

Mr. Robert Furniss

Southlands Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 March 2017 to ask the practice the following key questions; are services safe, effective, caring, responsive and well led?

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

Southlands Dental is a well-established dental practice situated on the outskirts of the market town of Swaffham. It provides private dentistry services to adults and children and serves about 3000 patients. The team

consists of four dentists, a dental therapist, four dental nurses, a receptionist and a dental nurse manager. There are three treatment rooms, a room for the decontamination of instruments, a reception and waiting area, and a staff room.

The practice opens on Mondays and Tuesdays from 9am to 7pm; on Wednesdays and Thursdays from 9am to 5.30pm, and on Fridays from 9am to 5pm.

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

Our key findings were:

- The practice had good facilities overall and was well equipped to treat patients and meet their needs.
- Information from 34 completed Care Quality Commission comment cards gave us a picture of a caring, empathetic and responsive staff. Patients told us they felt well looked after and that they never felt rushed. However, patients also described areas of the building as a little shabby and commented on holes in walls and cracks in the plaster that required attention.
- Staff had received safeguarding training and took action to protect vulnerable patients when needed.

Summary of findings

- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- Access to appointments was good: the practice opened late two evenings a week, and emergency slots were available each day for patients requiring urgent treatment.
- There were sufficient numbers of suitably qualified and competent staff. 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 had undertaken specific training in dementia to better understand the needs of patients living with this disease.
- Staff were not aware of recent safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) that affected dental practice.
- The identification of potential hazards within the practice was poor. Risk assessments were not detailed enough to ensure that patients and staff were adequately protected.
- The practice's recruitment process did not ensure that all relevant checks were undertaken before new staff started work and staff did not receive formal appraisal of their performance.

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 monitoring significant events; strengthening staff recruitment, implementing robust risk assessment, ensuring staff are aware of and follow national guidelines, and providing appraisal for staff.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review protocols regarding the prescribing and recording of antibiotic medicines in consideration of the guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing and in line with the requirements of the Health and Social Care Act 2015 Code of practice on the prevention and control of infections.
- Review the frequency of infection control audits and ensure that learning points are documented and shared with all relevant staff.

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?

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

There were sufficient numbers of suitably qualified and competent staff to meet patients' needs and the practice had arrangements in place for essential areas such as clinical waste, the control of substances hazardous to health and the maintenance of equipment. However, untoward events were not analysed to prevent their reoccurrence and staff were unaware of recent safety alerts affecting dental practice. Risk assessment, fire safety and recruitment procedures needed to be improved to ensure patients and staff were protected.

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No action



Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, options and costs were explained to patients in a way they understood. Patients were referred to other services as needed.

The staff were able to access professional training and development appropriate to their roles; although they did not receive regular appraisal of their performance.

No action



Are services caring?

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

We collected 35 completed patient comment cards and obtained the views of a further three patients on the day of our visit. Patients commented on friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. Staff gave us examples of additional support they had provided for some patients.

No action



Are services responsive to people's needs?

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

No action



Summary of findings

The practice had good facilities and was well equipped to treat patients. Patients could access routine treatment and urgent care when required and the practice opened late two evenings a week to meet patients' needs. Appointments were easy to book and the practice operated an appointment reminder service. The practice had made some adjustments to accommodate patients with a disability.

There was a clear complaints' procedure, although this was not well advertised to patients. The practice responded appropriately to issues raised by patients.

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 owners. Feedback from patients was actively sought, which staff acted on to improve services to patients.

However, we found a number of shortfalls indicating that the practice was not well-led including the analyses of untoward events, the recruitment and development of staff, the assessment of risk and consistency of adherence to some clinical national guidelines

Requirements notice 

Southlands Dental Practice

Detailed findings

Background to this inspection

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

The inspection took place on 7 March 2017 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with both dentists, the practice manager, a dental nurse and the receptionist. We received feedback from 35 patients who had completed

our comment cards prior to our visit, and spoke with another two during our visit. We reviewed policies, procedures and other documents relating to the management of the service.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff we spoke with had a good understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences). The practice had an incident file and we noted that the details of three accidents had been documented, including a staff faint, a patient who had suffered an angina attack and a patient who had slipped on a wet floor. There was no recorded evidence that these events had been fully investigated, or of any action taken to prevent their reoccurrence. Although one of the dentists told us that incidents were discussed at staff meetings, not all staff were aware that these events had even occurred within the practice.

