers were password protected and screens displaying patients' information were not overlooked. 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. Frosted glass was in downstairs windows to prevent passerbys looking in

Involvement in decisions about care and treatment

Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. However, there was little evidence that written information about various treatments was routinely given to patients to help aid their full understanding of it.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients told us they were satisfied with the appointments system and that getting through on the phone was easy. A text messaging service was available to remind patients of their appointments. Although the practice did not hold specific slots for emergency treatments, they did offer a 'sit and wait' service for patients experiencing dental pain. Staff told us this worked well and all patients would be seen the same day.

The practice had reviewed its opening times and now opened at 8am three mornings a week, and stayed open until 6pm one day a week to better meets patients' needs.

The waiting area provided good facilities for patients including a large screen TV, children's toys and interesting local magazines.

Promoting equality

The practice had level entry access and a downstairs treatment room. However**,** there was no disabled toilet to accommodate those with mobility problems or hearing loop to assist patients who wore hearing aids. Information about the practice was not available in any other languages or formats such as large print, despite serving a number of older patients. There was no information available about interpreting services that patients could access in the waiting area.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, and staff spoke knowledgeably about how they would handle a patient's concerns. Information about the procedure was available in the patient waiting area and included details of the timescales by which they would be responded to and other organisations that could be contacted.

The practice had received one formal complaint in the last year. We viewed the paperwork in relation to this complaint and found it was not possible to effectively track how it had been managed, or the timescales in which it had been responded to. There was no clear record of the contacts that had been made between practice staff and the complainant. We spoke with the patient who had made this complaint. He told us that he had not received formal notification that the practice had received his complaint, or a copy of the report into its investigation. He told us he was eventually invited to the practice to discuss it, but this was some months after he had raised his initial concerns.

There was no evidence to show that learning from this complaint had been shared across the staff team and used to improve the service.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the overall leadership in the practice, supported by a clinical co-coordinator who visited to assist her in the running of the service. We identified a number of shortfalls in the practice's governance arrangements including the analyses of untoward events, the assessment of potential hazards, the maintenance of equipment and the recruitment of staff that could affect the overall safety of the service.

Communication across the practice was structured around three monthly practice meetings that all staff attended.

There was no system in place to check staff's professional registration and if they had any fitness to practice conditions.

Leadership, openness and transparency

Staff told us they enjoyed their work and the small size of the practice, which meant that communication between them was good. They told us they felt supported and valued in their work and reported there was an open culture within the practice. Staff told us that they had the opportunity to, and felt comfortable, raising any concerns with the owner of the practice who was approachable and responsive to their needs.

The practice had recently implemented a policy in relation to its requirements under the Duty of Candour, although not all staff were aware of it.

Learning and improvement

The practice did not have a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography. Infection control audits were not undertaken as frequently as recommended and identified shortfalls had not been addressed. The clinical co-ordinator told us the dentists completed their own records audits, rather than peer review each other's to ensure better objectivity in their completion. The audits had not been effective in identifying the shortfalls we discovered, following our review of them.

All staff received an annual appraisal of their performance and we saw evidence of completed appraisals in the staff folders. Staff told us they found their appraisal useful as it gave them an opportunity to raise things on a one to one basis. Staff told us they completed mandatory training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so. For example, one nurse told us she had been supported to change her initial training provider and another nurse told us the practice had paid for her to sign up to an on-line dental training provider.

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

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Results we viewed indicated that respondents would recommend the practice. The principal dentist told us that in response to patients' feedback, the practice's opening times had been extended to better meet their needs.

Staff told us that the principal dentist listened to them and was supportive of their suggestions. For example, their request to redecorate their staff room had been implemented, as had their suggestion to dine out together in local restaurants to promote teamwork and communication. This was paid for by the practice.

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 The registered person did not have effective systems in place to ensure that the regulated activities at Bassingbourn Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** The provider did not have effective systems in place to : · Ensure that untoward events were analysed and used as a tool to prevent their reoccurrence. · Risk assessments were not detailed enough to ensure that patients and staff were adequately protected, and shortfalls were not actioned. · Ensure the safe recruitment of staff as essential pre-employment checks were not completed. · Ensure audits were effective. It was not clear if action had been taken to address identified shortfalls. · Ensure the practice's sharps handling procedures and protocols complied with The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1)