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Wiese & Associates - Cottenham

Inspection Report

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Overall summary

We carried out this announced inspection on 11 December 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Background

Wiese and Associates Dental Practice is a well-established practice based in Cottenham that provides mostly private dental treatment to about 2,200 patients. The dental team includes three part-time dentists, two dental nurses and two reception staff. There is a practice manager based at the provider's other service who assists in the running of the practice. There is one treatment room.

Summary of findings

The practice opens on Mondays to Fridays from 9 am to 5.30 pm, and on Saturday mornings by arrangement.

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 23 CQC comment cards completed by patients. We spoke with one of the owners, a dentist, the practice manager, a nurse and a receptionist.

We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- Information from completed Care Quality Commission comment cards gave us a positive picture of a caring and professional service.
- The appointment system met patients' needs and a text and email appointment reminder service was available.
- The practice appeared clean and well maintained, although some infection control procedures did not meet nationally recommended guidance.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff felt supported, appreciated and worked well as a team.
- The practice proactively sought feedback from staff and patients, which it acted upon.
- Medicines were not managed according to national guidance.
- Fire safety systems in the practice were not robust.
- Emergency equipment was not managed according to guidance and staff did not rehearse responding to incidents
- X-ray equipment had not been serviced according to guidance
- Legionella risk had not been properly assessed within the practice.

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

- Ensure care and treatment is provided in a safe way to patients.

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

- Review the practice's testing protocols for equipment used for cleaning used dental instruments taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the practice's responsibilities to meet the needs of people with a disability, including those with hearing difficulties and the requirements of the Equality Act 2010.
- Review the management of dental care records to ensure they are stored securely.

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 that 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 received training in safeguarding patients and knew how to recognise the signs of abuse and how to report concerns. Staff were qualified for their roles and the practice completed essential recruitment checks to ensure they were suitable.

Some of the practice's infection control procedures did not follow recognised national guidance.

Legionella risk had not been assessed and fire safety procedures were not robust.

Emergency medical equipment and drugs were not managed according to guidance and X-ray equipment had not been adequately maintained. The dentist did not know where the oxygen was stored and staff were not able to find the portable suction and an adult self-inflating bag

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 very happy with the quality of their treatment. Staff had the skills, knowledge and experience to deliver effective care and treatment. The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The staff received professional training appropriate to their roles and learning needs. Two of the dentists had undertaken further training in periodontics and endodontics.

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.

Are services caring?

No action

We received feedback about the practice from 23 patients. Patients were positive about all aspects of the service and spoke highly of the staff who delivered it. Staff gave us specific examples of where they had gone out of their way to support patients.

We saw that staff protected patients' privacy and were aware of the importance of handling information about them confidentially, although some patient records were not held securely.

Summary of findings

Are services responsive to people's needs?

No action

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

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

Staff considered patients' different needs and provided some facilities for disabled patients, including wheelchair access and a downstairs treatment room. However, the practice did not have a hearing loop or information about its services in any other formats or languages.

It was not possible for us to assess how the practice managed complaints as we were told none had been received in the previous few years. Information about how to complain to external agencies was not easily accessible to patients.

Are services well-led?

No action

We found that this practice was providing well-led care in accordance with the relevant regulations.

The practice had arrangements to ensure the smooth running of the service. These included systems for staff to discuss the quality and safety of the care and treatment provided.

Staff were supported and appreciated in their work. The principal dentist paid for all their essential mandatory training.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for, and listening to, the views of patients and staff.

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, 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. All staff had undertaken appropriate training in safeguarding people, and staff gave us examples of where they had acted to support and protect vulnerable people.

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

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

Dentists used rubber dams in line with guidance from the British Endodontic Society to protect patients' airways. One nurse told us the dentist had used one on a patient undergoing root canal treatment on the morning of our inspection. Staff were aware of recent guidelines in relation to the use of amalgam.

The practice did not have a formal written protocol in place to prevent wrong site surgery.

The practice had a recruitment policy and procedure to help them employ suitable staff which reflected the relevant legislation, although did not provide specific guidance about the need for disclosing and barring checks. Files we reviewed for one recently recruited staff member showed that the appropriate pre-employment checks had been undertaken for them.

Two nurses had been trained as fire marshals and we saw that firefighting equipment was serviced regularly. However, the practice's fire risk assessment was limited and had not identified potential fire hazards we saw. It had not been reviewed since 2010. Fire records indicated that no simulated evacuations had taken place between 2010 and 2018, a period of eight years. The smoke alarms had not been tested between 2015 and 2018 to ensure they worked effectively. There was no evidence to show that the practice's gas boiler had been serviced and there was no external signage to indicate that oxygen was held on the premises.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. These met current radiation regulations and the practice had the required information in their radiation protection file. However, we noted that the radiation equipment had not had its three-yearly full survey since 2014 and had been due in February 2017. Although eventually undertaken on 10 December 2018, this was serious oversight.

