Graham Wilding Ltd

Graham Wilding - Poulton-Le-Fylde

Inspection Report

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Overall summary

We carried out this announced inspection on 12 September 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

Graham Wildings practice is in Poulton le Fylde and provides private dental cosmetic treatments to adults.

There is level access to the reception for people who use wheelchairs and those with pushchairs.

Summary of findings

There are two members of staff working at the practice: the principal dentist and one dental nurse. The staff team has remained constant for a very long time. The practice has one treatment room on the first floor of the premises.

The practice is owned by an organisation 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 Graham Wilding Poulton le Fylde is the principal dentist.

On the day of inspection, we collected five CQC comment cards filled in by patients. During the inspection we spoke with the principal dentist and the dental nurse. We looked at practice policies and procedures, and other records about how the service is managed.

The practice is open:

Monday, Tuesday and Thursday 8.00am – mid-day and 1.00pm – 4.00pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Not all appropriate medicines and life-saving equipment were available.
- The practice had systems to help them manage risk to patients and staff.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures.
- The clinical staff did not provide patients' care and treatment in line with current guidelines and the dental care records lacked information.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The provider was not providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had limited information governance arrangements.

We identified a regulation the provider was not complying with. They must:

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

Full details of the regulation the provider is not meeting are at the end of this report.

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

- Review the procedure for the checking and recording of the fire alarm system, emergency lighting and firefighting equipment.
- Review the fixed electrical wiring within the premises. A safety check needs to be completed by a competent person.
- Introduce protocols regarding the prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

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.

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

Staff received training in safeguarding people and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles. The practice ensured clinical staff had received appropriate vaccinations and employment checks.

Premises and equipment were clean and properly maintained. A five-year fixed wiring electrical safety test had not been completed. Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were not regularly tested. Firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements for dealing with medical and other emergencies. Some equipment such as buccal midazolam and portable suction was missing and the weekly checks had failed to identify this.

Staff had received on line CPR training, but this had not been backed up with practical training support.

Are services effective?

No action

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

The dentist did not assess patients' needs in line with recognised guidance for periodontal and radiographic assessments. The practice did not keep detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist did not assess patients' treatment needs in line with recognised guidance. There was no evidence that the risks and benefits of treatment options were discussed with patients.

Patients described the treatment they received as excellent, effective and exceptional. The dentist discussed treatment with patients so they could give informed consent but this was not fully recorded in their records.

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

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

Summary of findings

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 five people. Patients were positive about all aspects of the service the practice provided. They told us staff were professional, friendly and approachable.

They said that they were given helpful, detailed and honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to electronic interpreter services and had arrangements to help patients with sight or hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

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 practice had arrangements to ensure the smooth running of the service. There was a clearly defined management structure and staff felt supported and appreciated.

The provider had limited systems of clinical governance in place which included policies, protocols and procedures.

There wasn't a system for receiving and acting on safety alerts. The practice was not registered with the appropriate agency to receive these alerts.

The practice did not have effective quality assurance processes to encourage learning and continuous improvement. There was no system to audit or evaluate the quality of dental care records or radiographs.

Summary of findings

The provider did not have systems in place for patient assessment and for the completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations, record keeping and the frequency of radiographs.

The practice team did not keep complete patient dental care records which were clearly written or typed. Treatment records were stored securely.

Patients were asked for their views and these were listened to.

Are services safe?

Our findings

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

The practice had 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 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. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

There was a system to highlight vulnerable patients on records for example those who required support with mobility or communication.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

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

As the staff team had not changed for over 20 years, the practice did not have a recruitment policy and procedure to help them employ suitable staff if required in the future. We looked at both staff recruitment records. These showed the practice had recorded the relevant checks for the staff such as disclosure barring service (DBS) checks and immunity.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including portable electrical and gas appliances. A five-year fixed wiring safety testing had not been completed.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were not regularly tested. Firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice had arrangements to ensure the safety of the X-ray equipment. We did not see evidence that the dentist justified and reported on the radiographs they took within the patient's treatment record. The taking of X-rays did not reflect current guidelines. The practice carried out radiography audits every year following current guidance and legislation but these lacked a summary of outcomes and any actions taken.

