

The Campbell Clinic Limited

The Campbell Clinic Limited

Inspection report

Edwalton Business Park
Landmere Lane
Nottingham
NG124JL
Tel: 01159823913
www.campbell-clinic.co.uk

Date of inspection visit: 5 May 2021
Date of publication: 19/05/2021

Overall summary

We carried out this announced inspection on 5 May 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we asked the following three questions:

- Is it safe?
- Is it effective?
- 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 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 well-led?

Summary of findings

We found this practice was providing well-led care in accordance with the relevant regulations.

Background

The Campbell Clinic is located in the Edwalton area of Nottingham and provides private dental care and treatment for adults and children primarily on referral, including dental implants and conscious sedation.

There is level access to the practice with automatic doors for people who use wheelchairs and those with pushchairs. On site car parking spaces are available at the practice including those for blue badge holders.

The dental team includes nine dentists including an orthodontist and a periodontist, three dental hygienists, nine dental nurses including one apprentice dental nurse, a clinical lead, five receptionists, nine administrative staff and a practice manager. The practice has six treatment rooms, all of which are on the ground floor.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC 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 Campbell Clinic Limited is the principal dentist.

During the inspection we spoke with two dentists, one dental hygienist, the clinical lead, two dental nurses and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Thursday: 9am to 5:30pm and Friday: 9am to 4:30pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The provider had systems to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- The provider had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked as a team.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	No action ✓
Are services effective?	No action ✓
Are services well-led?	No action ✓

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had clear systems to keep patients safe.

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 provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. There was a designated lead person for safeguarding alerts within the practice. They had completed safeguarding training to the required level.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider also had a system to identify adults that were in other vulnerable situations for example those who had mental health issues.

The provider 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, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. There was a lead for infection control as recommended by the published guidance. The lead had undertaken infection control training in line with their continuing professional development and had the necessary training certificates in their file.

The provider had introduced procedures to minimise the risks to patients and staff related to COVID-19. These included reduced patient numbers, social distancing, personal protective equipment for staff, the provision of hand sanitiser and face coverings for patients and any chaperones. In line with the standard operating procedure produced by the Chief Dental Officer additional measures had been introduced when completing aerosol generating procedures (AGP's). These are procedures which will produce a splatter (for example drilling into a tooth) and therefore increase the risk of spreading the COVID-19 virus. Increased cleaning regimes had been introduced and the time between procedures had also increased to allow any air borne particles to settle and be cleaned.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. *The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.*

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations in the assessment had been actioned and records of water testing and dental unit water line management were maintained. The risk assessment had been completed by an external company and kept under review. The most recent review was in January 2020.

We saw effective cleaning schedules to ensure the practice was kept clean. During the inspection we saw the practice was visibly clean.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Measures were taken to ensure clinical waste was stored securely.

Are services safe?

The infection control lead carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at five staff recruitment records. These showed the provider followed their recruitment procedure.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

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

A fire risk assessment was carried out in line with the legal requirements. This had last been reviewed in January 2020. All staff had completed fire awareness training. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits every six months following current guidance and legislation. The provider had registered with the Health and Safety Executive in line with changes to legislation relating to radiography. Local rules for the X-ray units were available in line with the current regulations.

Clinical staff completed continuing professional development in respect of dental radiography.

The practice used hand-held X-ray machines, they had two. We observed that these machines were stored in a locked treatment room when not in use. Staff had received training in their use and appropriate safeguards were in place for patients and staff. The batteries were not removed when the machines were not in use, as the manufacturer had advised against this.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

A Covid-19 risk assessment had been completed. We observed staff were wearing personal protective equipment and a social distancing regime was in place.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

Are services safe?

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

Staff had completed sepsis awareness training. This helped ensure staff triaged appointments effectively to manage patients who present with dental infection and where necessary, refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Immediate Life Support training with airway management for staff providing treatment under sedation was also completed.

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

A dental nurse worked with the dentists and dental hygiene therapist when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

Medical histories were scanned directly into the dental care records and were checked by the dentist at each visit.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required. We noted there were robust systems in place for the security of medicines.

The dentists were aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits were being completed which indicated the dentists were following current guidelines. One staff member had completed training in antibiotic stewardship which focussed on the safe and appropriate use of antibiotics.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

Are services safe?

In the previous 12 months there had been no safety incidents. The practice had systems and processes to record, investigate and analyse any safety incidents that occurred. These were discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required. The practice reviewed regular Coronavirus (COVID-19) advisory information and alerts. Information was provided to staff and displayed for patients to enable staff to act on any suspected cases. Patients and visitors were requested to carry out hand hygiene and wear a mask on entering the premises. Information for patients relating to COVID-19 was available on the practice website. This included information about cleaning and safety regimes.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered conscious sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment, for example the placement of dental implants. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The staff assessed patients for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the guidance.

The practice used intravenous sedation. The records showed that staff recorded important checks at regular intervals. This included pulse, blood pressure, breathing rates and the oxygen content of the blood.

The operator-sedationist was supported by a trained second individual. The name of this individual was recorded in the patients' dental care record.