Clinical staff completed continuous professional development in respect of dental radiography. Dental care records we viewed showed that dental X-rays were justified, reported on and quality assured. Regular radiograph audits were completed for the dentist. Rectangular collimation was not used on intra-oral X-ray units to reduce patient exposure.

Risks to patients

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. We viewed practice risk assessments that covered a wide range of identified hazards in the practice, and detailed the control measures that had been put in place to reduce the risks to patients and staff.

A sharps risk assessment had been completed in 2013 that indicated the need for all dentists to use the safest types of needles. We noted this had only been implemented recently, following a needle stick injury sustained by a dentist in October 2018.

Clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. The practice had taken satisfactory measures to protect one trainee nurse who had not received their vaccination due to a national shortage.

Staff knew had completed training in emergency resuscitation and basic life support every year. However, the dentist did not know where the oxygen was stored and staff were not able to find the portable suction and an adult self-inflating bag. Staff did not undertake regular medical emergency simulations to keep their knowledge and skills

Are services safe?

up to date. Not all recommended emergency equipment was available but missing items were ordered on the day of our inspection. Checks of emergency equipment were not as frequent as recommended by national guidance.

We noted that all 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.

The practice had an infection prevention and control policy and procedures. They mostly followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training, although the lead infection control nurse did not update this yearly in line with guidance. We noted the following shortfalls in relation to decontamination procedures:

- The illuminated magnifier glass was broken: therefore, it was not clear how staff were checking dental instruments.
- Sealant around units in the decontamination area was worn and needed to be replaced.
- Water used to manually clean instruments was not temperature tested.
- Infection control audits were completed yearly and not every six months as recommended.
- Staff did not complete daily TST testing to ensure the autoclave was working effectively.

The provider had not undertaken a legionella risk assessment for the practice, so it was not clear how any potential hazards had been identified and managed. There was no lead staff member for legionella and staff had not received specific training in legionella management. Water temperatures were tested each month but not to the recommended hot temperature.

The practice used an appropriate contractor to remove dental waste. Clinical waste was stored externally, but had not been secured adequately.

Safe and appropriate use of medicines

The dentists were aware of current guidance with regards to prescribing medicines, and the practice was taking part in a regional study of dental practices in relation to antibiotic prescribing.

The fridge's temperature, in which Glucagon was kept, was only monitored weekly, rather than each day, to ensure it operated effectively. Staff were uncertain as to what temperature medicines that required cool storage should be kept at. The practice's policy stated it should be between 3 and 5 degrees Celsius, but the temperature monitoring log stated between 0 and 5 degrees Celsius. The correct temperature should be between 2 and 8 degrees Celsius.

Prescription pads were held securely but there was no tracking in place to monitor individual prescriptions to identify any theft or loss. The practice issued some medicines privately but did not provide the required information on their labels.

Lessons learned and improvements

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. We found that untoward events were recorded and managed effectively to prevent their reoccurrence. Any unusual events were discussed at the practice meetings, evidence of which we viewed in the minutes of the meeting held on 13 September 2018.

The practice had a system in place to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA), and staff were aware of recent alerts affecting dental practice as a result.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 23 comments cards that had been completed by patients prior to our inspection. All the comments reflected high patient satisfaction with the results of their treatment and their overall experience of it.

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that dentists assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Dental care records we reviewed were comprehensive and clearly detailed patients' assessments and treatments. They were audited regularly to check that the necessary information was recorded.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. Staff told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. However, there was no information about local smoking cessation services, or oral health easily available to patients and the practice did not participate in any national oral health campaigns. Although the practice did not sell dental health products, free samples of toothpaste were available to patients on the reception desk.

Consent to care and treatment

Patients confirmed their dentist listened to them and gave them clear information about their treatment. The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists 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. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions.

Effective staffing

All clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. Staff told us there were enough of them for the smooth running of the practice and colleagues from the provider's other practice could cover vacant shifts if needed.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council and records we viewed showed they had undertaken appropriate training for their role. One of the dentist had a special interest in periodontology, and another in endodontics.

Co-ordinating care and treatment

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. There were clear systems in place for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice did not actively monitor non-NHS referrals to ensure they had been received and patients were not routinely offered a copy of their referral.

Are services caring?

Our findings

Kindness, respect and compassion

Patients told us they were treated in a way that they liked by staff and comment cards we received described staff as caring, patient and friendly. One patient told us that staff worked well with their autistic child, and arranged appointments at quiet times to reduce his stress.

The reception staff were local and had worked at the practice for many years. They had built up a good rapport with patients, evidence of which we saw during our inspection. Staff gave us examples of where they had gone out their way to help patients such as ringing them to ensure they got home safely and caring for them following a faint.

