1A Group Dental Practice Partnership

1A Dental Practice - Stanground

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 May 2015 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 a responsive service 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.

1A Dental Practice in Stanground provides primary dental care and treatment to patients whose care is funded through the NHS and to a small number of patients who pay privately. The service is part of the 1A Group Dental Practice Partnership owned by a large provider of dental care the IDH Group. The practice employs two dentists, two dental nurses, two trainee dental nurses and a receptionist. The practice manager works half time at the location and half at another dental practice in the city. The practice opens from 8.30am to 5pm Monday to Friday.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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.

We spoke with three patients and received a total of 13 CQC comments cards from patients who had visited the

Summary of findings

practice in the two weeks before our inspection. They told us staff were welcoming, kind and helpful and they valued the service they had received. Two patients told us they had advised family members to use the service and they had also had a positive experience of care and treatment at the practice.

Our key findings were:

- A range of safety systems were in place to identify risks such as safety incidents and learning was shared with staff.
- Infection control procedures were well managed to ensure that equipment was maintained for safe use.
- Patients received care and treatment to promote their dental health in line with clinical guidelines.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in decisions about it
- Patients were treated with dignity and respect and confidentiality of their personal information was maintained
- Staff were kind, caring, competent and put patients at their ease.
- We reviewed 13 comment cards and spoke with three patients who valued the service they received.

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

- Ensure that records are kept of staff induction and that staff have received appropriate training and supervision to carry out the duties they are employed to perform to ensure that patients receive safe, quality care.
- Ensure that robust checks of the emergency medicines are in place so that appropriate medicines are available in accordance with guidelines detailed within the British National Formulary.
- Ensure that all audits are recorded and action plans are clearly recorded to demonstrate that improvements have been completed.
- Ensure that all staff working with vulnerable people have appropriate checks with the disclosure and barring service.

You can see full details of the regulations not being met at the end of this report.

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

- Ensure that information and contact details for local safeguarding teams are easily accessed by the staff team if urgent contact is required.
- Offer patients a copy of their referral letter when they are referred for further treatment.
- Consider providing the patient survey to patients in alternative formats.
- Ensure that all staff are familiar with the Mental Capacity Act 2005.

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.

The practice had a range of safety systems in place. There were systems to identify, investigate and analyse patient safety incidents and learning from them was cascaded to staff. There were good systems in place for the safe cleaning and decontamination of dental instruments. There were cleaning procedures in place for the premises although some improvements were required to strengthen these. Emergency medicines were available although checks should be improved to ensure these were available and fit for use. Safeguarding procedures were in place although access to contact numbers required a review. X-ray and other items of equipment had been serviced, maintained correctly and were operated by the appropriate staff. Recruitment procedures were effective although we were concerned to find no record that a key member of staff had been through an enhanced check with the Disclosure and Barring Service.

Are services effective?

If all regulations being met state:

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

The dental care and treatment provided to patients followed current guidelines. Patients were given appropriate information to support them to make decisions about the treatment they received and to promote their oral health. The practice kept detailed clinical records of assessments and treatments carried out and monitored any changes in patients' oral health. The practice had systems in place to ensure patients were referred for specialist treatment in a timely manner and that essential information was shared between dental practices.

Staff had access to training and there were systems in place to support their continuing professional development.

Are services caring?

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

Patients told us they had very positive experiences of dental care provided at the practice. Patients felt well supported and involved with the discussion of their treatment options which included risks and benefits. Staff were helpful. kind and respectful to adults and children who used the service.

Are services responsive to people's needs?

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

The practice provided a range of dental services to NHS and private patients. We found that patients were able to access treatment and urgent and emergency care when required. Feedback from patients about the service was encouraged and acted upon so that further improvements could be made. There was an accessible complaints system in place so that concerns could be managed effectively.

Are services well-led?

We found that this practice was not always 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/Enforcement section at the end of this report).

Risks to both patients and staff had been identified and these were monitored and reviewed. The practice assessed and monitored the services they provided through patient feedback, audits and complaints. However records of

Summary of findings

audits and actions taken in response, were not always available. The practice was unable to assure us that all staff were up to date with relevant training or that new staff had completed an induction because records were incomplete or not available. An enhanced criminal records check had not been carried out on one member of staff who would be working with vulnerable people. Checking procedures of the emergency medicines had not identified that actions were required to ensure these were available in accordance with National guidelines.

