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Dental Surgery - 177 Unthank Road

Inspection Report

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Overall summary

We carried out this announced inspection on 15 January 2019 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. We had also received a number of complaints about the practice. 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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

177 Unthank Road Dental Surgery is based in Norwich and offers mostly NHS treatment. The dental team is small, consisting of one dentist and one dental nurse. An agency dental nurse also works at the practice four days a week. There is one treatment room. There is ramp access for people who use wheelchairs and those with pushchairs. On street parking is available a short walk from the practice.

The practice opens Mondays to Fridays from 9am to 5pm.

Summary of findings

The practice is owned by an individual who is the principal dentist there. He has 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 19 CQC comment cards filled in by patients and spoke with one other patient.

During the inspection we spoke with the dentist and two nurses. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- Staff treated patients with dignity and respect, and we received many positive comments from patients about the caring and empathetic nature of the dentist and nurses.
- Infection control procedures reflected published guidance and the practice appeared clean and well maintained.
- Patients received their care and treatment from staff who enjoyed their work. Staff felt involved and supported and worked well as a team.
- Patients' dental care was mostly delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- The management of risk in the practice was limited and potential hazards had not been assessed adequately.
- Some equipment had not been properly serviced or maintained.
- Patients' confidential dental care records were not stored securely in line with guidance.
- The practice did not have a plan in place to audit quality and safety. Staff had not received formal appraisal of their performance.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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 protocols for the use of rubber dams for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competence 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?

Requirements notice 

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Staff had received safeguarding training and were aware of their responsibilities regarding the protection of children and vulnerable adults, although the practice's safeguarding policy needed review.

Premises were clean and properly maintained and the practice followed national guidance for cleaning, sterilising and storing dental instruments. The practice had arrangements for dealing with medical and other emergencies, although did not have all the recommended equipment. Risk assessment to identity potential hazards within the practice was limited, as was fire safety. Patients' notes were not stored securely.

The dentist did not follow national guidance in relation to the use of rubber dams or the use of safer sharps.

Are services effective?

No action

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

Patients told us they were happy with the quality of their dental treatment and the staff who provided it.

The dental care provided was evidence based and focussed on the needs of the patients. The practice mostly used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice, although did not follow recommended guidance for managing gum disease, fluoride applications or prescribing antibiotics.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals, although non-NHS referrals were not actively monitored to ensure they had been received.

Not all staff had a clear understanding of the Mental Capacity Act 2005, or of Gillick competence and how this might impact on treatment decisions.

Are services caring?

No action

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

Summary of findings

We received feedback about the practice from 20 patients. Patients spoke highly of the practice's staff and had clearly built up strong relationships with them over the years. Staff were described as caring, thoughtful and reassuring. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

Staff described to us the practical ways they helped nervous patients manage their treatment.

Are services responsive to people's needs?

No action ✓

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

The practice had made some reasonable adjustments to accommodate patients with disabilities including ramp access, an accessible toilet and a downstairs treatment room. However, it did not provide a hearing loop to assist those patients with hearing aids and information was not available in any other languages or formats such as large print.

Complaints were managed in a timely and professional way, although Information about how to complain to external agencies was not easily accessible to patients.

Are services well-led?

Requirements notice ✗

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We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

The staff told us they enjoyed their work and felt supported by the dentist.

We found a number of shortfalls indicating that the practice was not well-led. Staff were not following current best practice guidance in several areas including the use of rubber dams, the management of medicines, the storage of patient information, the assessment of risk and the maintenance of equipment.

There were no systems to assess and monitor the quality of service provision and staff did not receive an appraisal of their work.

Are services safe?

Our findings

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

Staff knew their responsibilities if they had concerns about the safety of children and vulnerable adults and the nurses had received appropriate training for their role. The principal dentist had not undertaken any recent training in safeguarding matters.

The practice had some safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. However, we noted the polices were dated 2009 and had not been updated to reflect changes in national guidance. There were no specific guidelines in relation to vulnerable adults, only children.

The dentist did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment, and the justification for this was not recorded in patients' notes. Hand held files were not secured with floss or parachute chains to protect patients' airways and prevent the risk of inhalation or swallowing of instruments. Hypochlorite was used as an irrigant.

There was no formal written protocol in place to prevent wrong site surgery.

The practice did not have a business continuity plan describing how it would deal with events that could disrupt the normal running.

The practice did not have a recruitment policy in place but records we viewed for a recently recruited member of staff showed that appropriate pre-employment checks had been completed. An agency nurse was also employed at the practice and information about their DBS check, immunisation status and GDC registration had been obtained to ensure they were suitable for the role.