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

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

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

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

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, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency and completed on line training in emergency resuscitation and basic life support (BLS) every year. The training had not been supported by practical demonstrations. Some equipment required in the treatment of medical emergencies was missing. There was no buccal midazolam available to treat patients who may experience an epileptic seizure. There was no portable suction in the practice. Portable suction could be required if the emergency happens outside the actual dental treatment room.

Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. This process had not been effective at identifying the missing items.

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

Are services safe?

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

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. Staff completed infection prevention and control training and received updates as required.

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 were validated, maintained and used in line with the manufacturers' guidance.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

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

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 a sample of dental care records. Dental care records we saw were legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements, (formerly known as the Data Protection Act). We noted that individual dental care records were not written and managed in a way that kept patients safe.

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

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

There was a suitable 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.

The practice stored and kept records of prescriptions as described in current guidance.

The dentist was not fully aware of current guidance with regards to prescribing medicines.

Dental care records we reviewed, where antibiotics were prescribed, showed the dentist was not always following current guidelines. There was no audit of antibiotic prescribing and the reference numbers relating to prescriptions given out were not recorded. Symptoms were not always fully recorded in the dental care records for example; a patient presenting with temperature was not highlighted as a possible sepsis risk and followed up appropriately.

Track record on safety

The practice had a good safety record.

There were risk assessments in relation to safety issues. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. In the previous 12 months there had been no safety incidents.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

Are services safe?

The staff were aware of the Serious Incident Framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework.

There were limited systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice.

There wasn't a system for receiving and acting on safety alerts. The practice was not registered with the appropriate agency to receive these alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentist could not demonstrate that the care provided was in-line with current evidence-based practice. For example, they did not document that appropriate assessment, diagnosis and monitoring of periodontal conditions were carried out. They told us they rarely performed a Basic Periodontal Examination (BPE). The BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need.

We discussed how the dentist used radiographs as part of the assessment process. They did not document a justification for taking radiographs; including where full mouth radiographs had been taken in preference to intra-oral site-specific radiographs. The clinical records showed that the dentist did not grade the diagnostic quality of, or report on the findings of the radiographs they took. For example, we looked at radiographs where levels of bone loss as a result of periodontal disease was visible on radiographs. We highlighted the availability of evidence-based guidance from the Faculty of General Dental Practice (UK).

Helping patients to live healthier lives

The practice was not providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. This is an evidence-based toolkit published by Public Health England used by dental teams for the prevention of dental disease in a primary and secondary care setting). Adherence to the principles identified by this toolkit is considered 'good practice' for both NHS and private dental providers.

The practice was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services.

Consent to care and treatment

There was a process to obtain consent to care and treatment.

The practice team understood the importance of obtaining and recording patients' consent to treatment. There was some evidence that options were explained and discussed. We could not see documented evidence that the dentist explained and discussed the risks and benefits of these; or whether patients had been informed of the findings on radiographs which may influence their decisions. In patient feedback, patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. The staff were aware of the need to consider this 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 kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist did not consistently document assessments of patients' treatment needs in line with recognised guidance. Clinical records were hand written and lacked detail.

Patients' dental care records were not audited to check that the dentist recorded the necessary information. We discussed how the practice could use audits to review their current procedures and demonstrate improvements.

Effective staffing

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

There had been no new staff at the practice for a number of years. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at one to one meetings. We saw evidence of developing training plans. Staff had access to an electronic dental training program.

Co-ordinating care and treatment

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

Are services effective?

