Mr. Paul Gibbons

Hayes Croft Dental Surgery

Inspection Report

2 Heyes Croft
New Street
Barnsley
S70 1RY
Tel: 01226 282954

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Overall summary

We carried out this announced inspection on 19 June 2017 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.

We told the NHS England area team and Healthwatch that we were inspecting the practice. They provided information which we took into account.

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

Heyes Croft Dental Surgery is in Barnsley and provides NHS treatment to patients of all ages.

Access into the practice is via a set of steps from the pavement. The treatment room and main waiting areas are on the first floor. Alternative arrangements are available for patients with limited mobility. Car parking spaces are available near the practice.

The dental team includes one dentist, two dental nurses and a practice manager. The practice has one treatment room.

Summary of findings

The practice is owned by an individual who is the principal dentist 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 inspection we collected 60 CQC comment cards filled in by patients and spoke with two other patients. This information gave us a positive view of the practice.

During the inspection we spoke with the dentist, one dental nurse and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday 8.30am – 6.30pm

Tuesday, Wednesday, Thursday 8.30am – 5.00pm

Friday 8.30am – 2.00pm

Our key findings were:

- 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.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available but some processes could be improved.
- The practice had some systems to help them manage risk but improvements could be made.
- The practice infection control procedures did not reflect current guidance.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had a policy in place for staff recruitment.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked well as a team.
- Management processes and leadership could be improved.
- The practice asked staff and patients for feedback about the services they provided.
- The practice had processes in place to deal with complaints positively and efficiently.
- The practice was generally clean and suitably maintained. Some areas required additional attention.

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

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. For example, systems involving fire, sharps and control of substances hazardous to health (COSHH).

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 system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review the availability of medicines and equipment to manage medical emergencies taking into account guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.

Summary of findings

- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the storage of dental care records to ensure they are stored securely.
- Review the practice's protocol and staff awareness of their responsibilities under the Duty of candour to ensure compliance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 some systems and processes to provide safe care and treatment but we found improvements could be made to the process for identification, recording and learning from incidents.

Awareness of the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) was not embedded within the practice.

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

Processes involving COSHH, sharps incident management, fire safety and emergency medicines and equipment management could be improved.

Staff were qualified for their roles and the practice completed essential recruitment checks.

Premises and equipment were generally clean and properly maintained. The practice's processes for cleaning, sterilising and storing dental instruments could be improved.

The practice had suitable arrangements for dealing with medical and other emergencies.

Are services effective?

No action

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

The dentist assessed patients' needs and provided care and treatment generally in line with recognised guidance, but the completion of patient care records could be improved.

Patients described the treatment they received as great and said they were treated well and looked after.

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.

Summary of findings

We received feedback about the practice from 60 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, caring and reassuring.

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

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

Are services responsive to people's needs?

No action ✓

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

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

Staff considered patients' different needs. The practice had access to telephone interpreter services.

The practice had limited facilities for disabled patients, but would signpost patients to alternative options for treatment if required.

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

Are services well-led?

Requirements notice ✗

We found that this practice was not providing well-led care in accordance with the relevant regulations.

The practice had arrangements to ensure the smooth running of the service but these could be improved upon.

We found processes involving the assessment of risk for sharps, COSHH and Fire safety could be improved.

Processes such as incident reporting, infection prevention and control procedures and equipment validation could be improved to ensure these are established and embedded within the practice.

Archived dental care records were not stored securely.

We found improvement was required in monitoring clinical and non-clinical areas of their work to help them improve and learn.

The practice did ask for and listen to the views of patients and staff.

Hayes Croft Dental Surgery

Detailed findings

Are services safe?

Our findings

The practice had a generic template in place to report incidents and significant events but we found no documentation to support that a process was in place to identify, report and follow up incidents for improvement.

We were told the practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). We saw no documentation to support that relevant alerts were received, discussed with staff, acted on and stored for future reference.

The practice did not have a Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) policy in place and staff told us they were unaware of RIDDOR and associated reporting procedures. We highlighted these findings to the principal dentist and practice manager who assured us these processes would be implemented and embedded within the practice.

