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Old Grammar School Dental Surgery

Inspection Report

The Old Grammar School Dental Practice
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Overall summary

We carried out this announced inspection on 20 August 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. 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

The Old Grammar School Dental Practice is a well-established service based in St Ives, Cambridgeshire that offers both private and NHS general dental treatment to approximately 5,000 patients.

Summary of findings

The dental team consists of three dentists, a practice manager, five dental nurses and reception staff. There are three treatment rooms. The practice opens on Mondays to Fridays, from 8am to 5pm. There is portable ramp access for wheelchair users and parking right in front of the building.

The practice is owned by an individual who is the one of dentists 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 40 CQC comment cards filled in by patients and spoke with another two patients.

During the inspection we spoke with three dentists, two nurses and reception staff. 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 dentists.
- The practice was small and friendly, something which both patients and staff appreciated.
- The practice appeared clean and well maintained.
- The appointment system met patients' needs and patients could get an emergency appointment easily.
- There was no effective system for reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements were made as a result.
- Medicines were not managed effectively.
- There was no system in place to ensure that X-ray equipment was properly serviced.
- Patients' dental care records did not reflect standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Some of the practice's infection control procedures did not comply with national guidance.
- There were no effective systems to assess and monitor the quality of service provision.

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 dental dams for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking X-rays, a report on the findings and the quality of the image in compliance with Ionising Radiation (Medical Exposure) Regulations 2017.

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** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

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).

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 provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Contact information for local protection agencies was on display in the staff area. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

All staff, apart from the receptionist, had a disclosure and barring check in place to ensure they were suitable to work with vulnerable adults and children.

The provider had a whistleblowing policy and staff told us they felt confident to use it if needed.

Not all the dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. No dental dams were available for patients who might be allergic to latex.

Staff were aware of the new regulations about amalgam and its use in relation to children. At the time of our inspection the practice's website stated that it offered metal fillings to children . Following our inspection this statement was removed from its website.

The practice had a business continuity plan describing how it would deal with events that could disrupt its normal running. This was kept off site, so could be accessed in the event of an incident.

The practice had a recruitment policy in place which reflected relevant legislation. We viewed the personnel files for three recently recruited staff and found that appropriate pre-employment checks had been undertaken to ensure they were suitable for the role.

A fire risk assessment had been completed for the premises in April 2019 and its recommendations to install an emergency light and undertake a hard wire test had been implemented. However, fire drills were not undertaken, and one staff member told us they had never rehearsed a fire evacuation in the five years they had worked there. Following our inspection, we were provided with minutes to show that a meeting had been held with staff on 19 August 2019 to discuss fire evacuation procedures.

We were told that fire alarms were tested regularly but were not provided with evidence of this during our inspection. Following our inspection, the provider sent us information about weekly fire alarms tests that had been completed.

The provider had some risk assessments in place for the control of substances that were hazardous to health (COSHH). However, this did not include safety data sheets for the hazardous products used by the visiting cleaner. Missing safety data sheets were sent to us following our inspection.

Rectangular collimation was used on X-ray units to reduce patient exposure. However, the practice did not have suitable arrangements to ensure the safety of the X-ray equipment and could not provide evidence that X-ray units had been adequately maintained and serviced. We found limited recording of the justification on taking X-rays and their grading in the patient notes we viewed.

Risks to patients

A general risk assessment had been completed for the practice, but its recommendations for staff to have moving and handling training could not be evidenced during our inspection.

Dentists followed acceptable practice when using needles. A specific sharps risk assessment had been undertaken but was limited in scope. It only identified risks in relation to the use of needles and did not include other instruments such as matrix bands, scalpels and probes.

We noted from the practice's accident book that staff had received several sharps injuries in the previous months including those from instruments such as dirty probes and matrix bands. These had been poorly recorded, and it was not clear if advice from local occupational health services had been sought. Following our inspection, the provider sent us information to show that a new protocol had been implemented which reflected national guidance.

Are services safe?

Although not wall mounted, sharps boxes were sited safely. However, they had not been removed after a period of three months and risked becoming a contamination hazard.

Staff had not undertaken training in basic life support every year as recommended. One member of staff had not received any cardiopulmonary resuscitation (CPR) training, and another told us they had only received the training twice in the previous five years. In addition to this staff did not regularly rehearse emergency medical simulations so that they had an opportunity to practise their skills.

Medical emergency equipment and medicines were available as described in recognised guidance.

