Impressions Orthodontics Limited

Impressions Orthodontics (trading as Making Smiles)

Inspection Report

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Overall summary

We carried out this announced inspection on 13 November 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

Impression Orthodontics (trading as Making Smiles) is in High Wycombe and provides NHS and private treatment to patients of all ages.

The practice is based on the first and second floor. Patients are advised of this when they enquire.

Summary of findings

The dental team includes one specialist orthodontist, three dental nurses who also cover reception duties an orthodontist therapist, an administrator and a part time practice manager.

The practice has two treatment rooms.

The practice is owned by an individual who is the principal orthodontist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of our inspection we collected 32 CQC comment cards filled in by patients and obtained the views of a further 10 patients.

During the inspection we spoke with an orthodontist, 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 9am to 6pm Monday to Thursday and 9am to 1pm on Friday.

Our key findings were:

- The practice appeared clean and well maintained.
- The practice had infection control procedures which reflected published guidance but were not followed.
- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were generally available but some equipment was missing and the oxygen cylinder was not the recommended size.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice did not have thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- The practice did not have effective leadership or a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The practice dealt with complaints positively and efficiently.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. Specifically, audits, risk assessments, health and safety management and radiography.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

Full details of the regulations the provider was not meeting are at the end of this report.

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

- Review the practice's arrangements for receiving and responding to orthodontic specific patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare Products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- Review the practice's processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.
- Review the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 but improvements were needed

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

Staff were qualified for their roles. The practice did not complete all essential recruitment checks.

Premises appeared clean and properly maintained.

Improvements were required to the management of fire safety, legionella, radiography and emergency medicines and equipment.

The practice did not follow national guidance for cleaning, sterilising and storing dental instruments.

Are services effective?

No action

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

The orthodontist assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as caring and respectful. The orthodontist discussed treatment with patients so they could give informed consent but this was not routinely recorded in patient's care 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.

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 42 people. Patients were positive about all aspects of the service the practice provided. They told us staff were professional, kind and knowledgeable.

They said that they were given professional and well explained information, and said their orthodontist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the orthodontist.

Summary of findings

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 a hearing loop.

The practice did not have access to interpreter services. The practice addressed the interpreter shortfall during our visit.

The practice did not have arrangements to help patients with sight loss.

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 Actions section at the end of this report).

The lack of effective management and clinical leadership at the practice resulted in shortfalls in the frequency of audits and risk assessments, health and safety monitoring not undertaken, and the lack of patient feedback opportunity.

Are services safe?

Our findings

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

The practice 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 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 e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

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

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

The practice had a staff recruitment policy and procedure to help them employ suitable staff which reflected the relevant legislation. We looked at two staff recruitment records. Improvements were needed for one which did not include evidence of a second reference, proof of identity and eligibility to work in the UK. The second staff file did not include evidence of references.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC). Evidence of professional indemnity cover for the nurses was unavailable for inspection.

Firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice was unable to provide a five-year electrical installation test certificate.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly checked but following discussion with the practice manager we found this was not the case. Fire alarms were not tested weekly and emergency lighting was not tested monthly.

A fire risk assessment document was reviewed a week before our visit. There was mention of a gas boiler in the original assessment but not removed from the review in 2018 to reflect the removal of gas from the building. This indicated the responsible person did not review the document effectively.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

We were unable to evidence that the orthodontist justified, graded and reported on all the radiographs they took. The orthodontist confirmed they were aware of this shortfall.

The practice had a new X-ray machine commissioned in January 2018. An X-ray audit was not required until January 2019.

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

Risks to patients

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly. 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.

The practice sharps policy was generic and not relevant to the practice in part.

A sharps risk assessment had not been undertaken.

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 training in emergency resuscitation and basic life support (BLS) every year.

Are services safe?

Emergency equipment and medicines were not managed effectively. We found the oxygen cylinder size was not the recommended size, one piece of equipment was out of date and a number of pieces of equipment were missing which showed the practice did not follow recognised guidance.

There was no body fluid spillage kit available.

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

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

Staff completed infection prevention and control training and received updates as required. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

We noted staff did not follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Specifically, not using recommended gloves, not soaking instruments in solution prior to being decontaminated at the end of the clinical session and not scrubbing instruments appropriately.