(for example, treatment is effective)

The practice had limited systems to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that the treatment they received was excellent, effective and exceptional. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

An information folder was available for patients to read.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The structure of the appointment system ensured that patients were provided privacy when staff were dealing with them. Staff did not leave patients' personal information where other patients might see it. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the

The practice had systems to support Accessible Information Standard and the requirements under the Equality Act. The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given, for example on line interpretation services were available for patients who did not have English as a first language. Staff communicated with patients in a way that they could understand. Staff helped them ask questions about their care and treatment.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example photographs, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice, currently had some patients for whom they needed to make adjustments to enable them to receive treatment. The practice had made reasonable adjustments for patients with disabilities.

We did not see a disability access audit.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in their information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients had enough time during their appointment and did not feel rushed.

The staff provided an emergency on-call arrangement. The practices' website, and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The practice had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. The principal dentist was responsible for dealing with these.

The principal dentist aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received in a survey undertaken prior to our inspection. Responses to the questionnaire showed the practice maintained continually high scores for services available, practice arrangements, patient care, confidence in staff and administration and finance.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist had the capacity and skills to deliver high-quality, sustainable care and had the experience, capacity and skills to deliver the practice strategy and address risks to it. They were less knowledgeable about issues and priorities relating to the quality and future of services.

The two members of staff worked closely together to make sure they prioritised compassionate and inclusive leadership.

The practice had an effective process to develop skills, including planning for the future leadership of the practice.

Vision and strategy

There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

There were responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management, clinical leadership of the practice and was responsible for the day to day running of the service.

The provider had limited systems of clinical governance in place which included policies, protocols and procedures. There were limited process for managing risks issues and performance.

The provider did not have systems in place for patient assessment and for the completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations, record keeping, and the frequency of radiographs.

Processes were not in place to monitor and improve performance. We identified concerns in the processes to assess and document treatment need.

Appropriate and accurate information

The practice acted on appropriate and accurate information. The practice did not consistently act on appropriate and accurate information. For example, the grading and justification of radiographs were not recorded in dental care records and there was no evidence that patients were informed about radiological findings. The dentist routinely took whole mouth X-rays without justification instead of smaller area specific X-rays. This is not in line with the guidance or regulation.

The practice 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 their patients to support sustainable services.

The practice used patient surveys, comment cards and verbal comments to obtain patients' views about the service.

The practice shared feedback through meetings and informal discussions.

Continuous improvement and innovation

There were limited systems and processes for learning, continuous improvement and innovation.

The practice had a limited quality assurance processes to encourage learning and continuous improvement. There were no audits for record keeping. The radiological audit lacked a summary of outcomes and actions. Opportunities were missed to identify the concerns we found with patient assessments, the use of radiography and record keeping. We identified a lack of awareness of nationally agreed evidence-based standards and guidance in primary dental care.

We saw certificates of regular attendance at learning events and seminars but could not see evidence that these were used to review and improve practice.

Are services well-led?

Due to the small staff number there was no system of annual appraisals. There were discussions of learning needs, general wellbeing and aims for future professional development within meeting minutes.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included e-learning for medical emergencies and basic life support training annually. This type of learning was not supported by practical demonstration.

The General Dental Council also requires clinical staff to complete continuing professional development. The practice provided support and encouragement for them to do so.

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: Good governance** **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** The registered person did not have effective systems in place to ensure that the regulated activities at Graham Wilding Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider failed to identify the system to check medical emergency drugs and equipment was not effective. • The provider did not have systems to ensure that care was provided in accordance with current guidelines and research to develop and improve their system of clinical risk management. For example, periodontal assessments and taking radiographs at recommended intervals as part of the assessment. • The practice did not ensure that comprehensive dental care records were maintained. In particular, the legibility of hand written records and ensuring that assessments and explanations of these, and any risks or benefits were documented appropriately. • The was no system for receiving and acting on safety alerts. The practice was not registered with the appropriate agency to receive these alerts.

This section is primarily information for the provider

Requirement notices

- The provider did not carry out clinical audits. For example, of dental care records or radiographic quality. Opportunities were missed to identify and act on deficiencies in these areas.
- The provider did not document a justification for, grade the diagnostic quality of, or report on the findings of the radiographs they took.

Regulation 17 (1)