Mr. Martin Barrett

Orthodontic Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 November 2016 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 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

Stewart House Orthodontic Surgery is a well-established dental practice that provides primarily NHS orthodontic treatment to children. **The** team consists of an orthodontist, two trainee dental nurses and a receptionist. The practice has a treatment room, an x-ray room and reception/waiting area. It opens from 8.30 am to 4.30pmon Monday to Fridays.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. 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.

Before the inspection we sent comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 24 patients who commented positively about the quality of the service and the effectiveness of their treatment.

Our key findings were:

- Patients were treated in a way that they liked and were actively involved in decisions about their treatment.
- There were arrangements in place for identifying, recording and managing risks and implementing mitigating actions
- The practice was visibly clean and equipment was well maintained.

Summary of findings

- Patients' care and treatment was planned and delivered in line with evidence-based guidelines, best practice and current legislation. Patient dental care records were detailed and comprehensive.
- The practice listened to its patients and staff and acted upon their feedback.
- The practice's staff recruitment procedures and infection prevention and control practices needed to be strengthened.
- There was lack of an effective audit systems in place to ensure that a good service was being delivered to patients.
- Staff did not receive regular appraisal of their performance.

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

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This must include ensuring the safe recruitment of staff, responding to national safety alerts, implementing robust infection control procedures and undertaking effective audits of the service provided.

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

- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.
- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review the training, learning and development needs of staff members and implement an effective process for the on-going assessment and appraisal of all staff employed.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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.

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, assessing potential risks to patients and staff, and conducting radiology. Equipment was well maintained and serviced regularly. However, the practice's recruitment and infection control procedures needed to be strengthened, as did measures to control legionella.

Are services effective?

No action

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

Patients told us that they were happy with the treatment they had received from the orthodontist and that it was explained well to them. Dental care records were of good quality and showed that treatment was evidence based and focussed on the specific needs of patients. The orthodontist understood Gillick guidance well and used it to inform his work with younger patients.

Improvements were required to review staff's training at regular intervals and undertake appraisals.

Are services caring?

No action

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

We collected 24 completed patient comment cards and obtained the views of a further three patients on the day of our visit. These provided a very positive view of the service and the staff. Patients commented on the cleanliness of the practice, and described staff as welcoming, helpful and caring. Staff gave us specific examples where they had gone beyond the call of duty to support patients.

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 had good facilities and was well equipped to treat patients and meet their needs. Patients told us it was easy to get through on the phone to the practice, and they rarely waited long once they had arrived for their appointment. The practice had made adjustments to accommodate patients with a disability.

Staff managed patients' complaints professionally and empathetically, although information about how to raise concerns was not easily available.

Summary of findings

Are services well-led?

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

Staff told us that they enjoyed their work, that informal communication systems within the practice were good and that their suggestions were listened to by the orthodontist.

However there were no formal minuted staff meetings and staff did not receive any appraisal of their performance. Staff training was limited, as were audit systems. Many policies and risk assessments had only recently been implemented, and had not yet been fully embedded in the practice. A lack of oversight meant that nationally recommended infection control procedures were not being followed and staff had not been recruited safely.

Requirements notice 

Orthodontic Surgery

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was carried out on 15 November 2016 by a CQC inspector who was supported by a specialist dental adviser. During the inspection we spoke with the dentist, one dental nurse and the receptionist. We reviewed policies, procedures and other documents relating to the management of the service. We received feedback from 27 patients about the quality of the service, which included comment cards and patients we spoke with during our inspection.

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

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and details of how to report to this agency were in the practice's policy. There was a specific book available at the practice in which to record any accidents.

Staff were less clear about what was meant by significant events and near misses, and there was no policy or specific form in place in which to record these. However, we found good evidence that unusual events within the practice were discussed and learning from them shared across the staff team. For example, following an incident of a wrongly labelled dental impression, all staff had been retrained in handling impressions, and the practice's protocol for cleaning and labelling them had been changed.

Both the orthodontist and receptionist we spoke with had a good understanding of their obligations under the Duty of Candour and the practice had recently implemented a policy in relation to it. (Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity).

Reliable safety systems and processes (including safeguarding)

Records showed that staff had received recent safeguarding training for both vulnerable adults and children, although this was not at the recommended level for the dental nurses. Safeguarding policies were available to staff and a flow chart of reporting procedures was on display in the staff area, although this did not include local contact numbers. Staff we spoke with demonstrated they understood the importance of safeguarding issues although they were less sure of agencies involved in the protection of children out with the practice. The orthodontist told us of a specific safeguarding incident he had encountered with a young patient. At the time it occurred, he had not formally reported it, but following his recent safeguarding training, he now realised he should have done so. He told us the training had increased his confidence and knowledge in reporting matters of concern.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which might be contaminated). Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps' risk assessment had been completed for the practice.