1A Dental Practice - Stanground

Detailed findings

Background to this inspection

The inspection took place on 5 May 2015. The inspection team was led by a CQC Inspector with further support from a specialist advisor for dentistry.

Prior to the inspection we reviewed the information we already held about the service, requested some basic information from the provider and gathered information from their website.

During the inspection we spoke with the dentist, the practice manager, a dental nurse, two trainee dental nurses and the receptionist. We also spoke with three patients prior to or following their appointments, reviewed documents and made general observations in the reception area.

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

The practice had a process in place for reporting and logging any incidents and this included any adverse reactions to medicines experienced by the patients. Staff were encouraged to be open and report any issues of concern or raise comments to the practice manager. Once investigated, the practice manager raised incidents for discussion at staff meetings. Incidents were also reported to the provider's head office. Records of meetings we reviewed supported this.

We spoke with staff who told us they followed steps to ensure there were no errors made with wrong site treatment procedures. For example they ensured they checked with the patient, referred to X-rays and records.

Reliable safety systems and processes (including safeguarding)

There was a safeguarding policy in place to guide staff in supporting vulnerable adults and children. The manager told us they referred any concerns to a team based at the provider's head office before taking any action. The practice were able to demonstrate they had identified a concern and had made an appropriate referral to the safeguarding team. However, the policy did not include details of the safeguarding lead for the practice nor any contact numbers for the local authority if further advice was required. A flowchart was on display for staff to guide them on what to do if concerns were suspected although this did not contain any local contact numbers.

Safeguarding training was part of core online training for staff employed by the provider. Most staff had received this training within the last year. Records and certificates available to us did not show whether staff had received training in safeguarding adults as well as child protection and the manager was unable to confirm these details.

The practice had a whistleblowing policy in place that had been recently circulated to staff. This included details of a confidential enquiry line to which staff could report any concerns.

We spoke with the dentist available who was able to demonstrate they assessed patients appropriately for procedures to ensure that risks were well managed. For example by using rubber dams. A rubber dam is a thin, rectangular sheet, usually made of latex used to isolate the operative site from the rest of the patient's mouth.

Medical emergencies

All staff received annual training in dealing with medical emergencies. We found the dentists had both completed this training which included resuscitation training and were also qualified in first aid management.

Emergency equipment was stored in a central area and could be easily located by staff in an emergency situation. The equipment included an automated external defibrillator (AED) and oxygen therapy and met Resuscitation Council UK guidelines. An AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The equipment was checked regularly to ensure it was fit for use.

Staff recruitment

There were effective recruitment and selection procedures in place. We reviewed the employment files for six staff members. Each file contained evidence that satisfied the requirements of schedule 3 of the Health and Social Care Act, 2008. This included application forms, employment history and evidence of qualifications. The qualification, skills and experience of each employee had been fully considered as part of the recruitment process.

Appropriate checks had been made before staff commenced employment including evidence of professional registration with the General Dental Council (GDC) where required. Criminal records checks with the Disclosure and Barring Service (DBS) had also been completed for staff. However, we found that one dentist had only received a standard check when they should have received an enhanced check. This was because they worked in a role where they might have contact with adults or children who were vulnerable.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for

Are services safe?

risk of fire, the fire alarm was tested weekly and fire drills had been completed. Fire extinguishers were regularly serviced and staff were able to demonstrate to us they knew how to respond in the event of a fire.

We checked electrical items at random and found that electronic safety testing had been carried out. A central register of equipment was also held to ensure checks were completed annually.

Health and safety risk assessments were in place, for example for the management of hazardous substances. Additional health and safety advice was available from the IDH support centre.

Infection control

The lead dental nurse had designated responsibility to lead on infection prevention and control. They showed us the decontamination area and the processes used to clean and decontaminate dental instruments ready for use. There were clearly defined dirty to clean zones to prevent the cross contamination of instruments.

Dental nurses we spoke with were knowledgeable about the infection control procedures and told us they had an adequate supply of equipment to meet daily needs. The practice had systems in place for daily and weekly quality testing of the equipment used to decontaminate dental instruments and a review of the records confirmed these had taken place on a regular basis.

We found that clean instruments were stored in an appropriate area within sealed packaging. The date of sterilisation showed they were all in date and ready for use.

Dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was provided to support this.

