Ixia Dental

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Inspection Report

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Overall summary

We carried out a comprehensive inspection of Ixia Dental on 21 May 2015. Ixia Dental is located in the London Borough of Brent in north-west London. The premises consist of a waiting area with a reception desk and two treatment rooms. There is also a separate decontamination room.

The practice provides NHS and private dental services and treats both adults and children. The practice provides a range of dental services including routine examinations and treatment, veneers, crowns and bridges, tooth whitening and oral hygiene.

The staff structure of the practice is comprised of two dentists (who are also the owners and practice managers), four dental nurses, who also act as receptionists, and one trainee dental nurse. The practice is a training practice for the Dental Foundation Training (DFT) scheme. DFT provides postgraduate dental education for newly qualified dentists in their first (foundation) year of practice; usually within general dental practices. One of the principal dentists is a trainer for the DFT scheme and provides clinical and educational supervision. The practice currently has one dentist who is in their first (foundation) year of practice. The practice is open Monday to Thursday from 9.00am to 5.00pm and on Friday from 9.30am to 12.30pm.

One of the dentists is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. 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.

This practice was registered with the CQC in November 2013. We carried out an announced, comprehensive inspection on 21 May 2015. The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

We received 15 CQC comment cards completed by patients and spoke with three patients in the waiting area. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

We found that this practice was providing safe, effective, caring, responsive and well-led care in accordance with the relevant regulations.

Our key findings were:

- There were systems in place to reduce the risk and spread of infection. We found all treatment rooms and equipment appeared clean.

Summary of findings

- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, oxygen cylinder and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients' needs were assessed and care was planned and delivered in line with current guidance.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The feedback we received from patients indicated that they felt they were listened to and that they received good care in a clean environment from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentists had a clear vision for the practice and there were appropriate governance arrangements in place. Staff told us they were well supported by the management team.

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

- Review the storage of emergency medicines to reduce the risk of them being accessed inappropriately.

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 practice had systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness. The practice recorded and learnt from any incidents which had occurred. The practice had an effective recruitment process and staff engaged in on-going training to keep their skills up to date.

The practice had policies and protocols related to the safe running of the service. Staff were aware of these and were following them. The practice had systems in place for the management of infection control and waste disposal, management of medical emergencies and dental radiography. However, emergency medicines were not securely stored.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the Faculty of General Dental Practice (FGDP). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and pro-actively engaged in local initiatives to ensure that patients received treatment in good time. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received feedback from patients through comment cards that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient records were stored securely and patient confidentiality was well maintained. However, we noted that although doors to treatment rooms were closed, patients could sometimes be observed by other people during their treatment as there was some see through glass in the doors. This meant that patient's privacy and dignity could be compromised.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments which were available on the same day. Members of staff spoke six different languages which supported good communication between staff and patients. The needs of people with disabilities had been considered in terms of accessing the service.

Patients were invited to provide feedback via a satisfaction survey and suggestions box situated in the waiting area. There was a clear complaints procedure and we saw that the practice responded to complaints in line with the stated policy.

Are services well-led?

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

Summary of findings

There were good clinical governance and risk management systems in place. There were regular staff meetings and systems for obtaining patient feedback. We saw that feedback from staff or patients had been carefully considered and appropriately responded to.

The principal dentists had a clear vision for the type of practice they wanted to provide. This included providing care in an open and friendly environment. These values were shared and understood by other members of staff. Staff felt well supported and confident about raising any issues or concerns with the principal dentists.

Ixia Dental

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.

We carried out an announced, comprehensive inspection on 21 May 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with six members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 15 Care Quality Commission (CQC) comment cards completed by patients and spoke with three patients briefly in the waiting area. Patients we spoke with and those who completed comment cards were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. There was a new system for recording incidents in a dedicated book which started in October 2014. There were four incidents recorded in the book.

We saw evidence in practice meeting notes that incidents were discussed and action plans were implemented to prevent the recurrence of any problems. For example, following an incident where a patient's laboratory work had not been returned in good time from an external laboratory, the practice implemented a new system whereby reception staff now phoned the laboratory one day prior to the due date to check that the results would arrive on time. We also saw copies of letters demonstrating that patients were told when they were affected by something that went wrong, given an apology, and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was clearly displayed in the decontamination room so that staff could access the information promptly. These details were also kept with the safeguarding policy.

The registered manager, who was also one of the principal dentists, was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentists.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, a practice-wide risk assessment had been carried out in November 2014 which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). The practice identified areas for improvement as a result of this assessment. For example, the practice was in the process of implementing the use of new safety syringes which would minimise the risk of sharps injuries to staff. New protocols related to the use and disposal of sharps had been also discussed at a staff meeting. Staff knew what to do in the event of a sharps injury and there was a poster display showing how to deal with this issue effectively.