Medical emergencies

All staff had received medical emergency training, although they did not regularly rehearse emergency medical simulations so that they could keep their skills up to date. Staff had access to medical oxygen along with other related items such as an AED (automated external defibrillator), manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. However there were no oropharyngeal airways, or blood glucose measuring device available. The practice did not have eyewash or bodily spillage kits.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice's supply of glucagon (used to treat episodes of severe hypoglycaemia which is defined as having low blood glucose levels that requires assistance from another person to treat) was not kept in the fridge. Its expiry date had not been reduced as a result to maintain its effectiveness, although this was done during our visit.

Staff recruitment

We reviewed recruitment records for the most recently employed staff members and found a number of shortfalls. For example, no references had been obtained for the staff and there were no current Disclosure and Barring Service (DBS) checks in place. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they might have contact with children or adults who might be vulnerable (although the provider had undertaken FBI checks as the staff were American). Verification of their formal qualifications had not been obtained and no record was kept of their recruitment interview to demonstrate it had been conducted in line with good employment practices. The practice had not obtained vaccination status reports for the dental nurses.

New staff did receive an induction to their role and the receptionist told us she had worked closely with the previous receptionist for a week in order to learn the job.

Are services safe?

Monitoring health & safety and responding to risks

There were procedures in place for monitoring and managing risks to patient and staff safety.

We viewed a comprehensive practice health and safety risk assessment completed in November 2016 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. There was a health and safety policy available with a poster in the staff area that identified local health and safety representatives.

The practice did not undertake regular temperature monitoring of the water, and dental unit waterline flushing was not carried out in accordance with current guidelines to reduce the risk of legionella bacteria forming. This was especially critical as the water lines were not frequently used. A legionella risk assessment had been carried out by an external company just prior to our inspection and the results of the report arrived on the day of our visit. The orthodontist assured us that all recommendations made would be implemented. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings].

A fire risk assessment had been completed and firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** Regular fire evacuation drills were completed, but patients were not involved. This did not help ensure staff knew what to do in the event of a fire.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for all products used within the practice. The practice had a business continuity plan in place for major incidents such as the loss of utilities.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice, and the practice had policies in place for key areas such as blood borne viruses, decontamination, hand hygiene and clinical waste management.

We observed that all areas of the practice were visibly clean and hygienic, including the treatment room, waiting area and toilet. The toilet had liquid soap and paper towels to help maintain good hand hygiene. We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The room had sealed flooring and modern sealed work surfaces so they could be cleaned easily. There were separate hand washing sinks for staff. Dirty and clean zones were clearly identifiable. However, we noted a number of shortfalls which compromised effective infection control and prevention:

- The orthodontist did not wear clinical scrubs or a face mask when treating patients.
- The base of the treatment chair was sticky and dusty.
- One chair had rips and holes in it, making it difficult to clean effectively. No action had been taken to repair it.
- Hand washing sinks did not meet national guidance.
- The sharps' box was not sited securely.
- Staff who undertook decontamination procedures were not aware of national decontamination guidance
- We found loose instruments and medical consumables uncovered in treatment room drawers which risked becoming contaminated over time.
- Cleaning equipment was not colour coded and the same mop was used to clean all floors in the practice, including the toilet.
- There was no evidence to show that the dental nurses had been immunised against hepatitis B.

The practice had undertaken an infection control audit for the first time just prior to our inspection; national guidance states that these audits should be completed every six months. This audit had identified a number of shortfalls in the practice's procedures. The orthodontist told us that an illuminated magnifying glass for checking instruments and a wipable key board cover had been ordered as a result.

The practice did not have a separate decontamination room for the processing of dirty instruments, so all instruments were cleaned in the treatment room. The dental nurse used a system of manual scrubbing for the initial cleaning process. Instruments were then placed in an autoclave (a device used to sterilise medical and dental instruments). The dental nurse demonstrated that systems were in place to ensure that the autoclave used in the decontamination process was working effectively. However following sterilisation, instruments were not packaged in any form of sterile barrier such as pouches and therefore it was not possible to tell the date by which they should be used.

Are services safe?

An appropriate external contractor was used to remove clinical waste from the practice and waste consignment notices were available for inspection. Clinical waste was stored in a locked cupboard prior to being removed from the practice.

Equipment and medicines

The practice's equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, portable appliance testing had been completed in November 2016 and fire extinguishers had been serviced June 2016. Records viewed showed that the practice's autoclave and compressor were booked to be serviced in the fortnight following our inspection.

