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The Bridge Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 March 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 providing well-led care in accordance with the relevant regulations.

Background

The Bridge Dental Practice is situated in the basement of a large property on the main street in the centre of Marple Bridge. The practice is accessed via a small flight of stairs. Due to the age and design of the building there is no disabled access. People who require disabled access would be signposted to accessible dental practices in the local area. Parking is available in one of the municipal car parks. The practice offers predominantly (90%) NHS primary care dentistry to adults and children and a small amount (10%) of private treatments.

The staff group consists of the principal dentist, four associate dentists, a dental hygienist, a dental therapist and an orthodontist. They are supported by three registered dental nurses a registered orthodontic nurse and two apprentice nurses. There is a practice manager and a deputy manager who are also dental nurses. Reception duties are covered by the dental nurses on a rota basis. The practice is a member of the British Dental Association (BDA) Good Practice Scheme. There were three treatment rooms, a dedicated decontamination room, reception/waiting area, toilet and a staff kitchen.

The practice opening hours are Monday to Thursday 8.45am to 5pm and Friday 8.45am to 4.30pm. Appointments are available on Saturday by appointment only.

The principal dentist (the owner) is the registered provider. Registered providers are 'registered persons'.

Summary of findings

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.

We received feedback from 34 patients via CQC comment cards and speaking to patients on the day of the inspection.

Our key findings were:

- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an automated external defibrillator and medical oxygen was available on the premises.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Governance arrangements were in place for the smooth running of the practice that included a system of audits to monitor the quality of the service.
- The practice had systems in place to assess and manage risks to patients and staff including infection prevention and control, fire safety and health and safety.
- Patients were able to access both routine and emergency appointments and there were clear instructions on how to access out of hours emergency dental treatment.
- The practice had procedures in place to take into account any comments, concerns or complaints that were made to improve the practice.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit' (DBOH).

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?

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

The principal dentist and practice manager were aware of their responsibilities in relation to the Duty of Candour regulation. The Duty of Candour is a legal duty on health providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

There were effective systems in place in the areas of infection control, clinical waste control, management of medical emergencies and dental radiography.

Decontamination of instruments was carried out in line with guidance issued in the Department of Health Technical Memorandum Decontamination in primary care dental practices (HTM 01:05).

Are services effective?

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

Consultations were carried out in line with good practice guidance from the National Institute for Health and Care Excellence and the Faculty of General Dental Practice (FGDP). For example, the frequency of recalls and taking X-rays.

We saw evidence staff had received training appropriate to their roles and further training needs were identified and planned through an effective appraisal system.

All new patients had an assessment of their oral health and were asked to provide a medical history. This information was used to plan patient care and treatment. The practice kept detailed dental care records of oral health assessments and treatment carried out and monitored any changes in the patient's oral health.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. There were systems in place for recording written consent for treatments. Staff had a good understanding of the Mental Capacity Act 2005 and the importance of obtaining valid consent from patients.

Are services caring?

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

We observed staff were polite and considerate when speaking with patients. The patients we spoke with spoke highly of the staff and the care they received at the practice and told us staff treated them with respect and kindness. All of the patients commented that the quality of care was good they were treated with compassion and felt at ease.

Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Staff spoke with enthusiasm about their work at the practice and told us they were proud of what they did.

Are services responsive to people's needs?

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

Summary of findings

The practice provided mainly NHS treatment with a small number of patients being able to access private treatment. The practice had extended opening hours to accommodate working people and school children.

Patients were able to access both routine and emergency appointments and there were clear instructions on how to access out of hours emergency dental treatment. We saw emergency appointment slots were available each day to respond to patients' needs, such as a patient experiencing dental pain.

There was an easily understood, well publicised and accessible complaints procedure to enable patients to raise their concerns.

Are services well-led?

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

The culture within the practice was seen by staff as open and transparent. Staff told us that they enjoyed working there.

There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions with the principal dentist and practice manager.

Appraisals were in place for all staff, training and development was encouraged and performance was monitored.

There were good governance systems in place that included risk assessment and audits. A range of policies and procedures which were regularly reviewed were available to support staff in their role.

The Bridge Dental Care

Detailed findings

Background to this inspection

The inspection was carried out on 30 March 2016 and was led by a CQC inspector. The inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

The methods that were used to collect information at the inspection included interviewing staff, observations and reviewing documents.

During the inspection we spoke with the principal dentist, practice manager and deputy manager, a dental nurse and patients. We observed staff interactions with patients and reviewed documents.