We found that staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover in place.

The practice ensured that facilities were safe and that most equipment was maintained according to manufacturers' instructions, including portable electrical and gas appliances. However, fixed wiring testing had not been undertaken every five years to ensure the hard wiring in the building was safe. The practice's ultrasonic bath had not been serviced.

Records showed that fire extinguishers had been serviced regularly but no risk assessment had been completed to identify any potential fire hazards in the building. Staff had not received any fire training and did not practice emergency evacuations from the building. There was no smoke or fire alarm system in place. There was no signage on the outside of the building to warn that oxygen was stored on site.

The practice had some arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. A rectangular collimator had been fitted to the X-ray unit to reduce patient exposure. However, we noted that annual mechanical and electrical checks of the equipment had not been completed, despite this being a recommendation in a full survey undertaken in February 2018. We could not find evidence that the dentist had undertaken training in the previous five years in relation to radiology and he did not conduct regular radiograph audits.

We saw evidence that the dentist justified and reported on the radiographs he took; however, they had not been graded.

Risks to patients

No risk assessment had been undertaken to identify potential hazards within the practice, such as the storage of oxygen, legionella, carpeting in the treatment room or the fact that the reception area was sometimes unstaffed when only one nurse was on duty.

Safer sharps syringes were available in the practice but were rarely used. A specific sharps risk assessment had not been undertaken as recommended in the Sharps Regulations 2013. The sharps box was not sited securely in the treatment room.

A system was in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus

Staff had completed training in resuscitation and basic life support. However, they did not regularly rehearse emergency medical simulations so that they had a chance to practise their skills. Most emergency equipment and

Are services safe?

medicines were available as described in recognised guidance, apart from ambubags, portable suction, and full sets of airways and face masks. No logs were kept demonstrating that that regular checks of the medicines and AED were undertaken.

Risk assessments and safety data sheets were in place for some hazardous materials used in the practice, but there were none available for the cleaning products used.

We noted that areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However, there was some carpeting in the treatment room which compromised infection control.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed most equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance, apart from the ultrasonic bath.

Staff were not aware of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and no annual statement had been completed. No infection control audits had been undertaken to ensure the practice's procedures met essential quality standards.

Safe and appropriate use of medicines

There was not a suitable stock control system in place and we found a number of out of date medical consumables in the store cupboard. We also found out of date toothpaste samples that were given to patients. We noted that Glucagon was stored in the fridge, but the fridge's temperature was not monitored to ensure it operated effectively. Prescription pads were held securely but there was no tracking in place to monitor individual prescriptions in order to identify any theft or loss.

Lessons learned and improvements

The practice had a significant events' policy, although there was no other guidance for staff on how to manage other types of events**.** We found that staff had a limited understanding of what might constitute an untoward event and they told us there had not been any. However, they later went on to describe to us two incidents involving aggressive patients. Neither of these incidents had been documented as unusual events, and there was no evidence of learning from them.

The principal dentist had signed up to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Staff were aware of recent alerts affecting dental practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 19 comments cards that had been completed by patients prior to our inspection. The comments received reflected that patients were very satisfied with their treatment and the staff who provided it.

Our discussion with the dentist and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines, although the dentist was not implementing recommended guidance in relation to basic periodontal examinations.

Dental care records were not audited to ensure they met FGDP guidelines and standards.

Helping patients to live healthier lives

The practice sold inter-dental brushes and free samples of toothpaste were available for patients. Dental care records we reviewed indicated that the dentist gave oral health advice to patients including advice around smoking, alcohol consumption and diet. However, fluoride applications for children were not undertaken in line with Delivering Better Oral Health guidance. There was no information about local smoking cessation services easily available to patients and the practice did not participate in any national oral health campaigns.

Consent to care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment. The dentist gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.

The practice had a patient consent policy but this did not include any information or guidelines in relation to the Mental Capacity Act or Gillick competence. The dentist had not undertaken specific training in the Mental Capacity Act, but we found he was applying its principles. We found staff had a limited knowledge of Gillick competence guidelines and how this might affect treatment options in relation to younger patients.

Effective staffing

The staff team was very small consisting of one dentist and a nurse. As a result, an agency nurse had been employed to work four days a week at the practice. Staff told us there were enough of them to run the practice and meet patients' needs.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council. Records we viewed showed they had undertaken appropriate training for their role, apart from radiography and safeguarding training for the dentist.

