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D O'Connor & Associates Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 27 October 2015

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

D O'Connor & Associates are located in Anerley in the London Borough of Bromley. The practice occupies a house and consists of two treatment rooms, waiting and reception area and patient toilet facilities which are situated on the first floor.

The practice provides NHS dental treatment to children and adults. The practice offers a range of dental treatments such as routine examinations, treatments of dental decay, veneers, crowns and bridges. The practice is open Monday – Friday 10.00am - 5.30pm.

The staff structure consists of a principal dentist, one associate dentist, two dental nurses and a receptionist.

The principal dentist is in day to day management of the practice.

The inspection took place over one day and was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

We received 22 CQC comment cards completed by patients and spoke with 10 patients during our inspection visit. 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 staff.

Our key findings were:

Summary of findings

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice had implemented clear procedures for managing comments, concerns and complaints.
- The principal dentist had a clear vision for the practice.
- There were governance arrangements in place and the audits undertaken were effective in improving the quality and safety of the services;

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Regularly monitor and record water temperatures as part of the Legionella risk assessment giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Review the training, learning and development needs of individual staff members at appropriate intervals and ensure an effective process is established for the on-going assessment, supervision and appraisal of all staff.

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. We found the equipment used in the practice was maintained annually and checked for effectiveness.

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. There were staff meetings to provide staff with feedback from any incidents, although these were not very frequent. Improvements could be made to ensure staff were aware of and handling sharps, such as used needles in accordance with current health and safety regulations.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence, (NICE) and the General Dental Council (GDC). 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 followed up on the outcomes of referrals made to other providers. Staff were undertaking continuous professional development (CPD) and were meeting the training requirements of the GDC.

Are services caring?

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

We reviewed 22 completed CQC comments cards and spoke with three patients on the day of the inspection. Patients were positive about the care they received from the practice. Patients commented they felt fully involved in making decisions about their treatment, were made comfortable and felt, their concerns, if any would be listened to.

We noted that patients were treated with respect and dignity during interactions at the reception desk and over the telephone.

Patients were invited to provide feedback via a satisfaction survey and the feedback was positive.

Are services responsive to people's needs?

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

The needs of people with disabilities had been considered. There was level access to the waiting area and one of the treatment rooms, although the front access to the building had some steps, staff were available to provide assistance.

Patients were invited to provide feedback via a satisfaction survey. There was a process in place to handle complaints as they arose, although there were no reported complaints received within the last year.

Patients had access to appointments on a daily basis; although the practice was not open at week-ends or late evenings, patients' told us they could access emergency appointments on the same day if needed.

Summary of findings

Are services well-led?

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

The practice had some suitable clinical governance and risk management structures in place. Staff met on a daily basis and the practice had some staff meetings for dissemination of information and to receive feedback. There were appropriate audits used to monitor and improve care.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues highlighted.

There was a strategy and vision in place to expand the practice and improve the practice environment within the next year.

D O'Connor & Associates Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 27 October 2015. The inspection took place over one day and was led by a CQC inspector. They were accompanied by a dental specialist advisor.

During our inspection visit we spoke with five members of staff including and the principal dentist. We also reviewed policies and procedures. We carried out a tour of the practice and looked at the maintenance of equipment and storage arrangements for emergency medicines. We asked one of the dental nurses to demonstrate how they carried out decontamination procedures of dental instruments.

Twenty-two people provided feedback about the service. Patients 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 policy for staff to follow for the reporting of incidents and staff told us were aware of how to access this information. There were no reported incidents from July 2014-October 2015.

Staff were aware of Duty of Candour and operated in an open and transparent manner in the event that something went wrong, although the practice did not have a specific policy and had not received any formal training.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We noted that no accidents had occurred between July 2014-October 2015.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. The staff we spoke with were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable patients who may present with learning difficulties or dementia.

The practice had a children and adults safeguarding policy which referred to national guidance and local authority contact details for escalating concerns that might need to be investigated. The policy contained a follow flow chart for staff to follow.

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, there was a risk assessment and associated protocols in relation to fire safety. Staff received training in fire safety and there were named fire marshals. Emergency exit routes were shown on the back of each surgery door and appropriate assembly point outside had been established following advice from the fire service.

There was appropriate and up to date information dated May 2015 in line with EU guidance available on re-sheathing of needles. There was a sharp risk assessment which was however not dated and there was lack of clarity as regards the safe handling of used needles.

Medical emergencies

The practice had suitable arrangements in place to deal with medical emergencies. The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. Oxygen and other related items, such as manual breathing aids and portable suction, and an automated external defibrillator (AED) were available in line with the Resuscitation Council UK guidelines. (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).

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment within the premises.

