Trinity Dental Centre

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Inspection Report

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Overall summary

Trinity Dental Centre provides dental care mainly under private arrangements but has a small NHS dental contract for children up to the age of 18 years. We found that the practice provided safe and effective dental care in clean, well equipped and maintained surroundings. At our visit we found all members of staff were kind, caring and put patients at their ease and were led by practice owners who placed adopting a kind and gentle approach to dentistry at the heart of the practice philosophy.

This inspection took place on Friday 19 December 2014. It was a comprehensive inspection.

The practice consists of a large waiting area with a reception desk away from the waiting area to ensure privacy and dignity for patients when discussing sensitive matters in relation to their dental treatment. The practice currently has two dental treatment rooms. One is on the ground floor with level access from the street enabling patients with various physical disabilities to access dental care.

The team at the practice included two dentists, one of whom is the registered manager, and a practice manager who supports the registered manager to deliver the practice's administration and clinical governance systems. She also works as a dental nurse. There is one other dedicated dental nurse and two dental receptionists one of whom is a trained dental nurse. The practice has the services of two part time dental hygienists who give oral health advice and carry out preventative and gum treatments on prescription from the dentists working in the practice.

Thirty-one patients completed our comment cards. All gave positive opinions about their care at Trinity Dental Centre. The words excellent, fantastic, patient and professional were often repeated. Patients said they had found a patient-focussed service where they had felt welcome, comfortable and understood by the dentist and staff.

Complimentary letters from adults had been retained over several years. Two patients in the waiting room said they found the service was brilliant and they had no complaints. They said they hated visits to the dentist but had never before been so happy with a dental service and had been impressed that the dentist was able to give injections that were almost pain free.

However, there were also areas of practice where the provider could make improvements;

The provider should

- monitor and assess accidents to staff at regular intervals in order to reduce any risks and share any learning amongst the team.
- carry out audit of dental X-rays at least annually and add the quality assurance score to the clinical record.

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?

There were good systems in place for infection control, clinical waste control, management of medical emergencies and dental X-rays. We found that all the equipment used in the dental practice was well maintained and in line with current guidelines.

There were systems in place for identifying, investigating and learning from patient safety incidents and an emphasis in the practice to reduce harm or prevent harm from occurring. The practice had not monitored accidents that had been recorded, to share learning amongst the team.

Are services effective?

The dental care provided was evidence based and focussed on the needs of the patients. We saw examples of very good collaborative team working.

The staff kept their training up-to-date and received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC) demonstrated that they were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

Patients told us they had positive experiences of dental care provided at the practice. The comment cards and patient experience records demonstrated that patients, their families and carers felt well supported and involved in their treatment plans.

Staff showed compassion, kindness and respect at all times. We found the staff to be hard working, caring and committed to the work they did. Staff were proud of their work and their good relationships with patients.

Are services responsive to people's needs?

The friendly, family-orientated dental care provided was well suited to those patients who were nervous about dental treatment. Patients could access treatment and urgent and emergency care when required. The practice offered dedicated emergency slots enabling effective and efficient treatment of patients with dental pain so that patients could be seen and helped on the same day when necessary.

Are services well-led?

The vision and overview of a caring service was maintained by systematic attention to detail. Staff we spoke with told us that the registered manager and practice manager were very approachable and the culture within the practice was seen as open and transparent.

Staff were aware of the practice ethos to provide a caring and responsive service. They said that it was a good place to work and they would recommend the practice to family members or friends.

There were structures in place to maintain clinical governance and risk management.

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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 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 19 December 2014 by a lead inspector and a specialist dental advisor.
- We reviewed the information we had about this provider from the previous inspection. The provider sent us the statement of purpose.
- During the inspection we toured the premises and spoke with people using the service, spoke with the dentists and staff, observed methods of working and reviewed documents. To assess the quality of care provided by the practice, we looked at practice policies and protocols and other records. The specialist dental advisor also assessed the quality of the clinical records. In dentistry, clinical records can give an indication of the quality of care provided by a dentist because well-structured and detailed personalised records are an indication of good quality care.
- Thirty-one patients completed our comment cards and we spoke with two other people using the service.

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?

Are services safe?

Our findings

Learning and improvement from incidents

Two significant events had been recorded over the 14 years of this practice. We saw records of staff discussion and action taken to improve support to patients in the event of a recurrence to avoid a recurrence.

We looked at the record of accidents over the past three years. There had been three and they had been similar, with injuries sustained by a nurse while cleaning sharp instruments. The repeats had not been noticed by management. The provider had not taken action to improve safety by reviewing incidents and accidents at regular intervals and sharing any learning amongst the team. The accidents had not been referred to occupational health for advice but had been assessed by the dentist, in accordance with the infection control policy.

Reliable safety systems and processes including safeguarding

The practice had policies for child protection and safeguarding vulnerable adults, reviewed in July 2014 to ensure they were in accordance with current guidance. The registered manager took the lead, with the practice manager as her deputy to ensure there was always a person to take responsibility in the event of an alert. Information about the contact details for raising an alert were provided. Staff told us about their safeguarding training, and knew who to speak to if anyone made a disclosure to them.