An infection control audit had been completed in March 2014 which had scored the practice 96%. The next audit was completed in February 2015 and resulted in a lower score of 88%. The detail of the audits was not available to us although the practice manager told us the actions from the last audit had all been implemented.

The practice was visibly clean and tidy. A cleaning plan and schedule was in place. However, staff had been covering the cleaning themselves for several weeks because the provider had not appointed a new cleaner to cover the practice. The manager told us the interviews would be arranged soon but was unable to provide further detail. The records showed that cleaning schedules were not being fully completed and the practice manager confirmed that staff were having to prioritise high risk areas and leave others as they did not have sufficient time to complete all of the cleaning duties.

Cleaning equipment was stored near the practice manager's office and could only be accessed using a keypad lock. We noted these items were in line with the recommended systems used by the NHS to prevent the risk of cross infection.

There were clear procedures in place for the disposal of clinical, non-clinical and hazardous waste. We found some sharps bins that had not been labelled upon opening. Staff addressed this immediately. Clinical waste and completed sharps boxes were sealed and stored in a cupboard until collection by a waste contractor. An external clinical waste bin was on order to improve the safe storage of waste. There was a cleaning policy in place although this did not clearly state the areas of responsibility for dental staff as well as the cleaner and required a review.

Equipment and medicines

We noted that the practice stocked an adequate amount of dental instruments and equipment required for the size of the practice. Electrical items had been safety tested and other items such as dental chairs had been serviced on a regular basis.

We found that emergency medicines stocked by the practice mostly met national guidelines in the British National Formulary (BNF). However, a sedative was out of date and although they also had one available that was in date, in an emergency situation the wrong item could be used. There was no medicine available to treat patients experiencing an asthma attack.

Radiography (X-rays)

The practice had a named radiation protection adviser (RPA) and radiation protection supervisor (RPS) to monitor safe practice and ensure that best practice guidelines were in place. The practice's radiation protection file contained

Are services safe?

the necessary documentation demonstrating the maintenance of the X-ray equipment. These included critical examination certificate for each X-ray set along with the three yearly maintenance logs in accordance with current guidelines. A copy of the local rules was displayed in each treatment room. An inventory of X-ray equipment used in the dental practice was displayed with each X-ray set.

Records confirmed that staff had completed appropriate training updates. Audits of dental X-rays had also been completed but the practice could not provide any evidence of the actions taken following them.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

When patients attended the practice for a consultation we found they received a thorough assessment of their dental health needs. They were asked to supply information about their medical history such as any health conditions, current medicines being taken and whether they had any allergies. Patients were asked to review and update this information at routine examinations.

The dental assessments were completed in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC). This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and observation for the signs of mouth cancer. Dentists discussed the findings with patients including whether their oral health had changed since the last appointment. They also discussed treatment options, risks, benefits and costs.

The patient records were updated with the proposed treatment and reflected discussions with the patient. All of the records we checked contained clear and detailed information.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to NICE guidelines in relation to deciding when to recall patients for examination and review.

Health promotion & prevention

The practice considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients.

We spoke with the dentist on duty who told us they always offered children aged three and over, a fluoride varnish application. This was also offered to any other patients at high risk of tooth decay. They also conducted a basic assessment of the health of each patient's gums. If potential concerns were identified these were assessed further using a more in-depth assessment tool. Where relevant, preventative dental information was given in order to improve the outcome for the patient and this included smoking cessation advice, guidance on alcohol consumption and general dental hygiene. Records we reviewed supported this.

Staffing

Most of the staff employed at this practice had worked there for less than a year and this included the practice manager. This meant that only one member of staff had received an appraisal within the last year. Staff told us they had enough staff to meet patients' needs although they were in the process of recruiting to the vacant role of practice cleaner. Staff planned their annual leave so that they could cover for one another and additional staff could be 'borrowed' from other practice locations if necessary.

The practice manager was unable to show us information about the training completed by staff to date, or any planned training. The practice manager told us the provider had recently introduced a new online training system that would identify training completed by each member of staff but she had not yet checked the records to identify any training that was overdue.

There was an induction process in place so that new staff received adequate support from a more experienced team member. When we reviewed the personnel files of two staff members we found induction records were either incomplete or not recorded.

Staff we spoke with said they were supported by their line manager on an informal basis. The practice manager was supported by an Area Manager. There was no structure in place to ensure that staff received regular one to one meetings of formal supervision.