Staff had access to a range of equipment to enhance the delivery of care. For example, microscopes, a dental milling machine, hand-held X-ray machines, intra-oral camera, digital cameras, digital X-rays and cone beam computed tomography (a CBCT scanner). A CBCT scanner uses X-rays and computer-processed X-ray information to produce 3D cross-sectional images of the jaws and teeth.

Helping patients to live healthier lives

The practice offered advice and support to patients with regard to oral health and dentists discussed oral health during consultations.

Staff were aware of national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

The practice had a specialist periodontist on the team and offered treatment and advice to patients with severe gum disease.

Consent to care and treatment

Staff 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 staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who were looked after. Practice policies were in place covering these topics. The computer system being used at the practice could insert a mental capacity assessment form directly into the patients notes if required. This allowed the dentists to complete the assessment as part of the examination, and formed a permanent part of the dental care record.

Are services effective?

(for example, treatment is effective)

The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' dental records.

The practice's consent policy referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age. The team were aware of the Mental Capacity Act 2005 (MCA) and understood their responsibilities under the act when treating adults who might not be able to make informed decisions. This included making best interest decision. All staff had received training, and there was a specific consent policy relating to the MCA.

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 kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist assessed patients' treatment needs in line with recognised guidance. The relevant information was recorded in a detailed and clear manner and was easily accessible for clinical staff.

We saw that dental care records were audited on a six-monthly basis for each dentist. The audits had action logs and follow up plans. The most recent audits had been completed in January 2021.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a structured induction programme. Documentation relating to induction was seen in staff files. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. There were systems to monitor staff training and copies of training certificates were held in the practice.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. This included patients who required complex oral surgery and patients with special needs. If a patient was referred for NHS treatment this was usually through the NHS electronic referral portal.

The practice was primarily a referral clinic for services including conscious sedation, dental implants and periodontal disease (gum disease). Referral systems were monitored and tracked.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Are services well-led?

Our findings

We found this practice was providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability

We found leaders and managers had the capacity, values and skills to deliver high-quality, sustainable care.

Leaders and managers were knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them.

Leaders at all levels were visible and approachable. Staff told us they worked closely with those leaders and managers to make sure they prioritised compassionate and inclusive leadership.

We saw the provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population. The COVID-19 pandemic had reduced numbers of patients seen at the practice. However, the provider had taken steps to ensure the maximum number of patients who could receive an appointment, received one. Provided this could be done safely and giving due consideration to the restrictions imposed by COVID-19.

Culture

The practice had a culture of high-quality sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice. Managers had systems to identify and act on behaviour and performance that was not consistent with the vision and values of the practice. These included a range of human resources policies and procedures.

Staff discussed their training needs at annual appraisals and had a six-monthly review. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals and personal development plans where appropriate in the staff folders.

The practice held regular staff meetings to share information and support staff. Clinicians held three-monthly meetings and dental nurses met weekly. The computer system also contained an information sharing portal, where information could be shared among all staff or a selected group.

The staff focused on the needs of patients, the ground floor treatment rooms and level access made accessing treatment for patients with mobility issues easy. There was parking for blue badge holders near the front door. The main entrance was an electronic door which opened automatically. One treatment room was larger than the others and this tended to be used for sedation cases. There was a recovery room next to it if required and both rooms had easy access for the emergency services if required.

We saw the provider had systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Are services well-led?

The leadership of the practice were committed to supporting local good causes. Staff supported food banks in the area (a different one each month), and a staff charities committee oversaw funding raising activities. These included an annual charity ball, bake sales and bicycle rides to raise funds. There was a commitment to give 1% of the annual turnover of the business to good causes. Charities supported also included the dental charity Bridge2Aid who work in Africa, particularly in Rwanda and Tanzania.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management, clinical leadership and the practice manager and clinical lead shared the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

We saw there were clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example surveys and audits were used to ensure and improve performance. Performance information was combined with the views of patients.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. There was a staff survey which ran every two years. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Before the COVID-19 pandemic the practice had its own patient survey and a comments box was available in the waiting room for patient feedback. COVID-19 had meant these had been temporarily suspended, although the plan was to reinstate them when it was safe to do so.

Continuous improvement and innovation

The provider had systems and processes for learning, continuous improvement and innovation.

The provider had quality assurance processes to encourage learning and continuous improvement. These included a robust audit system which included audits of dental care records, radiographs and infection prevention and control. Clinical audits were also completed regularly, and the dental chairs had an in-built monitoring system which recorded every time a dental water line was flushed. Staff kept records of the results of these audits and the resulting action plans and improvements. This gave the management team an oversight of how the practice was operating.

The registered provider showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. There were systems in place to support staff in training and meeting the requirements of their continuing professional development. There was a dental training academy attached to the

Are services well-led?

practice. This particularly specialised in training related to dental implants. Training for foundation dentists, that was those dentists in the first year of practice after qualification had been offered at the training academy, as well as in-house training for the practice. The provider wanted the academy to provide an environment where dental skills could be shared and developed for use in the wider dental community.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.