We informed NHS England area team / Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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

The practice had effective systems in place to learn and improve when significant events, accidents and near misses took place. Staff were aware off their responsibilities to report any significant incidents or accidents in accordance with the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager told us that any such accidents or incidents would be discussed at practice meetings or whenever they arose.

The principal dentist and practice manager were aware of their responsibilities under the Duty of Candour regulation. They told us if there was a mistake that affected a patient they would offer an apology and taken action to ensure there was no reoccurrence.

Reliable safety systems and processes (including safeguarding)

Staff we spoke with were aware of safeguarding procedures and knew the signs of abuse and how to report any suspected incident. There was a flow chart available for staff detailing the referral process and contact details of local safeguarding teams. The principal dentist took the lead responsibility for safeguarding and attended local network support group meetings. We saw that staff had received training that covered the key elements of safeguarding people who may be living in vulnerable circumstances. The principal dentist was trained to level three and other staff to level two in safeguarding.

We spoke with staff who were able to describe the signs of abuse and were aware of the referral process. All staff said they would speak with the principal dentist if they had any concerns about a patient's welfare. We looked at the safeguarding policy and found it was last reviewed in August 2015 with a planned review date of August 2016.

One of the dentists had a special interest in endodontics and championed the use of rubber dams within the practice. All of the dentists used a latex free rubber dam when carrying out root canal work. The British Endodontic Society uses quality guidance from the European Society of endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work.

The principal dentist was signed up to receive email alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), the UK's regulator of medicines and medical devices. These were then communicated to relevant staff.

The practice was a member of the British Dental Association (BDA) good practice scheme and as such was subject to annual assessments from the BDA. In addition the practice received regular updates from the BDA about the latest guidance in dentistry which were cascaded to staff.

Medical emergencies

The practice had appropriate emergency equipment and medicines available in accordance with the Resuscitation Council UK guidelines and the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that they were of the required type. We saw records to show that the drugs were checked monthly. All medicines were within their expiry date.

There was an automated external defibrillator on site, (an AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

There was a medical oxygen cylinder that was checked each day to ensure the level and flow rate were sufficient to respond to a medical emergency. Adult and paediatric face masks were available. We checked the oxygen cylinder and found it was of the approved size, the expiry date was 2018. The emergency kit also had a pulse oximeter a device that monitors the oxygen saturation of a patient's blood.

Staff recruitment

There was a recruitment policy and procedure in place which had been It was the practice policy to request a Disclosure and Barring Services (DBS) check for all staff. The practice had a detailed checklist for the safe recruitment of staff which included seeking references,

Are services safe?

proof of identity and checking qualifications and professional registration. All newly recruited staff had a period of induction to familiarise themselves with policies and procedures and the way the practice ran.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies and a variety of risk assessments had been undertaken to minimise risks to patients, staff and visitors. All new employees were required to read policies and procedures relating to safe working practices during their induction.

There was a well maintained Control of Substances Hazardous to Health (COSHH) file. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease.

There was a fire risk assessment in place and fire extinguishers had been recently serviced. The staff we spoke with were able to demonstrate to us they knew how to respond in the event of a fire. We saw staff had attended fire safety training in 2015 and a mock emergency evacuation was carried out in February 2016.

Infection control

We were taken on a tour of the practice and found the treatment rooms, decontamination room, waiting area, reception and toilets were clean, tidy and clutter free. There were sealed floors and work surfaces in treatment rooms and the decontamination room that could be cleaned with ease to promote good standards of infection control. We saw there were clearly identified 'dirty' and 'clean' zones identified in each of the treatment rooms and the decontamination room. There were hand washing facilities in each treatment room and there were ample supplies of personal protective equipment (PPE) for patients and staff members. We spoke with patients who confirmed staff wore gloves when providing treatment.

A specialist contractor had carried out a Legionella risk assessment in January 2016. The principal dentist told us these were carried out annually and identified no risk to patient safety. In addition the practice carried out daily checks and tests of the water lines using a dip slide system. (Dip slides are used to test for the presence of microorganisms in liquids).

An external contractor carried out a deep clean of all areas of the practice on a monthly basis. Dental nurses were responsible for cleaning the treatment rooms between patients and at the end of each session. Cleaning schedules were in place for the premises and a cleaner was employed to carry out routine cleaning duties in non-clinical areas. We saw the cleaning schedule was reviewed in October 2015.

We reviewed staff files and found all clinical staff had been vaccinated against Hepatitis B. It is recommended that people who are likely to come into contract with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

The decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01- 05), decontamination in primary care dental practices. The infection control lead demonstrated the decontamination process from taking the dirty instruments through to clean and ready for use again. Used instruments were transferred from treatment rooms in sealed plastic boxes to minimise the risk of cross contamination.