When we spoke with the trainee nurses they told us they received informal support from the lead dental nurse and the dentists they worked with. They found this was helpful.

We also found there was a process in place to manage the performance and conduct of staff.

Working with other services

When patients had more complex dental issues, the practice referred them to other healthcare providers. This included, for example conscious sedation, as the practice

Are services effective?

(for example, treatment is effective)

did not provide this service. Patients were offered a choice of being referred to either an NHS or private dental service and information about the differences were explained to them.

The practice maintained a record of referrals they made so that outcomes could be tracked. However, on the day of our inspection, the staff were unable to demonstrate they followed a written referral protocol. Immediate action was taken and a protocol was sent to us after the inspection visit. Patients were not being offered a copy of their referral letter so they had a record of this for their own information.

Consent to care and treatment

We spoke with a dentist who explained to us how valid consent was obtained for all care and treatment. The dentists checked each patient's understanding and sought verbal or written consent before treatment was progressed. Records we checked showed that staff confirmed individual treatment options, risks, benefits and costs with each patient and documented this in a written treatment plan. When a patient was required to give written consent to treatment, they were provided with a copy of their consent form.

Patients we spoke with confirmed they were given time to make informed decisions about the treatment they wanted.

Whilst there was no training provided to staff in understanding the principles of the Mental Capacity Act 2005, the dentist demonstrated a clear understanding of how the Mental Capacity Act 2005 applied in considering whether or not patients had the capacity to consent to dental treatment. They explained how they would consider the best interests of the patient and involve family members or a responsible person to discuss treatment decisions and to ensure their needs were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that staff greeted patients in a friendly and welcoming way and were respectful. The reception and waiting area were very small and conversations could easily be overheard by others. We raised this with the receptionist who said that most private conversations were held in the treatment rooms with the dentist.

Patients we spoke with told us they felt their privacy was respected; staff were welcoming, kind and helpful. Two patients we spoke with told us they had recommended the service to family members who had also had positive experiences following attendance and treatment at the practice.

We received a total of 13 CQC comments cards completed by patients during two weeks leading up to the inspection. The cards were all very positive showing that patients valued the service they received. One person told us the staff helped to put their children at ease and this included a child with a learning disability.

Involvement in decisions about care and treatment

The patients we spoke with told us they received a good level of information about their treatment or general dental needs. They felt able to make informed choices about their treatments and were provided with clear information about their treatment options.

We found that not all staff were clear about when young people could be seen without an adult present or were knowledgeable about the Gillick competence test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We spoke with one dentist who described that they enabled patients to make their own decisions and treatment choices by explaining treatment options, risks and benefits. This was recorded in their records.

Records we checked showed that patient's consent had been obtained before treatment plans were progressed. Patients were provided with a copy of their written consent forms.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice leaflet included an overview of the service provided. The website for the provider (1A Dental Group) contained more in depth information about a range of treatments and services. The practice provided mainly NHS treatments although some private treatment was also available. Costs were clearly displayed in the practice and patients told us this was explained to them during their consultation.

A member of staff showed us the booking system and told us they always scheduled enough time with each patient to assess and undertake their care and treatment needs. On the day of the inspection one dentist was on leave. Some double appointments had been booked to accommodate patients who required emergency appointments. Staff told us this added some pressure to the day but patients were never rushed and time allocated for a lunch break was often used to accommodate time required to treat patients. Our observation of the appointment system, of activities during the day and comments we received from patients supported this view.

Tackling inequity and promoting equality

The practice was at ground floor level and was accessible for patients who used a wheel chair.

The practice welcomed patients from all cultures and backgrounds. Several members of staff spoke other languages and an interpreters service could be accessed if required. We did not see any evidence of written information such as how to raise concerns or access out of hours services, that may be available in alternative languages.

Access to the service

The practice offered a range of dental services and treatments that included preventive care, dentures, crowns and protective dental health. The practice treated mainly NHS patients but also offered some private treatments. The service opened weekdays from 8.30am until 5.00pm closing between 1.00 and 2.00 pm. Patients could book their appointments by phone, in person or through an online booking system if they had registered to do so.

The practice displayed information on how to access emergency care when the practice was closed in the waiting room and in the practice leaflet. This stated that it was provided through Cambridgeshire Emergency Dental Service. Patients might also find it useful to have this information on the practice website.