The practice followed national guidelines on patient safety. For example, the practice had recently started to use rubber dam for root canal treatments. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually with the most recent training having been completed by all staff in May 2015. Practice meeting notes showed that emergency scenarios were had been discussed. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated external defibrillator and oxygen. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. There were face masks of different sizes for adults and children. The equipment was regularly tested by staff and a record of the tests was kept. However, we noted that there was no warning signs on the room

Are services safe?

where the oxygen was stored to alert people to the potential hazard. We discussed this with the registered manager, who agreed to display such signage the following day. The practice also stored emergency medicines in accordance with guidance from the British National Formulary (BNF). However, we noted that emergency medicines were stored in an area which could potentially have been accessed by patients as they walked through the practice. We made the registered manager aware of this risk.

Staff recruitment

There were effective recruitment and selection procedures in place. The practice held a staff file for each person which showed that checks of staff were being carried out in line with the relevant regulations. This included the use of application forms, a review of employment history, evidence of relevant qualifications, the checking of references, a check of registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service (DBS).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place which staff were required to read and sign. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. This file was being regularly updated whenever new substances were being used or when the use of any given item was discontinued. We saw that COSHH products were securely stored. Staff training files indicated that staff had received relevant training in managing COSHH products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the principal dentists who then disseminated these alerts to the other staff. For example, advice regarding Ebola virus was sent in December 2014 which was subsequently discussed at a staff meeting to check that all of the correct precautions were in place.

There was a business continuity plan which had been reviewed on an annual basis. There was an arrangement in place with another practice to provide continuity of care in the event that the practice's premises could not be used. Key contacts, for example, for the servicing of electrics or plumbing, were kept up to date in the plan.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the dental nurses had recently been appointed as the infection control lead; this responsibility had previously been held by one of the principal dentists.

There had been regular, six-monthly infection control audits with the last one having been completed in January 2015. This had identified a list of actions which had been signed and dated when they were completed. For example, the renewal of in-house hand hygiene training had been completed in March 2015. Staff files we reviewed showed that staff regularly attended, external training courses in infection control.

All of the staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B and Rubella to prevent the spread of infection between staff and patients.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room with a clear flow from

Are services safe?

'dirty' to 'clean.' We observed two dental nurses working in the room and they demonstrated a good understanding of the correct processes. Dental nurses wore appropriate protective equipment, such as heavy duty gloves and eye protection. An illuminated magnifier was used to check for any debris during the cleaning stages.

Items were placed in a washer-disinfector prior to the use of an autoclave (steriliser). Instruments were placed in pouches after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective. The autoclave was regularly checked for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a Legionella risk assessment had been carried out by an external company in May 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). This process identified some risks and we saw that the practice had either immediately taken action to reduce these risks or had a plan with a timeline in place to minimise risks. For example, spray inserts had been immediately cleaned and disinfected and there was a plan to replace rubber hoses with copper piping by August 2015. We saw evidence that dental water lines were being flushed in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy. There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were dedicated hand washing facilities in both surgeries, the decontamination room and toilet. We noted that there was no alcohol gel in the decontamination room and no poster related to hand hygiene in the toilet.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. There were dates set for when each item needed to be checked again. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and there was an effective system to monitor their use. Pads were securely stored in locked drawers.

Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in this file. The procedures and equipment had been assessed by an independent expert within the recommended timescales. There were staff training records to demonstrate that staff kept up to date with their knowledge and use of the X-ray equipment. Audits of X-ray use were carried out every six months to determine whether staff were following best practice recording procedures and were using the equipment effectively. The audit trail over the preceding two years demonstrated a record of continuous improvement.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed patient records kept by each dentist and discussed patient care with the dentists. We found that the dentists regularly assessed patient's gum health and took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. We observed that patients were asked to complete a form to identify any update to their medical history when they arrived for their appointment.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (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). Different BPE scores triggered further clinical action.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines and records showed that patient's soft tissues (including lips, tongue and palate) were regularly examined. The practice was not currently using the evidence based Delivering Better Oral Health Toolkit when considering care and advice for patients. The registered manager was aware of this issue and had discussed with staff how best to improve their performance. For example, some of the dental nurses were interested in taking a greater role in this area and investigating the possibility of post-qualification training in oral health.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. Dentists also identified patients' smoking status and offered advice regarding smoking cessation services that were available in the local area.

They carried out examinations to check for the early signs of oral cancer. We noted that patient records also contained information about smoking status and alcohol consumption.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies and infection control. There was an induction programme for new to staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had yearly appraisals which identified their training and development needs; notes were kept from these meetings. This led to changes which reflected their career development goals. For example, one dental nurse had been encouraged to take on additional responsibility as an infection control lead. Another dental nurse told us the principal dentists were supporting her to explore further training options in either oral health education or radiography.