Staff wore personal protective equipment (PPE) throughout the decontamination process that included aprons, eye protection, face mask and heavy duty gloves. Instruments were manually cleaned and scrubbed in the 'dirty' zone before being examined under an illuminated magnifying glass to check for any remaining debris. They were placed into one of the autoclaves for sterilisation prior to being packaged and dated ready for use.

Temperature and pressure checks were carried out on both autoclaves on a daily basis. A log was kept of the results demonstrating that the equipment was in good working order. We saw

infection control audits were carried out on a six monthly basis by the infection control lead last one was carried out in March 2016 with a score of 100%. In addition a six monthly hand hygiene audit was undertaken.

The practice had policies and procedures for dealing with needle-stick injury and other sharps injuries. Staff described the actions that would take should they experience such an injury.

Are services safe?

There was an on-going contract with an authorised carrier for the collection and safe disposal of clinical dental waste. Clinical waste was stored securely pending collection.

Equipment and medicines

There were maintenance contracts in place to ensure all equipment was regularly serviced, including the air compressor, autoclaves, fire extinguishers, oxygen cylinder and the X-ray equipment. We reviewed the annual servicing certificates and found equipment used in the practice had been maintained in accordance with the manufacturer's guidelines.

We saw portable appliance testing (PAT) was completed March 2016 in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety. We saw an electrical safety certificate dated August 2013 that was valid for five years.

Prescription pads were stored securely and we saw an up to date a log of all prescriptions issued which provided a clear audit trail. Anaesthetics were stored appropriately all dentists recorded in dental care records the type, amount and batch number of the anaesthetics used. Other than anaesthetics and emergency medicines, no other medicines were kept at the practice.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection supervisor (RPS) and a radiation protection advisor (RPA) had been appointed and their details recorded in the radiation protection file.

Staff responsible for taking X-rays had received the required training. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The local rules were also displayed in each of the treatment rooms. We saw the X-ray machines were fitted with a rectangular collimator. (A rectangular collimator is a device that narrows a beam of particles or waves and reduces the amount of radiation the patient is exposed to).

The practice used an X-ray digital processor that enabled them to display the X-ray image on a TV screen for the patient to see. This was used to explain proposed treatment options to patients.

The practice manager told us that quality audits of the X-rays taken were carried out every six months in accordance with the Faculty of General Dental Practice) guidelines.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs, and the frequency of recalls.

We reviewed a sample of dental care records that showed intra and extra-oral examinations were undertaken. The basic periodontal examination (BPE) screening tool was used to assess the condition and treatment needs of each patient. Careful assessment of the periodontal tissues (gums) is an essential component of patient management. The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need.

A check of the temporomandibular joint (TMJ) was also carried out as part of the extra-oral examination. (The TMJ is the joint that connects the jaw to the temporal bones of the skull).

Dental care records we reviewed contained a comprehensive written patient medical history which was updated on every examination. We found that where X-rays had been taken the justification, findings and quality assurance of X-ray images taken was recorded. X-rays were taken at appropriate intervals in line with guidance issued by the Faculty of General Dental Practice (FGDP).

Health promotion & prevention

We found the practice worked in accordance with guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

There were a range of health promotional leaflets available in the practice advising patients how to prevent gum disease and maintain their teeth in good condition.

Staffing

All dental care professionals were registered with the General Dental Council (GDC). To maintain their registration dental professionals were required to complete a specified number of hours training. Staff told us they were encouraged and supported to maintain their continuing professional development (CPD).

The staff group consisted of the principal dentist, four associate dentists, a dental hygienist, a dental therapist and an orthodontist. They were supported by three registered dental nurses a registered orthodontic nurse and two apprentice nurses. There was a practice manager and a deputy manager who were also dental nurses. Reception duties were covered by the dental nurses on a rota basis.

We saw all the dentists and dental nurses had personal insurance or indemnity cover in place. These policies help ensure patients could claim any compensation to which they may be entitled should the circumstances arise. In addition, there was employer's liability insurance which covered employees working at the practice which was due to expire in December 2016.

The practice manager told us staff covered for each other in the event of sickness or leave so that patients received continuity of care.

Working with other services

The dentists referred patients for specialist treatments when necessary. They would refer patients for minor oral surgery and conscious sedation. The practice used digital technology that allowed them to send X-ray images with the referral.