Privacy and dignity

The practice did not have a separate waiting room, so the reception area was not particularly private. However, the receptionist described to us some of the practical ways they maintained patient confidentiality. The reception computer screen was not visible to patients and staff did not leave patients' personal information where other patients might see it. Staff password protected patients' electronic care records and backed these up to secure storage. However, we noted that filing cabinets where some patient information was kept were not secured adequately at night.

All consultations were carried out in the privacy of the treatment room and we noted that the door was closed during procedures to protect patients' privacy. The treatment room window was frosted to prevent passers-by looking in.

Involving people in decisions about care and treatment

Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. Two patients commented that the dentists always listened to their concerns and took them seriously.

Dental records we reviewed showed that treatment options had been discussed with patients. The dentists described to us the methods they used to help patients understand treatment options discussed. These included photographs, pictures and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had its own website, providing patients with information about its staff and the services it provided.

The practice had made some adjustments for patients with disabilities which included level access side entry and a downstairs surgery. However, there was no fully accessible toilet and no hearing loop available to assist those with hearing aids. Information about the practice was not available in any other formats or languages. Staff were unaware of translation services that could be offered to patients who did not speak or understand English.

Timely access to services

At the time of our inspection, the practice was not registering any new adult NHS patients.

Patients told us they were satisfied with the appointments system and that getting through on the phone was easy. Patients could book appointments on-line and the practice offered a text and email reminder appointment service. Four emergency appointment slots were available each day. Three patients told us that getting an emergency appointment was straightforward.

Information about out of hours services was available in the patients' information sheet.

Listening and learning from concerns and complaints

Information about the practice's complaints procedure was on display in waiting area. However, we noted the information was limited and did not include details of other agencies that patients could contact to raise concerns or the timescales in which their complaint would be responded to.

The practice manager and principal dentist had recently undertaken a complaints handling course, which the practice manager told us they had found very useful. We viewed evidence that complaints were shared at the joint practice meetings with the provider's other practice, so that learning could be shared across the two sites.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. She was supported by a senior nurse who had additional responsibilities for stock control and auditing. The practice manager from the provider's other dental surgery was also available for support. The nurses and dentist worked across both the provider's practices to enhance peer contact and reduce isolation.

Culture

Staff stated they felt respected and valued in their work. They told us they felt listened to by the principal dentist. It was clear they focused on the needs of patients.

The practice had a Duty of candour policy in place and staff were aware of their obligations under it. Staff told us of a recent event involving a patient minor injury. An investigation had been undertaken and the dentist had rung the patient to apologise.

Governance and management

Clinical staff worked across both provider's practices. We noted a number of variations in how the two practices operated, indicating that oversight and management was not consistent between them.

Communication across the practice was structured around regular meetings. Staff told us the meetings provided a good forum to discuss practice issues and they felt able and willing to raise their concerns in them. Minutes we viewed were comprehensive. In addition to full practice team meetings. Dentist and nurses also met separately to discuss issues specific to their roles.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. We found that all records required by regulation for the protection of patients and staff and for the effective and efficient running of the business were maintained, up to date and accurate. However, filing cabinets in which some patients' information was held, were not locked at night.

Engagement with patients, the public, staff and external partners

The practice used patient surveys to gather feedback about its services. This asked questions, about the appearance of the waiting room, the ease of getting appointments and the quality of their treatment. 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.

We found that patients' feedback was acted upon. For example, patients' suggestions to install a new air conditioning unit, cut the hedging back at the entrance and update the practice information leaflet had been implemented.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us that the principal dentist listened to them and was supportive of their suggestions. For example, their suggestions for access to a lap top, new bins and computer training had been implemented.

Continuous improvement and innovation

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs, antibiotics and the use of personal protective equipment. We viewed minutes of the practice meeting held on 13 September 2018 where results of these audits had been discussed so that learning could be shared.

Staff told us the principal dentist paid for all their core professional development training, and one staff member stated that they had recently undertaken first aid training. The receptionist told us they had done a one-day reception skills course which they had enjoyed. The principal dentist had just completed a Master's degree In Periodontology.

The dental nurses had been appraised by the senior nurse and the reception staff by the principal dentist. However, the associate dentists did not receive an annual appraisal so it was not clear how their performance was assessed. The practice manager told us they had not received an appraisal in the previous two years.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12- Safe Care and Treatment.** **Care and treatment must be provided in a safe way for service users.** **How the regulation was not being met** • Some emergency equipment was not available in the practice. • There was no protocol in place to prevent wrong site surgery. • The practice's gas boiler had not been maintained. • Fire safety systems were not checked to ensure they were effective. • Some of the practice's infection control procedures did not meet national guidance. • A legionella risk assessment had not been undertaken. • Prescriptions were not managed according to best practice guidance. • X-ray equipment servicing had not been undertaken in line with guidance. Regulation 12 (1)