Reliable safety systems and processes (including safeguarding)

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. We saw the practice had a whistleblowing policy in place; staff told us they felt confident they could raise concerns without fear of recrimination but they were not sure if a policy existed within the practice.

We looked at the practice's arrangements for safe dental care and treatment and found some processes could be improved and embedded within the practice.

We reviewed the practice's control of substances hazardous to health (COSHH) folder and found some materials used at the practice were listed but a comprehensive review of all materials used under COSHH had not been carried out. No safety data sheets or risk assessments were in place.

The practice followed relevant safety laws when using some sharp dental items but sharps incident protocols could be improved. Staff told us they were unsure of the process to follow should there be a sharps incident. The practice had no sharps incident immediate action protocol and staff were not aware of who to contact for further assistance following a sharps incident.

The dentist did not routinely use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. We spoke with the dentist to identify if they used any other safety precautions during root canal treatments; we were told other measures were in place.

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

We reviewed the practice's fire safety management processes and found these could be improved. For example, we were told the smoke detectors were checked regularly but no documentation was available to support this. Fire extinguishers were not fixed to a specific location; one extinguisher was hidden from view down the side of a desk, others were free standing making it easy to move them to an unsuitable location. Staff were unable to tell us where the fire muster point was should there be a fire evacuation.

We highlighted these areas of concern to the principal dentist and practice manager who assured us they would be addressed.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were available as described in recognised guidance, but the practice procedures for its management required improvement. For example, we found dispersible aspirin had passed the expiry date, emergency medicine glucagon was stored in the staff fridge which was not temperature monitored. There was no spacer device and some airways were out of date. We were told that the emergency equipment and medicines were checked regularly but no documentation was seen to support this. We informed the principal dentist of our findings and we were assured this process would be reviewed.

Staff recruitment

Are services safe?

The practice had a staff recruitment policy and procedures to help them employ suitable staff. This reflected the relevant legislation. The last staff member to be recruited was in 2010. We looked at a selection of staff recruitment files and found no areas of concern.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Monitoring health & safety and responding to risks

We saw that some of the practice's health and safety policies and risk assessments were up to date, these covered general workplace and specific dental topics. We found areas for improvement relating to fire and COSHH risk management and assessment.

The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentist when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe, but we found these required improvements. For example, the practice did not follow the most current guidance found in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. There were also some deviations from HTM 01 05 guidance, for example, there was only one sink for rinsing instruments and there was no separate bowl. The water temperature was not monitored and the clinical waste bin was not foot operated. There was no light magnification for instrument inspection. We found debris on various surfaces and sterilising equipment. We also found a selection of loose instruments in a drawer, which we were told were clean and unused but confirmation of this was not obvious. We also found areas within the treatment room which did not reflect current guidance, for example, clinical work surfaces were cluttered and the clinical waste bin was not foot operated. The treatment room and waiting area walls were covered with 'thank you' sketches from younger patients. The dentist told us they were proud to display these sketches for all of their patients. We agreed that this represented a positive view on the practice and suggested the sketches should be located in the waiting area only.

The practice carried out an infection prevention and control audit quarterly, but no action plan was produced to highlight any areas for improvement.

We highlighted these areas to the principal dentist who agreed to review the areas identified in accordance with current guidance in HTM01-05.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment.

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

Equipment and medicines

We saw servicing documentation for the equipment used. Equipment validation for the instrument cleaning processes were not in line with current guidance, for example, no cleaning efficacy test was carried out on the washer disinfector. There was no steam penetration test or air leakage tests carried out on the autoclave.

The practice had suitable systems for prescribing medicines; the practice stored and kept records of NHS prescriptions as described in current guidance.

We observed the medical emergency medical kit was stored in the decontamination room; the temperature of which was extremely hot on the day of inspection. We highlighted this to the practice manager and discussed the temperature sensitive nature of some emergency medicines; they agreed to discuss an alternative storage location with the principal dentist.