Co-ordinating care and treatment

The dentist told us referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. The practice also had systems and processes for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice did not actively monitor non- NHS referrals to make sure they were dealt with promptly and patients were not routinely offered a copy of their referral for their information.

Are services caring?

Our findings

Kindness, respect and compassion

We received positive comments from patients about the caring nature of the practice's staff. One patient reported that their son was no longer afraid of visiting the dentist. Another patient commented that they were very anxious but the dentist always explained the treatment clearly, which reassured them. The nurses told us some of the practical ways they supported nervous patients during their treatment.

It was clear the dentist had built up very strong relationships with patients over the years, and patients spoke very highly of him. A number of them expressed great sadness that he was about to retire.

Privacy and dignity

All consultations were carried out in the privacy of treatment room and we noted that the door was closed during procedures to protect patients' privacy.

We noted that patients' notes were stored on open shelving and not in fire proof lockable filing cabinets as recommended in national guidance. This compromised the confidential information held about them, especially as a cleaner visited the practice unsupervised in the evening.

Involving people in decisions about care and treatment

Patients told us the dentist listened to them and gave them clear information about their treatment. Staff used dental models to help patients understand their treatment and information leaflets about gum disease and sensitive teeth were available in the waiting area for patients to read.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had made some adjustments for patients with disabilities. There was ramp access to the building, a ground floor treatment room and accessible toilet. We noted there was no portable hearing loop to assist those who wore hearing aids. There was no information about translation services for patients who did not speak or understand English, and information about the practice was not produced in any other formats or languages.

Timely access to services

Patients told us they were satisfied with the appointments system and that getting through on the phone was easy. One patient told us they had managed to get an appointment at short notice just before Christmas. Two patients told us that staff always rang them to remind them of their appointment which they greatly appreciated. Two emergency slots were available each day for patients experiencing dental pain.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales for responding to them. The policy stated that patients could contact the Dental Complaints Service, however this service was for privately paying patients only and not those receiving NHS treatment. A poster detailing how patients could raise their concerns was in the waiting room, but was in very small print and placed high up on the wall making it difficult to see. It did not contain any information about other agencies that patients could contact should they wish to raise their concerns externally to the practice.

We were shown the paperwork in relation to one complaint the practiced had received and saw it had been managed in a timely and professional way.

Are services well-led?

Our findings

Leadership capacity and capability

The dentist had overall responsibility for both the management and clinical leadership of the practice. As there was not a dedicated practice manager, he had taken on most administrative tasks himself.

Staff spoke highly of the dentist, telling us he was approachable and responsive to their suggestions. Although the staff team was small, it was clear they worked and communicated well together. Staff told us they enjoyed their work, and one staff member had returned, having left for a short period to work at another practice.

Vision and strategy

The practice did not have any specific vision or strategy in place, other than to continue offering services to its current patients. At the time of the inspection the principal dentist was about to retire and was in the process of closing the service.

Culture

The practice was small and friendly, and had built up a very loyal and established patient base over the years.

The practice did not have a duty of candour policy in place, and we found staff had a limited knowledge of its requirements.

Governance and management

The practice did not have robust governance procedures in place. We found that the dentist worked in relative isolation, and had not kept up to date with current dental practices and guidelines.

No formal staff meetings were held.

Engagement with patients, the public and external partners.

The practice did not conduct any of its own patients' surveys but patients could 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 had scored three and half stars out of five on NHS Choices review.

Continuous improvement and innovation

The practice did not have robust quality assurance processes to encourage learning and continuous improvement. No audits were undertaken to assess whether the practice met national guidelines in respect of record keeping, radiography, infection control and antibiotic prescribing.

There was no system in place for either the nurse or dentist to receive appraisal or any sort of peer review.

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 There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: · Audits of dental care records, antibiotic prescribing, infection control and radiography were not undertaken. · There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence. • Dental care records were not stored securely in line with guidance. · Staff did not receive formal appraisal of their performance. · There was no system in place to monitor stock and ensure medical consumables remained in date for safe use. **Regulation 17 (1)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

· **The dentist did not follow national guidance in relation to sharps' management, and the use of rubber dams to protect patients' airways.**

· **Safeguarding policies and procedures were not kept up to date or reviewed.**

- There was insufficient equipment to manage medical emergencies.
- Risk assessment was limited and potential hazards within the practice had not been identified.
- Some equipment had not been maintained and serviced.
- There was no five yearly fixed wire test certificate available and fire safety management systems were limited.

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