At the time of our inspection, the practice was accepting new NHS patients and staff told us they were receiving several patient's applications each day. We were able to see this involved completion of a registration form to include their personal contact information as well as medical and dental history.

Concerns & complaints

The practice had an appropriate complaints policy in place and the practice manager was responsible for dealing with any complaints received by phone, letter or in person at the practice. Information on the complaints procedure was available in the waiting room although this was not available on the website.

The practice manager had received seven complaints within the last year. There were clear electronic records that summarised the issues raised, the response to the patient and the actions taken. Learning opportunities were taken and shared with staff involved in the complaint.

None of the patients we spoke with or who had completed CQC comments cards had felt the need to raise a complaint or concern with the practice.

Are services well-led?

Our findings

Governance arrangements

The practice had a risk assessment file in place and was able to demonstrate that these were reviewed annually for example when new equipment was purchased such as the safe syringe/needle system. Risk assessments included the use of sharp instruments, visual display units, staff welfare and radiographic equipment.

The practice completed regular audits to ensure that staff followed best practice and identified further improvements. These included audits of patient records, radiography, prescriptions and infection control. Some actions were recorded and discussed with staff at meetings or by email. However, details of infection control audits were not available. The practice manager told us that all actions from the last audit had been implemented but there were no records to support this. In addition, the practice could not provide any evidence of the actions taken following X-ray audits.

We found that some monitoring procedures in the practice were not working effectively. For example checks of the emergency medicines had not identified that a recommended medicine was missing or that an expired medicine should have been removed.

One member of staff who may work with vulnerable adults and children had not undergone the appropriate level of criminal record check when they joined the practice. this had not been identified in the practice's monitoring of risks relating to the safety and welfare of patients.

The provider had introduced annual quality assurance checks in October 2014. These were completed by the practice manager and validated by the area manager. Actions had been taken such as ensuring staff read the safeguarding policies and introducing three monthly medical emergency simulations.

Leadership, openness and transparency

Most members of the team had been employed for less than a year and staff told us they felt supported by the practice manager and dentists. The practice manager was working to embed systems and processes that supported an open culture and was available at the practice two or three days each week. They were also contactable by phone at other times.

There was a clear leadership structure in place and staff knew who had specific lead responsibilities for example, infection control and first aid.

There were arrangements for sharing information across the practice on a daily basis and through practice meetings although these were still being established on a regular basis.

Management lead through learning and improvement

Each dentist at the practice was supported by a trainee or a qualified dental nurse. There was always a minimum of one qualified dental nurse who could provide additional support and supervision to the trainees if required.

Staff told us they had good access to training provided through the IDH group and were supported to maintain their continuous professional development as required by the General Dental Council (GDC).

A new training database had been very recently introduced to help ensure more effective management and monitoring of staff training. However, the registered manager was unable to assure us that all staff were up to date with relevant training. While some certificates and staff training records were available, the manager told us this was not a complete record. For example, there was no record to clearly show whether staff had received safeguarding vulnerable adults training as well as child protection training.

An induction process was in place but when we checked, there were no records to show that staff were supported to complete the induction process. There was no structure in place to ensure that staff received regular one to one meetings of formal supervision.

All dentists and dental nurses at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.

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

Are services well-led?

The practice had recently introduced a patient survey and the forms were available in the waiting room. The forms referred to the complaints process and NHS Choices website. We noted that the leaflet was in small print and might be difficult for some patients to read.

The provider was able to show the responses collated for this practice from 38 patients during April 2015. The survey was planned to run continually and there had not been an opportunity to analyse the on- going results.

The practice was able to demonstrate they had made improvements to the telephone system as a result of patients feedback from the comments cards that were also available to patients.

The IDH Group had a patient support team who respond to comments placed on the NHS Choices website and managed the feedback received through the NHS friends and family test (FFT). Results from the FFT during April 2015 showed that 73% of patients would recommend the service and an analysis of the results were being considered so that the scores could be improved upon.

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 provider must ensure that records are kept of staff induction and that staff have received appropriate criminal records checks, training and supervision to carry out the duties they are employed to perform to ensure that patients receive safe, quality care. Regulation 17(2)(d)(i) Robust checks of the emergency medicines must be in place so that appropriate medicines are available in accordance with guidelines detailed within the British National Formulary. All audits must be recorded and action plans documented clearly to demonstrate that improvements have been completed. Regulation 17(2)(a)(b)