There was a no formal system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned and the orthodontist was unaware of recent safety alerts affecting dental practice. Prescription pads were not held securely to prevent their loss due to theft, and there was no logging system in place to account for the prescriptions issued.

Radiography (X-rays)

The practice had a radiation protection file and a record of the X-ray equipment including service and maintenance histories. A Radiation Protection Advisor and Radiation Protection Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available and records showed that the orthodontist had received training for core radiological knowledge under Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000..

The orthodontist did not record the justification or grading of patients' x-rays taken, as recommended by national guidance.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with three patients during our inspection and received 24 comments cards that had been completed by patients prior to our inspection. All the comments received reflected that patients were very satisfied with the quality of their orthodontic treatment and the staff who provided it.

We found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Our discussion with the orthodontist and check 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 British Orthodontic Society guidelines. We saw evidence that patients' medical history had been taken on their initial assessment and updated at subsequent visits. Dental care records were of a good standard.

The orthodontist told us he regularly assessed the effectiveness of his treatment using a nationally recognised tool called PAR (peer assessment rating). He scored highly on these assessments indicating that the standard of orthodontic treatment provided was good. He also attended a regional study group every three months to discuss recent research in the field of orthodontics, and individual patient case studies so that learning could be shared. He was a member of the British Orthodontic Society and British Dental Association and received regular information from both organisations to keep his knowledge and skills up to date.

Health promotion & prevention

Staff were not aware of the guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention', although our discussion with the orthodontist and dental records we viewed showed that patients' oral hygiene was assessed and that they were given appropriate advice and instruction. The practice stocked leaflets produced by the British Orthodontic Society on how to keep teeth and gums healthy which were also regularly given to patients.

Staffing

Staff told us the staffing levels were suitable for the small size of the practice and the orthodontist always worked with a dental nurse. Both staff and patients told us they did not feel rushed during appointments.

Files we viewed demonstrated that the orthodontist was appropriately qualified, trained and had current professional validation and indemnity insurance. At the time of our inspection it was not clear whether the dental nurses had adequate indemnity. However, following our visit, the orthodontist contacted his insurers and added the nurses to his policy. The practice had appropriate Employer's Liability insurance in place.

We found that staff training was limited. Although staff had undertaken essential training in safeguarding patients, infection control and basic life support, they had not undertaken any other training such as information governance, equality and diversity, fire safety, or health and safety. Neither dental nurse was actually qualified, although both had recently signed up to accredited on-line dental nurse training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. Patients were offered a copy of the referral for their information, although a log of the referrals made was not kept so they could be tracked.

Consent to care and treatment

Patients told us that they were provided with good information during their consultation and the orthodontist explained treatments to them in a way that they understood. Evidence of patients' consent to treatment had been recorded in the dental care records we viewed. The practice used additional written consent forms for clinical photography.

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice had implemented a MCA policy and checklist a few days prior to our visit, although not all staff we spoke with had a clear understanding of its principles. The orthodontist demonstrated a good understanding and application of Gillick competency guidelines in relation to working with younger patients who

Are services effective?

(for example, treatment is effective)

might not want certain types of treatment, despite their parents' wishes. These guidelines help clinicians to identify children aged under 16 who have the legal capacity to consent or refuse medical examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection, we sent comment cards so patients could tell us about their experience of the practice. We collected 24 completed cards and obtained the views of a further three patients on the day of our visit. These provided a very positive view of the practice. Patients commented that staff were supportive, caring and explained treatments well. Parents reported that the orthodontist worked with their children in an age appropriate and respectful way. Staff gave us specific examples of how they had helped anxious patients, which included allowing them to bring in their own music to be played in the treatment room.

We observed the receptionist interact with about 10 patients both on the phone and face to face and noted she was consistently polite, helpful and caring towards them, despite being very busy herself. Patients told us reception staff worked hard to find them appointments at suitable times, especially if they had to cancel at short notice: something they greatly appreciated.

We noted that patients' paper notes were kept in lockable cabinets and the computer screen at reception was not easily overlooked. However, the treatment room was not private. The door was left open, and throughout our inspection we could easily over hear the orthodontist asking about patients' medical histories and current medications. Caster plaster dental models were stored in the x-ray room and the patients' names were clearly identifiable to other patients using the room. Thus there was a risk of breach of confidentiality and there should be an enclosed storage facility for the models to protect that patient confidentiality.