Staff recruitment

The practice staffing consisted of a principal dentist (who was also the owner), one associate dentist, two dental nurses and a receptionist.

There was a recruitment policy in place dated January 2015 and we saw that relevant checks to ensure that the person being recruited was suitable and competent for the role had been carried out. Evidence of relevant qualifications, and registration with the General Dental Council were available and filed separately from people's personal files. We noted that it was the practice's policy to carry out Disclosure and Barring Service (DBS) checks for all members of staff and details related to these checks were kept. (DBS checks are undertaken to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) However, the principal dentist held personal files on each member of staff which contained individual contracts and these were not made available for the inspection team to review.

Are services safe?

Staff we spoke with told us that they had responded to advertisement and there was a formal interview process undertaken before the start of their employment at the practice. References were sought prior to a job offer being made and there were job descriptions which outlined roles and responsibilities.

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. 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 (COSHH regulations were implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.) There was a COSHH file where risks to patients and staff associated with hazardous substances were identified. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were reviewed by the principal dentist and disseminated by them to the staff, where appropriate.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area.

Infection control

There were 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.

Staff and patients were able to easily access supplies of protective equipment which included gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets with posters displaying hand washing techniques.

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)'.

We checked the cleaning and decontaminating of dental instruments which was carried out in the decontamination room. One of the dental nurses demonstrated the decontamination process and showed a good understanding of the correct processes. We did note that in scrubbing the instruments the nursing staff did not use a thermometer to check the water temperature during this process. The guidance recommends that the temperature of the water is monitored throughout the cleaning procedure to ensure it is 45 0C or lower (a higher temperature will coagulate protein and inhibit its removal). Following inspection of cleaned items, they were placed in an autoclave (steriliser) and were pouched, dated and stored appropriately

The dental nurse showed us that systems were in place to ensure all decontamination equipment such as the autoclaves were working effectively. These included the automatic control test and steam penetration tests for the autoclave, foil tests for the ultrasonic cleaning bath. The data sheets used to record the essential daily validation were fully completed and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and domestic waste were properly separated and stored. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

The practice had carried out practice-wide infection control audits every six months; the most recent audit was conducted in August 2015 with no actions noted.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current guidance about decontamination and infection control in primary care dental practices '. A Legionella risk assessment had also

Are services safe?

been carried out by an appropriate contractor; however staff were not carrying out and recording regular temperature checks on the water supply in line with the recommendations.

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 in 2015. Portable appliance testing (PAT, is the name of a process during which electrical appliances are routinely checked for safety); had been completed in the previous year.

All prescriptions were written manually. FP10 prescription pads were stored safely and logged. The expiry dates of medicines, oxygen and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

The practice had a Radiation Protection Adviser in place and a nominated Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). A radiation protection file and local rules were displayed within the surgeries. Included in the file were the critical examination pack for the X-ray set, which included dose assessment reports, the maintenance log and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years and was last carried out on 10 June 2014. We saw evidence that staff had completed radiation protection training.

A copy of the most recent radiological audit carried out in January 2015 was available for inspection and showed that the standard required had been met. Staff told us that quality assurance checks were carried out and all the dentists were audited biannually to ensure the quality was maintained and reasons for any retakes were documented. We checked a sample of individual dental care records to confirm the findings which showed dental X-rays were justified and required as part of the patient care plan.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised professional and General Dental Council (GDC) guidelines. A dentist we spoke with described how they carried out patient assessments. The practice used a pathway approach to the assessment of the patient which was supported and prompted by the use of computer software. The assessment began with a review of the patient's medical history. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues of the mouth. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

Following the clinical assessment, the diagnosis was discussed with the patient and treatment options were fully explained. The dental care record was updated with the new treatment plan after discussing the options with the patient. The care given to patients was monitored at their follow-up appointments in line with their individual requirements.

During the course of our inspection we checked dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw notes containing details about the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) These were carried out at each dental health assessment. Details of the treatments carried out were also documented; local anaesthetic details such as type of anaesthetic, site of administration, batch number and expiry date were also recorded.

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 such as tooth brushing and dietary advice and where applicable smoking cessation and alcohol consumption with their patients. The dentist also carried out examinations to check for the early signs of oral cancer.

The waiting area had health promotion material available as well as toothpaste and interdental brushes to support patients with their oral hygiene. Health promotion material included information on how to prevent gum disease and how to maintain healthy teeth and gums. There was also a children specific oral hygiene promotion video using a children's television character, played within the surgeries while children were having treatment.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff training records and saw that this included responding to emergencies, safeguarding and X-ray training.

There was an induction programme for new staff to ensure that they understood the protocols and systems in place at the practice.