Working with other services

The practice had an effective system of onward referral to other providers, for example, for oral surgery, orthodontics or advanced conservation. One of the principal dentists showed us a recent documented case where they had worked with another provider on behalf of a patient to ensure a good outcome. The practice had also volunteered to take part in a local, pilot referring initiative with an NHS Foundation Trust hospital with a view to reducing the time taken to receiving treatment for oral surgery.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. The practice had computer software which allowed them to give visual demonstrations of the different types of treatments.

We saw evidence that the requirements of the Mental Capacity Act 2005 (MCA) had been discussed at staff meetings. Dentists and dental nurses could accurately

Are services effective?

(for example, treatment is effective)

explain the meaning of the term mental capacity. They described to us their responsibilities to act in patient's best interests, if patients lacked some decision-making abilities.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on staff's caring and helpful attitude. They indicated they were treated with dignity and respect. We observed staff were welcoming and helpful when patients arrived for their appointment. Staff greeted people by name and engaged patients in relaxed conversation while they were waiting.

Doors were always closed when patients were in the treatment rooms. However, we noted that patients, while they were receiving treatment could be observed by other members of staff, and by other patients who were walking around the practice,. This was because the treatment room doors included a slim, glass window. We discussed this with one of the principal dentists who told us this window was in place to ensure patients were observed during x-rays. However, this meant that patient's privacy and dignity may not always have been respected .

Patient records were stored electronically. They were password protected and regularly backed up. Historical patient records in a paper format were being retained in line with the Data Protection Act. These were also stored securely in a locked cabinet.

Staff understood the importance of data protection and confidentiality. They described systems in place to ensure that confidentiality was maintained. For example, computer systems automatically shut down after 30 seconds of inactivity. Staff also told us that people could request to have confidential discussions in an empty treatment room, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. The practice website also displayed this information.

Staff told us that they took time to explain the treatment options available and that they made use of visual aids that were available via their computers to illustrate problems and treatments. They spent time answering patient's' questions and gave patients a copy of their treatment plan. However, we noted that other written information, such as leaflets describing types of treatment, were not routinely given to patients so that they could consider their options at home following a consultation.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The reception staff we spoke with were clear about which types of treatment or reviews would require longer appointments. Time was also set aside each day for emergency appointments, for example, if someone presented with severe dental pain or an accidental injury. Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff spoke six different languages meaning that the need for interpreting services was greatly reduced. They provided written information for people who were hard of hearing. A disability discrimination audit was carried out yearly to monitor access to the service. The premises were restricted meaning that only some actions from this audit could be implemented. For example, there was a portable ramp for wheelchair access, but the size of the site did not allow for the redevelopment of the toilet to ensure that it met disability access standards.

Access to the service

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

We asked the reception staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out of hours emergency treatment. Additionally, there were emergency treatment slots set aside in the morning and in the afternoon for people who needed urgent treatment on the same day.

There was some feedback from patients in the practice's satisfaction survey to indicate that patients would prefer longer opening hours. We discussed this issue with one of the dental nurses staff and one of the principal dentists. The reception staff told us it was part of the practice's ethos to be accommodating and flexible. If someone could provide a good reason as to why they could not be seen during regular appointment slots, the dentists worked towards accommodating this person's needs, within what was reasonably practicable. The principal dentist also commented that opening hours had already been extended over the past two years and that they were considering further staffing options as part of a development plan which could include alternative opening times.

Concerns & complaints

There was a complaints policy describing how the practice handled formal and informal complaints from patients. There had been two complaints received in the past year and these had been dealt with in line with the practice policy. We saw that that these complaints were discussed with staff at meetings and actions were identified regarding how the practice could improve their service so that the root cause of the complaint was addressed and did not reoccur. For example, on one occasion additional staff training had been organised to improve their communication skills following a complaint about staff attitude.

Information about how to make a complaint was not immediately available in the reception area or on the practice website. However, there was a notice in the reception area asking patients to request a copy of the complaints procedure from reception staff if they needed it. There was a suggestions box available in the waiting area.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. There were suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of these policies and procedures and acted in line with them. There were monthly practice meetings, which included all staff members, where governance issues were discussed to ensure an environment where improvement and continuous learning were supported.

Leadership, openness and transparency

The staff we spoke with described an open and transparent culture which encouraged openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentists and that they were listened to and responded to when they did so.

Staff told us they enjoyed their work and were well supported by the management team. There was a low staff turnover and trainees were being retained when they qualified. This demonstrated a commitment on behalf of the principal dentists to support and maintain good relationships with their staff.

A system of staff appraisals was also used to identify staff's training and career goals. We saw that the registered manager took on board staff aspirations in terms of their personal development. For example, the registered manager had taken a decision to delegate authority to a dental nurse in the area of infection control. The dental nurse had now become the infection control lead.

One of the principal dentists told us that their aim was to provide high-quality care in a warm and family-friendly environment. Staff shared this vision and demonstrated that they worked towards it by getting to know their patients well and by providing a warm welcome.