One dentist told us the practice had only recently signed up to receive patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Therefore staff were not aware of some alerts affecting dental practice that had been issued in the previous six months to our inspection.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. There was information on display around the practice, which provided reporting details. We also noted information for patients in the waiting room concerning domestic violence support services. Staff had received regular training in safeguarding people, and their knowledge of local protection agencies was good. Staff gave us an example of the action they had taken in response to their concerns about a vulnerable patient living with dementia to ensure they were protected. All staff had been checked via the Disclosure and Barring Services to ensure they were suitable to work with vulnerable adults and patients.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which may be contaminated). A sharps' risk assessment had been completed for the practice and the dentists used a sharps safety system, which allowed them to discard needles

without the need to re-sheath them. Single use disposable matrix bands were also used and a sharps' protocol was on display in areas where they were used. Sharps' boxes were wall mounted, although staff were not aware that they needed to be disposed of after a three month period, regardless of how full they were. Staff spoke knowledgeably about action they would take following a sharps' injury.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. Two of the dentists routinely used rubber dams but one dentist told us he had never used one. Following our inspection we received a statement from him declaring his intent to use a rubber dam for all future endodontic work, and outlining the measures in place to ensure he did this.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. An automated external defibrillator (AED) was available and staff had access to oxygen, along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. We noted that oxygen masks were not bagged to ensure they remained clean and dust free. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. However, staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date.

All staff had access to first aid and eyewash equipment if needed.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The medicines were checked weekly to ensure they were fit for use. Glucagon (a medicine used to treat hypoglycemia) was kept in a fridge, although the fridge temperature was not effectively monitored to ensure it operated correctly.

Staff recruitment

We checked recruitment records for the most recently employed member of staff. Notes from their recruitment

Are services safe?

interview were kept to demonstrate they had been conducted in line with good employment practices, and standardised questions were used to ensure consistency. Although written references had not been requested, we saw a record of two verbal references that had been obtained. However there was no photographic proof of their identity and a DBS check had only been completed some months after they had been employed at the practice.

The practice had a specific employee handbook, which provided staff with good information about their conditions of employment, essential practice policies and various personnel matters

Monitoring health & safety and responding to risks

We viewed risk assessments for each area of the practice. These were very basic and did not adequately identify the potential hazards or detail in enough depth the action needed to be taken by staff to prevent them. The practice's fire risk assessment was also very limited and failed to adequately identify what was required to prevent an incident.

Hot and cold-water temperatures were monitored monthly; dental unit water lines were treated with a biocide and staff ran the water lines each day in accordance with national guidance to reduce the risk of legionella bacteria forming. The practice had completed a legionella risk assessment, but once again this was very basic. However, following our inspection one of the dentists informed us that the practice had engaged an accredited company to conduct a full assessment, and to provide a new policy and log book.

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

The practice had a business continuity plan in place for major incidents such as the loss of utilities or natural disasters. A copy of the plan was kept off site to ensure it was accessible in the event of an incident.

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 room, toilets and staff areas were clean and uncluttered. Cleaning equipment used for different areas of the practice was colour coded and stored correctly 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.

The practice complete infection control audits and had scored 96% on its most recent audit dated March 2016, indicating that it met essential quality requirements. These audits were not being undertaken every six months as recommended by national guidance.

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

The practice had a separate decontamination room for the processing of dirty instruments, which was organised, tidy, and clutter free. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Instruments were initially cleaned manually, although we noted that they were rinsed under running water that risked the spread of aerosol contamination. Following inspection with an illuminated magnifying glass, instruments were then placed in an autoclave (a device used to sterilise medical and dental instruments). When the instruments had been sterilized, they were pouched and stored hygienically until required. All pouches were dated with an expiry date in accordance with current guidelines. Staff wore appropriate personal protective equipment throughout the process.

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, which was stored in a locked bin outside the practice. This bin needed to be secured more robustly to ensure it could not be removed.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, portable

Are services safe?

appliance testing had been completed in February 2017, gas safety on February 2017 and fire extinguishers serviced on August 2016. Fixed wire testing had been booked for March 2017.

The practice had a fridge, and although we were told the temperature was monitored daily, this was not recorded. We found that glucagon medicine had been kept at a temperature of zero degrees, and not between two and eight degrees as recommended.