We noted that most areas of the practice were visibly clean, including the waiting area, toilet and staff area. We checked treatment rooms and surfaces including walls, floors and cupboard doors and noted dust on the horizontal blinds in one treatment room. We found loose and uncovered local anaesthetics in treatment room drawers that risked aerosol contamination. We also found rusty burs.

Staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. However, staff wore the same trousers for both work and home, compromising infection control. One full-time staff member told us they had only been issued with two sets of uniform and had bought their own to make it easier to have a clean uniform on each day.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments which were mostly in line with national guidance. However, we noted the following shortfalls which risked compromising good infection control.

- Non-pouched instruments were not reprocessed at the end of the day.
- A daily check of the autoclave's sterilisation process was conducted, but not of each cycle to ensure the correct temperature and pressure was achieved, as recommended in national guidance.
- Nurses handled instruments in a dangerous way, that risked their injury.
- It was not possible to determine from the colour coding on mops, which was to be used for toilet areas and which for clinical areas.
- Flooring had not been sealed in treatment rooms. Following our inspection, we received a photograph showing us that flooring had been sealed subsequently.
- Staff were not aware of the need to flush water lines for 30 seconds between patients.
- A bin for sanitary products was available in one of two toilets.

The practice had procedures to reduce the possibility of legionella or other bacteria developing in the water systems. A full legionella risk assessment had been undertaken in April 2019 and its recommendations to remove a water tank and start monitoring water temperatures had been implemented.

Safe and appropriate use of medicines

Staff were aware of the yellow card scheme for reporting adverse reactions to drugs or defective medicines. Although no antibiotic audit had been completed at the time of our inspection, one dentist told us this was in progress.

The dentists told us that medicines were not dispensed to patients. However, we found boxes of medicines such as Amoxicillin and Erythromycin (both antibiotic medicines), for patient use. There was no system of stock control or accountability in place for these.

Prescription pads were held securely but there was no tracking in place to monitor individual prescriptions to identify theft or loss. We also found that prescriptions had been pre-stamped, thereby comprising their security. The practice's name and address were not included on medicines labels dispensed to patients.

Glucagon was kept out of the fridge, but its reduced expiry date as a result had not been recorded on the box.

Lessons learned and improvements

Staff had a satisfactory understanding around significant event reporting. However, we noted several incidents that had been recorded in the accident book, including sharps injuries and a scald to a staff member's foot. We noted two identical incidents, some months apart, where a staff member had caught their thumb in the filing cabinet. There was no evidence to show how learning from these incidents had been shared to prevent their recurrence.

The principal dentist received alerts from the Medicines and Healthcare Products Regulatory Authority and national

Are services safe?

patient safety alerts but there was no clear system for disseminating them to ensure all staff had seen and read them. There was no alternative arrangement for receiving them if the principal dentist was unavailable. Following our inspection, the provider informed us that if the principal dentist was not able to disseminate information, alternative arrangements would be made.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 40 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. One patient commented, 'Procedures were done with the utmost care and consideration'. Another patient stated, 'My dentist is warm and welcoming, reassuring me at all times during dental treatment. She is fabulous with our three children and has provided a positive experience for them all'.

Our review of dental care records indicated that patients' dental assessments and treatments were not carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC). For example, the findings from intra and extra oral assessments were not always recorded. Patients' risk of caries, periodontal disease and oral cancer had not been recorded consistently to inform patient recall intervals. There was not always a clear record that treatment options had been fully discussed with patients. In one instance we found that patients' notes were missing from both the computer and card records.

Audits of the quality of dental care records were undertaken but they had not been effective in identifying the shortfalls we found during our records' review.

Helping patients to live healthier lives

There was good information in the downstairs waiting room in relation to children's oral health, the amount of sugar in food and fizzy soft drinks, and smoking cessation services. The dentists told us they gave oral health advice to patients in relation to smoking, alcohol intake and diet, but dental care records we reviewed did not always demonstrate this.

Consent to care and treatment

Patients confirmed their dentist listened to them and gave them clear information about their treatment.

Effective staffing

The practice had faced significant challenges recently with 70% of staff having retired at around the same time. Three new nurses had been employed and were still settling into their roles.

Staff told us there were enough of them for the smooth running of the practice and to allow for annual leave. The nurses told us they never felt rushed in their work.

We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

The dentists told us they 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.

Are services caring?

Our findings

Kindness, respect and compassion

Patients spoke highly of the practice's staff and had clearly built up strong relationships with them over the years. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist. They also valued the continuity of care they received from their dentist. Patients described staff as warm, caring and courteous. Several patients commented that staff worked well with their children. Staff told us of the additional care they had provided for one patient following their extensive bleeding afterwards after a tooth extraction.