Where oral cancer was suspected patients were seen by a specialist within two weeks of the referral using the urgent referral pathway. We reviewed an urgent referral that had been completed and noted that the patient was seen by a specialist within 10 days. We saw a letter from the specialist service advising the practice of the outcome of their investigations. The principal dentist had signed and dated the letter to demonstrate it had been read before it was scanned onto the patient's records.

Consent to care and treatment

The staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions

Are services effective?

(for example, treatment is effective)

for themselves. Staff told us if they were concerned about a patient's capacity to give informed consent they would involve relatives and/or carers to ensure that treatment was delivered in the best interests of the patient.

The staff we spoke with were familiar with Gillick competence. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own dental treatment without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 34 patients via CQC feedback cards and through speaking with patients on the day of the inspection. Patients expressed a high level of satisfaction with the care and treatment they received. Comments included complete trust, extremely professional, courteous and professional, kind and polite, excellent interpersonal skills and understanding.

Patients we spoke with told us the dentists were sensitive to the needs of nervous patients and spent additional time explaining treatment.

Patients' dental care records were stored electronically and in paper form. Electronic records were password protected and regularly backed up to secure storage with paper records stored in lockable cabinets.

Treatment rooms were located away from the waiting are and doors were closed during consultations so conversations could not be overheard.

Involvement in decisions about care and treatment

Television screens were affixed to the walls in treatment rooms. These screens were used to show X-rays and photographic images to demonstrate treatments to patients such as root canal treatment and the reasons an extraction may be needed. In addition explanations of various treatments were available on the practice website.

Patients told us they were given a treatment plan that explained the type of treatment required, including the risks, benefits and costs. Before treatment started patients signed the plan to confirm they understood and agreed to the treatment.

A list of NHS was displayed in the waiting area. A list of private charges were also available to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Emergency appointments were available to all patients who were experiencing dental pain or discomfort. Dentist had vacant appointment slots each day so they could see any patient in an emergency.

Staff ensured laboratory work such as crowns and dentures had been received to avoid unnecessary visits and delays in the patient's treatment.

Tackling inequity and promoting equality

The practice is situated in the basement floor of a large period property. The practice was accessed via a flight of stairs and as such was not accessible to people with restricted mobility or wheelchair users. People requiring level access were signposted to local dental practices that occupied ground floor premises.

Staff told us they had access to a language translation service which they had used recently. The service is via telephone and additional time was allocated to allow for the three way discussion.

Access to the service

The practice opening hours are Monday to Thursday 8.45am to 5pm and Friday 8.45am to 4.30pm appointments are available on Saturday by appointment only. The answer machine message advised patients on how to access treatment when the practice was closed.

The practice displayed its opening hours on the premises and on the practice website. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

Concerns & complaints

There was a complaints policy and procedure describing how the practice would respond to complaints from patients. This was in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. There had been no complaints in the last 12 months.

We spoke with patients who told us they were happy with the care and treatment they received and had no cause for complaint. They told us they would speak to the dentist or practice manager if they had any concerns.

Are services well-led?

Our findings

Governance arrangements

The practice manager and deputy manager were responsible for the day-to-day management of the practice. They were supported in their roles by the principal dentist. The practice had a statement of purpose that detailed the practice vision and values.

There were good governance arrangements in place that included a wide range of policies and procedures designed to monitor and improve the services provided for patients. We saw there was a clear management structure with staff taking on dedicated lead roles such as infection control and safeguarding children and vulnerable adults.

There was a system of audits in place for all aspects off the practice including, the quality off X-ray images, dental care records, infection prevention and control and the environment. The principal dentist had implemented arrangements for identifying, recording and managing risks by undertaking risk assessments.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty. Staff told us they were able to speak with the practice manager, deputy manager or principal dentist if they had concerns about a colleague.

Staff told us it was a nice environment to work in and they enjoyed working at the practice and felt valued and supported by the practice manager, deputy manager and principal dentist.

Learning and improvement

Staff working at the practice were supported to maintain their continuing professional development (CPD) which was a requirement of their continued registration with the General Dental Council (GDC).

We saw that the dental nurses received an annual appraisal with the practice manager. Staff were able to discuss their on-going professional development and any training needs. Appraisals were kept under review to monitor progress and check if the objectives identified were being met.

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

We saw the practice held regular practice meetings which were minuted and gave everybody an opportunity to share information and discuss any concerns or issues which had not already been addressed during their daily interactions. Staff valued these meetings and said they had the opportunity to discuss any changes and improvements.

The practice participated in the NHS 'Friends and Family Test' survey. The FFT responses for February 2016 had been positive, with 100% of the patients who participated stating they would be 'likely' or 'extremely likely' to recommend this practice to a friend or relative.