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. We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were recorded in patients' clinical notes. Patients' prescriptions were recorded on headed paper and printed off only when required. However there was no logging system in place to account for the prescriptions issued and the practice did not keep an overview of its antimicrobial prescribing.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the local rules for each unit. Included in the file were the critical examination packs for each X-ray set and the necessary documentation pertaining to the maintenance of the X-ray equipment. However we noted a report on equipment dated June 2016 that had made a number of recommendations and it was not clear whether or not these had been implemented. Rectangular collimation was not being used as recommended by national guidelines to help reduce patient dosage.

Training records showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations. Regular radiographic audits were completed for the operators to ensure the quality of X-rays taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

All new patients to the practice were asked to provide their medical history including any health conditions, current medication and allergies and these were updated regularly to ensure the dentists were aware of any health concerns. Patients told us they were always asked about their health prior to treatment stated they were very satisfied with the quality of their dental treatment.

Our discussion with the dentists and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. Assessments included an examination covering the condition of the patient's teeth, gums and soft tissues. Antibiotic prescribing for patients, wisdom tooth extraction and patients' recall frequencies also met national guidance. Patients' basic periodontal examinations were recorded with appropriate referrals made if needed. Where relevant, preventative dental information was given in order to improve the outcome for the patient. The dental care records we saw were detailed and well maintained.

We saw a range of clinical audits that the practice regularly carried out to help them monitor the effectiveness of the service. These included the quality of dental radiographs, dental care records and infection control.

Health promotion & prevention

Two patients told us that they had received excellent care from the practice's dental therapist and reported that their oral health had greatly improved as a result. A number of oral health care products were for sale to patients including interdental brushes, mouthwash and dental floss. Free samples of toothpaste for patients were also available on the reception desk. A part-time dental therapist was available at the practice to focus on treating gum disease and giving advice to patients on the prevention of decay and gum disease. Staff told us the hygienist had recently given a presentation about oral health to a local GP patient participation group.

The dentists regularly asked patients about their alcohol intake and smoking habits and we noted good information about local smoking cessation services in the waiting area

and patient toilet. Not all dentists were fully aware of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.

Staffing

The practice had a well-established staff team, many of whom had worked there a long time. Staff told us they were enough of them for the smooth running of the practice and a nurse worked with the hygienist. An additional nurse was available most days to provide extra support. One nurse had recently left, but the practice was in the process of replacing her. Each dentist saw about 15-20 patients a day and both staff and patients told us they did not feel rushed during appointments

Files we viewed demonstrated that staff were appropriately qualified, trained had current professional validation and professional indemnity insurance. The practice had appropriate Employer's Liability insurance in place. In addition to core training, all staff had undertaken specific training in the care and treatment of patients with dementia in the dental setting to help them better understand the specific needs of these patients.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. Urgent referrals were telephoned in and then followed up with a letter or email. Staff told us how they had worked closely with oncology and maxillo-facial departments in order to provide a coordinated and multi-disciplinary approach to the care of one patient.

A log of the referrals made was not kept so they could be tracked and patients were not routinely offered a copy of the referral for their information.

Consent to care and treatment

Patients told us that they were provided with good information during their consultation and they had the opportunity to ask questions before agreeing to a particular treatment. Dental records we reviewed demonstrated that treatment options had been explained to patients. The dentists did not routinely use information leaflets about complex treatments to give to patients to enhance their understanding and consent

Are services effective?

(for example, treatment is effective)

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Dental staff had undertaken training in relation to the MCA and most had a clear understanding of

patient consent issues. Not all dentists were fully conversant with the principles of the MCA or able to demonstrate recent training in assessing patient competency.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as professional, caring and empathetic to their needs. Patients commented on the relaxed and friendly environment of the practice and told us staff understood their oral health concerns.

Staff told us of additional support they had provided for one patient who had required multiple extractions and a socially isolated patient who regularly popped in to talk to staff. Staff told us they regularly rang patients after complex treatment and checked if older patients had arrived home safely after their appointment.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients. However, staff assured us that they were careful not to give out patients' personal details when speaking on the phone and tried to ring patients when the waiting room was empty. Treatment rooms doors were closed at all times when patients were with dentists and conversations between patients and dentists could not be heard from outside the rooms. Blinds were hung on windows to prevent passerbys looking in.