Privacy and dignity

The waiting room was separate from the reception area, allowing for patients' confidentiality. The reception computer screen was not visible to patients and staff did not leave personal information where other patients might see it.

All consultations were carried out in the privacy of the treatment rooms and we noted that the doors were closed during procedures to protect patients' privacy. We noted blinds and frosted glass were on the window to prevent passers-by looking in.

Patients' records were stored in fire proof filing cabinets, although one of these could not be locked safely.

Involving people in decisions about care and treatment

Patients confirmed the dentist listened to them and gave them clear information about their treatment. One told us, 'I am always informed about each step of my treatment'. Another stated, 'our queries are answered, and the treatment is clearly explained'. However, dental records we reviewed did not always show what treatment options had been discussed with patients or document the consent process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a website which gave patients information about the services it offered and their costs. It also offered them a payment plan to help them spread the cost of dental treatment.

The practice had made some adjustments for patients with disabilities. There was portable ramp access to the entrance and a ground floor treatment room. However, there was no hearing loop to assist patients with hearing aids and information about the practice was not produced in any other formats or languages.

Timely access to services

Reception staff told us that the dentists were good at running to time and patients rarely waited, having arrived for their appointment. Patients' comments cards we received also reflected this.

At the time of our inspection the practice was not able to take on any new NHS patients. The waiting time for a routine appointment was about two weeks, as was the time for treatment. The practice offered a telephone appointment reminder service to patients.

Emergency appointments were available, and each dentist had two slots per day for patients experiencing dental pain. Privately paying patients could contact the dentists out of hours on a specific mobile telephone number.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales and other agencies that could be contacted. Information about how patients could raise their concerns was available in the waiting room. However, this was in small print, making it hard to read and only gave details of a web site patients could access. Reception staff were not familiar with the practice's complaints policy and did not have access to written information to give patients.

We viewed the paperwork in relation to one recent complaint and found it had been manged in a professional and timely way.

Are services well-led?

Our findings

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).

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They were supported by a part-time practice manager who took responsibility for a number of administrative and financial tasks. The practice manager and the principal dentist met for an hour each week to discuss the management of the service.

There were no specific staff lead roles within the practice, although the principal dentist told us this was something he wanted to implement once all the new staff had settled into their role.

Staff told us the dentists were approachable and responsive, and their suggestion for name badges had been implemented.

Culture

The practice was small and friendly and had built up a loyal and established patient base over the years. Staff told us they enjoyed their job and most felt valued in their work.

The practice had a duty of candour policy in place, and staff had an adequate knowledge of its requirements.

Governance and management

The practice did not have effective governance procedures in place. We identified several shortfalls during our inspection including the quality of dental care records, infection control procedures, fire safety and equipment maintenance, which demonstrated that governance procedures in the practice were ineffective.

Communication systems between staff were very informal and there were no regular practice meetings to share key messages or discuss the practice's procedures and policies. Staff told us they would value regular meetings to 'find out about things' and as a 'forum of learning'.

Engagement with patients, the public and external partners.

Systems for obtaining feedback from patients were limited. The practice had a patient survey but it had not been used effectively to gather patients views of the service. NHS patients were able 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. However, only one form had been completed since March 2019.

Continuous improvement and innovation

The practice did not have effective quality assurance processes to encourage learning and continuous improvement. Audit results were not effectively analysed then used to drive improvement. The dental records and infection control audits had failed to identify many of the shortfalls we noted and were not consistent with our findings. There was no evidence of resulting action plans, re-audits and improvements.

None of the staff received a regular appraisal so it was not clear how their performance was assessed, or their training needs identified.

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.** • Staff had not received yearly training in basic life support. • Staff did not regularly undertake fire drills. • Radiation equipment had not been regularly serviced. • Some of the practice's infection control procedures did not meet the Department of Health's Technical Memorandum 01-05: Decontamination in primary care dental practices. • Medicines were not managed effectively. There was no system in place to monitor and track individual prescriptions.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Good Governance** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The registered person had ineffective systems or processes in place as they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

In particular:

- There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.
- There were no systems to ensure that the completion of dental care records followed guidance provided by the Faculty of General Dental Practice.
- Audits of dental care records and radiography were not effective in identifying shortfalls and areas for improvement.
- There was no system in place to ensure staff received regular appraisal of their performance and to identify any learning and development needs.