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. A risk assessment was carried out in April 2017. We noted recommendations had not been actioned.

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. The audit carried out on 7 November 2018 showed the practice was meeting the required standards. We were advised this was the only audit the practice had carried out.

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 orthodontist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe.

Dental care records we saw were legible and were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues. In the previous 12 months there had been no safety incidents.

Lessons learned and improvements

The practice had systems in place to learn and made improvements if things went wrong.

The staff were aware of the Serious Incident Framework.

There was a system for receiving and acting on safety alerts. We noted not all the relevant alerts were received which related to orthodontics.

Are services effective?

(for example, treatment is effective)

Our findings

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 needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The orthodontist told us that where applicable they discussed diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

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. Information about schemes were available in the waiting area.

Consent to care and treatment

The practice obtained consent to care and treatment. We noted verbal consent was not routinely recorded in patients notes.

The orthodontist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their orthodontist 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 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.

We were unable to confirm the orthodontist's record card audit was effective as we were only able to see one page.

We noted the orthodontic therapist did not audit patients' dental care records to check that the orthodontists recorded the necessary information.

Effective staffing

We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs informally.

We saw evidence of completed appraisals for two of the five staff currently working at 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 orthodontist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

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

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

The practice monitored all referrals to make sure they were dealt with promptly.

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 staff were professional and knowledgeable. We saw that staff treated patients respectfully and caring way and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients.

The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

We noted window in the patient toilet was not completely frosted to protect privacy. We advised the provider and practice manager who immediately ordered a covering to address the shortfall.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard.

Interpretation services were not available for patients who did not have English as a first language. This was immediately addressed during our visit.

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

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

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

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 had a hearing loop but did not have any facility to support those patients with sight loss.

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 on their website.

They took part in an emergency on-call arrangement with another local practice.

The practice 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 complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice manager was responsible for dealing with these. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager told us they 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. Information for patients showed that a complaint would be acknowledged within three days and investigated within ten days.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The principal orthodontist was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Improvements were needed to ensure the principal orthodontist had the capacity and skills to deliver high-quality, sustainable dental care and treatment. They fully acknowledged that their lack of effective governance management at the practice had resulted in many clinical and managerial shortfalls in the efficiency of the practice.

Culture

Staff stated they felt respected. They were proud to work in the practice. The practice focused on the needs of patients. The provider had a system in place to act on behaviour and performance inconsistent with the vision and values.

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

Staff we spoke with told us they could raise concerns and were encouraged to do so.

Governance and management

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

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

The arrangement indicated that the practice fell short of effective clinical and managerial leadership. This became apparent when we noted shortfalls in the management of emergency medicines and equipment, fire safety, radiography, consent, risk assessments, audits, patient safety alerts and staff appraisals.

Appropriate and accurate information

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

The practice used social media and verbal comments to obtain patients' views about the service. As a result of patient feedback, the practice introduced more seating in the waiting area.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. As a result of staff feedback, the practice improved internal communication.

We saw systems for seeking and learning from patient feedback. We noted that formal patient feedback had not been undertaken.

Continuous improvement and innovation

The principal orthodontist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff but it was evident that improvements were required. Peer reviews were not carried out. Clinical audits were either not actioned or not carried out. For example, legionella, sharps and patient records for the orthodontic therapist.

Staff discussed learning needs, general wellbeing and aims for future professional development but this was informal. Two of the five staff received appraisals.

Continuous improvement and innovation

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

The practice had quality assurance processes to encourage learning and continuous improvement but improvements were needed.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

Are services well-led?

The General Dental Council also requires clinical staff to complete continuing professional development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person 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.** This was in breach of regulation 17(2) in particular: • There was no evidence of the effective management of Legionella, Radiography and Fire Safety • The practice did not follow national guidance for cleaning and sterilising dental instruments. • Staff appraisals were not carried out. • Management of emergency medicines and equipment did not follow national guidance.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed.** This was in breach of Regulation 19 in particular: **Pre-employment checks missing included:** • Proof of identity • Eligibility to work in the UK • References