Radiography (X-rays)

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.

The name of the radiation protection advisor (RPA) was incorrect on the local rules and required confirmation and updating. This was brought to the attention of the principal dentist.

Are services safe?

We saw evidence that the dentist justified, graded and reported on the X-rays. The practice carried out X-ray audits every year following current guidance and legislation.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. Although the practice kept dental care records containing information on past treatment and medical history, we found areas where improvement could be made to the level of detail being recorded. For example, we found incomplete note taking to confirm consent to treatment had been gained from the patient, we found that the administration of local anaesthetic was not being routinely recorded. We also found that some post-operative instructions were not recorded in the records when instruction was given to a patient. The dentist agreed with our findings and would review this process.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child.

The dentist told us they discussed smoking, alcohol consumption and diet with patients during appointments.

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 at annual appraisals. We saw evidence of completed appraisals.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included 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 urgent referrals to make sure they were dealt with promptly. Routine referrals were monitored.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment but recording consent in the patient care records could be improved. The dentists 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 dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. We found the team had limited knowledge of the detail of their responsibilities under the Act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence and the dentists was aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were friendly, caring and reassuring. We saw that staff treated patients respectfully, appropriately, kindly and were friendly towards patients at the reception desk and over the telephone.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided some privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

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

We observed that a significant number of archived paper records were not properly secured; paper records were found in unlocked filing cabinets which were located in two unsupervised and unlocked rooms. We highlighted this to the principal dentist who assured us they would secure the records without delay.

Involvement in decisions about care and treatment

The dentist told us they involved patients in decisions about care and treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them.

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

The NHS Choices website provided patients with information about the range of treatments available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

Staff described an example of a patient who found it unsettling to wait in the waiting room before an appointment. The team kept this in mind to make sure the dentist could see them as soon as possible after they arrived.

Promoting equality

Patients with mobility difficulties would be signposted to an alternative practice for dental treatment.

Staff said they had access to interpreter and translation services if required.

Access to the service

The practice displayed its opening hours in the premises, their information leaflet and on the NHS Choices website.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept some appointments free for these patients. The NHS Choices website, information leaflet 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.

Concerns & complaints

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

The principal dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Contact details for organisations patients could go to if not satisfied with the way the practice dealt with their concerns was out of date, the principal dentist agreed to review the policy to reflect current external contacts.

We looked at comments, compliments and complaints the practice received in the last 12 months. 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

Governance arrangements

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

The practice had policies, procedures and some risk assessments to support the management of the service and to protect patients and staff but some areas could be improved. We found medical emergency equipment and medicines management, infection control processes, COSHH management, fire risk management and incident reporting procedures could be improved.

A number of policies and processes required embedding within the practice to ensure staff had a level of knowledge. For example, staff were not fully familiar with current infection prevention and control and equipment validation processes, sharps incident management was unclear and raising concerns could be improved. Staff awareness of Duty of Candour and MCA was limited.

We found the monitoring of clinical and non-clinical areas of their work to help them improve and learn could be enhanced, for example the infection control audit was completed but areas for improvement were not identified and acted upon. We also found several items of expired dental materials still in use and some instruments were being stored loose in a drawer, all of which could not be confirmed as fit for use.

Leadership, openness and transparency

Staff told us there was an open, no blame culture at the practice. They said the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the principal dentist was approachable, would listen to their concerns and act appropriately. The principal dentist discussed concerns at staff meetings and it was clear the practice worked as a team and dealt with issues professionally.

The practice held quarterly meetings where staff could raise any concerns. Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records and X-rays. They had records of the results of these audits and the resulting action plans and improvements.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. The dental nurses had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff told us they completed essential training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

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

The practice used annual patient surveys to obtain staff and patients' views about the service.

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.

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 did not have effective systems in place to ensure that the regulated activities at Heyes Croft Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: • The registered provider failed to ensure its infection control procedures and protocols were suitable having due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'. • The registered provider failed to ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. For example, systems involving fire, sharps and control of substances hazardous to health (COSHH).