Involvement in decisions about care and treatment

Feedback we received from patients clearly indicated that the orthodontist was good at explaining treatments and involving them in decisions about their care. In particular, patients told us the orthodontist explained the long-term nature of the treatment and the action needed by them to ensure a successful outcome. A plan outlining all proposed treatment was given to each patient so they were fully aware of what it entailed, along with leaflets explaining it in more depth.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was located in the centre of Bury St Edmunds and there was plenty of on street car parking nearby. Patients told us that accessing the practice was easy, as was getting through to it on the phone. They commented that the orthodontist was good at running to time and rarely waited long having arrived for their appointment.

The practice had a helpful website that gave patients good information about the practice, the staff, what to expect at their first visit, and provided links to leaflets explaining a range of treatments and dental appliances. Patients could also download the practice's specific information leaflet.

The practice was open Monday to Friday, from 8.30am to 4.30pm, although staff told us appointments could be organised outside of these times and gave us specific examples where this had been done to meet patients' needs. However, patients told us that the practice was very busy and they often had to wait some time before treatment could start. Although the practice did not offer a text messaging service, a letter was sent to each patient a week before they started their treatment as a reminder.

There were formal arrangements in place with another practice nearby to cover any emergency appointments when the orthodontist was on annual leave. The practice's answering machine gave details of an emergency out of hours contact telephone number, although details were not displayed outside the practice should a patient come when it was closed.

Tackling inequity and promoting equality

The practice had taken measures to meet the needs of patients with disabilities. There was step free access to the premises at the rear of the property and the treatment room was on the ground floor. The toilet had been fully enabled for those with limited mobility and the reception desk was low making it easy for reception staff to communicate with wheelchair users.

Translation services were available for patients who did not speak English.

Concerns & complaints

The practice had an appropriate complaints procedure in place which included the timescales within which complaints would be dealt and other agencies that patients could contact such as the NHS area team and the General Dental Council. However, there was no information on display in the waiting area or on the practice's web site providing patients with information about how they could raise their concerns.

We viewed the paperwork in relation to the one complaint received by the practice in the last year and found it had been dealt with professionally and empathetically. A full apology had been given to the complainant and the dental appliance concerned had been replaced. Staff told us that the complaint had been discussed with them in depth and a new protocol had been implemented to prevent its reoccurrence.

Are services well-led?

Our findings

Governance arrangements

There were some policies and procedures in use to support the management of the service and guide staff, although many of these had been implemented a few days prior to our inspection and were not yet fully embedded. There was no system in place to formally disseminate these policies and ensure that staff fully understood their application. Staff told us there were occasional practice meetings, however minutes of these were not kept and it was not clear how information was communicated to staff who were not present at the meeting.

Systems within the practice to monitor quality and to make improvements were limited. No regular audits were undertaken to assess the quality of the radiographs or dental care records. An infection control audit had only been completed for the first time a few days prior to our inspection visit. Measures to assess risk within the practice had only just been undertaken, and the practice had not yet had time to implement control measures to ensure patient safety.

None of the staff had received an appraisal of their performance or had personal development plans in place. They had not received any training in areas such as information governance, health and safety, fire, equalities and diversity, and the Mental Capacity Act.

The practice had yet to complete the information governance self-assessment tool kit and therefore it was not possible for us to determine whether it was managing patient information in line with legislation.

Leadership, openness and transparency

The orthodontist told us he was aware that he had not been managing the practice as well as he would have liked for a number of reasons. Despite this, staff told us they enjoyed their work and the small size of the practice which meant informal communication systems were good. Staff reported there was an open culture and they had the opportunity to raise issues with the orthodontist, and felt confident in doing so.

Both the orthodontist and receptionist we spoke with had a good understanding of their obligations under the duty of candour and the practice had recently implemented a policy in relation to it. We found staff to be open and honest about the shortfalls within the practice, and they were clearly keen to address the issues we found during our inspection. We found the receptionist in particular had a good grasp of what needed to be done to improve the service, and how to implement it.

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

The practice had introduced the NHS Friends and Family Test (FFT) as a way for patients to let them know how well they were doing. 59 responses had been received since April 2015, only three of which did not recommend the practice. In addition to this, a box was available in the waiting area so that patients could make any suggestions to improve the service. As a result of patient feedback the practice had implemented reading materials for all ages in the waiting room.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the orthodontist. We were given examples where staff's suggestions had been implemented. For example, staff's request for a fridge, microwave and kettle had been met. As three of the practice's staff were American nationals, the orthodontist had agreed that the practice would close on American national public holidays, allowing staff to celebrate the holidays with their families.

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 How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate risks to the health, safety and welfare of people who may be at risk which arise from the carrying on of the regulated activity. This includes: · ensuring the safe recruitment of staff · responding to national safety alerts · implementing robust infection control procedures · undertaking effective audits of the service provided **Regulation 17 (2)(b)**