Involvement in decisions about care and treatment

Patients told us that they were provided with good information during their consultation and that they had the opportunity to ask questions. Dental care records we viewed demonstrated that treatment options had been discussed with patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was easily accessible with its own car parking spaces and a bus stop just opposite. The waiting area provided good facilities for patients including a children's play area and interesting magazines. There was a website giving patients basic details about the services it provided and the dental clinicians. The practice offered the full range of general dentistry services including fillings, crown and bridge work, root canal treatment and denture work. A dental therapist was employed who specialised in the treatment of children and nervous patients.

The practice opened on Mondays and Tuesdays from 9am to 7pm; on Wednesdays and Thursdays from 9am to 5.30pm; and on Fridays from 9am to 5pm. Out of hours cover was provided on a rota system with three other practices. The practice operated an telephone appointment reminder service and emergency slots were available each day between 1 and 2 pm. Patients told us it was easy to get an appointment at a time that suited them and one patient reported that they received very prompt treatment following a road traffic accident.

Tackling inequity and promoting equality

The practice had made some adjustments to help prevent inequity for patients that experienced limited mobility and there was level access ramp entry to the building. All treatment rooms were downstairs, although the toilet was not accessible to wheelchair users. There was no wide seating or chairs of different height in the waiting room to accommodate those with mobility problems and no portable 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 or audio.

Concerns & complaints

One of the senior nurses was the lead for dealing with complaints and the practice had a policy and a procedure that set out how complaints would be addressed, timescales and other organisations that could be contacted for support. However information on how to raise concerns was not easily accessible to patients. There was no information on the practice's website and details in the waiting area were not easily visible.

We viewed the details of the three most recent complaints received by the practice and although they had been responded to in a professional, timely and empathetic way, there was no evidence to show that learning from them had been shared across the staff team and used to improve the service.

Are services well-led?

Our findings

Governance arrangements

There was no practice manager in place and one of the lead nurses had taken on a number of managerial tasks as a result. She told us that this had involved a lot of additional work and she considered that a dedicated practice manager would be better placed to provide leadership. We identified a number of shortfalls in the practice's governance arrangements including the analyses of untoward events, the assessment of potential hazards and the recruitment of staff that could affect the overall safety of the service.

We found a lack of consistency of practice between the dentists and it was not clear how their performance was monitored to ensure it met national guidelines and recommendations. Although audits were completed, there was not always a record to show that shortfalls they had identified had been addressed.

We noted that fixed wire testing, portable appliance testing and gas safety checks had been completed just prior to our visit: however when we asked to see evidence of previous checks these were not available.

Communication across the practice was structured around regular practice meetings that all staff attended. Copies of minutes were distributed to staff who could not attend. Staff told us the meetings provided a good forum to discuss practice issues and they felt able and willing to raise their concerns in them. Although staff had personal development plans, they did not receive regular appraisal to monitor and assess their performance. 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 generally felt well supported. They described their morale as good and stated there was good teamwork at the practice. One staff member had greatly appreciated that her request for extended leave so she could travel had been granted by the practice. However, staff told us that unavoidable absence by a senior member of the team had affected the general oversight and running of the practice.

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.

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

We were shown a patient satisfaction survey that had been just prior to our inspection. This asked if patients felt welcomed at the practice, if they were listened to and treated well by staff and if they ever felt rushed. Only a very small number of responses had been received (10), but all indicated a high rate of satisfaction with the service offered. In response to feedback, the practice had lowered a mirror in the toilet, as it was too high, had changed the typeface on its private fee list so it would be read more easily and had redesigned the patients' survey to make it easier to complete.

The practice gathered feedback from staff generally through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues. We were provided with examples of where staff's suggestions had been implemented such as gravelling the driveway, purchasing a dishwasher and providing Wi-Fi in the waiting room.

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 Southlands Dental Surgery were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example: • There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence. • There was no system in place to ensure consistency of practice between the dentists and of assuring they adhered to some clinical national guidelines. • Systems to identify potential hazards within the practice were limited. Risk assessments were not detailed enough to ensure that patients and staff were adequately protected. • Systems to ensure the safe recruitment of staff were not robust as essential pre-employment checks were not completed. • Staff did not receive regular appraisal to assess their working practices and performance. • Audit systems were not effective and it was not clear if action had been taken to address identified shortfalls.