At the time of our inspection the practice was not carrying out annual appraisals for each member of staff. However the principal dentist told us that an appraisal system had been put into place to commence from November 2015. Staff told us that they had the opportunity to discuss their current performance as well as their career aspirations on a regular basis, although no formal records were kept. Both the dental nurses had been supported to undertake their formal qualifications whilst working at the practice.

Working with other services

The principal dentist explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored in the patient's dental care records. A log was kept for all patients referred into the practice as well as to other care providers.

Consent to care and treatment

Consent was obtained for all care and treatment patients' received. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed.

Are services effective?

(for example, treatment is effective)

Staff were aware of the Mental Capacity Act (2005). They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' 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

We collected comment cards from 22 patients. They were complimentary of the care, treatment and professionalism of the staff and gave a positive view of the service. Patients commented that the team were courteous, friendly and kind. During the inspection we observed staff in the reception area and found them to be polite and courteous towards patients.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Electronic records were password protected and paper records were stored securely, in locked cabinets. Staff understood the importance of data protection and confidentiality and had received training in information governance. Staff told us that people could request to have confidential discussions in the treatment room, if necessary.

The practice obtained regular feedback from patients via a satisfaction survey'. We noted from their report in 2015 that the feedback about staff was positive and this corroborated our own findings regarding staff's caring attitude. People completing the feedback stated they would be likely to recommend the practice to other people.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area regarding NHS dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. We checked dental care records to confirm the findings and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with the principal dentist, the dental nurses and receptionist on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment plans. They emphasised that patients were given time to think about the treatment options presented to them and offered an appointment to go ahead with their treatment.

The patients we spoke with and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Staff told us they scheduled additional time for patients receiving more complex treatments; this included scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and were able to have enough time in between each patient to document care and prepare equipment for each patient.

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. The practice had access to a telephone translation service, if needed. The receptionists spoke several languages and we observed them using sign language to communicate with a patient with hearing impairment.

The practice had not formally assessed disability access at the practice and were planning a full refurbishment of the premises within the next 12 months. One of the surgeries was on the ground floor and there was adequate parking outside the practice; there were some steps to access to the practice, the principal dentist told us they did have a ramp to assist patients if required.

Access to the service

The practice is open Monday – Friday 10.00am - 5.30pm
The practice displayed its opening hours at their premises.

New patients were also given a practice information leaflet which included the practice contact details and opening hours. Information leaflets gave details of each dentist at the practice.

Staff told us that dentists planned some gaps in their schedule on any given day to ensure that patients, who needed to be seen urgently, for example, if they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case.

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. Staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could usually get an appointment and did not experience long delays in the completion of their treatment. Patients' also told us they had adequate time scheduled with the dentist to assess their needs and receive treatment and did not feel rushed.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the reception area.

There had been not been any written complaints recorded in the past year. The complaints log and report sent to NHS England confirmed this. Staff told us if a patient raised concerns about their treatment they would escalate any concerns to the dentist.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place and there was a clear management structure in place.

The principal dentist had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. The majority of policies and procedures in place were in date and contained relevant references. Improvements however could be made as some policies and procedures contained some out of date guidance. . Staff were however aware of the current policies and procedures and acted in line with them. Records, including those related to patient care and treatments, as well as staff employment, were kept securely.

The principal dentist organised some staff meetings although these were infrequent and records showed the last meeting was held in May 2015. .

Leadership, openness and transparency

The staff we spoke with described an open and transparent culture which encouraged honesty. Staff said that they felt comfortable about raising concerns with the principal dentist or the associate dentist. They felt they were listened to and responded to when they did so. Staff were aware of their responsibilities relating to the Duty of Candour.

The principal dentist shared with us their future plans for the practice. We were told there was a plan which covered changes to the premises and increasing the number of surgeries and dentists working to three.

We found staff to be hard working, caring and a cohesive team committed to providing a high standard of care.

Learning and improvement

The practice had a rolling programme of clinical audit in place. These included audits for infection control, patient waiting time, clinical record keeping and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. We looked at some audits which generally revealed a high level of compliance against agreed standards. For example, the dental quality assurance X-ray audit carried out in April 2014 showed that the practice had only met 70% of the required standard. The action plan outlined a repeat audit which was carried out in July 2014 and showed that the required standard had been met and this was the case for all subsequent audits we reviewed. The practice also had a programme of risk assessments in place that were being successfully used to minimise the identified risks.

Staff were supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. The principal dentist supported the professional development of all members of staff.

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

The practice gathered feedback from patients through the use of a yearly patient satisfaction survey. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The responses indicated a high level of satisfaction.

We noted that the practice acted on feedback from patients where they could. For example, a system had been set up where reminders were sent to patients text prior to their appointment

Staff commented that the principal dentist was open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums to give their feedback.