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. We saw by examining six patient records that a written medical history was obtained prior to the commencement of dental treatment in all cases and updated on an on-going basis. Risks factors were identified and flagged up. For example, when taking medical histories, staff asked patients who suffered with epilepsy what might be a trigger for them. The clinical records we saw were all structured and contained sufficient detail enabling another dentist to tell what the dentist was intending to do, what was done so far, what was going to be done next and details of any possible alternatives. Recording these findings enabled dentists and other staff to be always aware of any risks to patients and would ensure that they were safe during a consultation. Patient records were paper based. Some were stored in an unlocked room. The provider proposed taking action to improve security by moving them to a lockable room.

Infection control

The practice had a suitable policy for infection control (IC). It covered minimising blood borne virus (BBV) transmission, including contact details for occupational health. The policy for decontaminating instruments used in dentistry was clear, describing the process for manual cleaning, inspection, sterilisation and storage. The policy had been reviewed regularly, we saw the new expiry date (ie one year) for sterilised and bagged instruments had been entered into the policy.

The policy also covered the following areas - work surfaces and equipment, impressions and all work sent to the laboratory, hand hygiene, clinical waste disposal, personal protective equipment (PPE), and the procedure to be followed in the event of an incident of blood spillage. The guidance was readily available for staff who had all signed to show they had read and understood. It had been reviewed regularly, most recently in July 2014.

We noted that the dental treatment areas, decontamination rooms as well as the general practice environment used by patients were clean, tidy and clutter free.

Through discussions with members of staff and a review of practice protocols, we found that the essential requirements for infection control as set out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05;National guidance from the Department of Health for infection prevention control in dental practices) were being met.

Decontamination of dental instruments was carried out in separate decontamination rooms adjacent to both treatment rooms. A dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. It was clearly observed by us that dirty instruments did not contaminate clean processed instruments. The process of cleaning, disinfection, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. A line was marked with tape along the work top, to show the boundary between

Are services safe?

the dirty and clean areas. Clear zoning was also apparent in the treatment rooms. The practice used a system of manual scrubbing and rinsing followed by inspection of each item under a magnifying lamp before sterilisation.

When instruments had been sterilized they were pouched and stored until required. All pouches were dated with an appropriate expiry date. The nurse also demonstrated to us that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. We noted that data sheets were used to record the essential daily and weekly validation checks of the sterilisation cycles. We also observed six monthly maintenance schedules, ensuring that autoclaves were maintained to the standards set out in current guidelines.

Staff had carried out an audit of infection control in line with current guidelines for assessing the quality of infection prevention control systems, processes and procedures carried out within a general dental practice setting.

We found that the drawers in each surgery were very clean, tidy and free from clutter. All of the instruments were either pouched or those instruments which were stored unwrapped were used within the same day and then reprocessed as per current guidelines. Items designed for single use were clearly new. All surgeries had the appropriate personal protective equipment available for staff and patient use. This was also the case with both decontamination rooms ensuring that patients and staff were protected from the risk of infection.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Flushing of the water lines was carried out in accordance with current guidelines and supported by a practice protocol. A Legionella risk assessment had been carried out by an appropriate contractor. This ensured that patients and staff were protected from the risk of infection due to Legionella.

The segregation of dental waste was in line with current guidelines laid down by the Department of Health. The treatment of sharps and sharps waste was in accordance with the current European Union directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. We observed that sharps containers were correctly maintained and labelled. The practice used an appropriate contractor to remove dental waste from the practice and waste consignment notices were available for inspection. The practice stored the clinical waste prior to collection in appropriate bags in one of the decontamination rooms, accessed only by staff. However, it was not stored in a dedicated bin prior to collection which would ensure that waste bags did not split or cause a trip hazard to members of staff.

Equipment and medication

The practice manager showed us a comprehensive file of risk assessments covering all aspects of clinical governance. These were well maintained and up to date. She had a method that ensured tests of machinery were carried out at the right time and all records of service histories. The equipment used in the practice was maintained in accordance with the manufacturer's instructions, this included the equipment used to sterilise the instruments, the x-ray sets and the compressor. This ensured that patients were at a reduced risk of untoward occurrences. She inspected the practice regularly for any building or maintenance issue.

A recording system was in place for the prescribing and recording of the medicines and drugs used in clinical practice. The systems we viewed were complete, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as prescribed. The batch numbers and expiry dates for local anaesthetics were always recorded. These drugs were stored safely for the protection of patients.

Monitoring health & safety and responding to risks

There was a fire risk assessment that had been reviewed annually, most recently in February 2014. Fire extinguishers were serviced annually, in March each year. The intruder and fire alarm systems had an annual check, the most recent inspection and test dated 4 July 2014. Fire drills were held at six monthly intervals, and recorded. A fire drill had been discussed at a recent staff meeting, to consider any issues arising.

The team carried out their control of substances hazardous to health (COSHH) assessments together during a staff meeting. This ensured that all staff were aware of risks and their responsibilities in handling the substances.

Moving and handling training was provided for new staff during induction, to ensure their good back care.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. There was a range of suitable equipment

Are services safe?

including an automated external defibrillator (AED), emergency drugs and oxygen available for dealing with medical emergencies. This was in line with the Resuscitation UK guidelines. The emergency drugs were all in date and the drugs were securely kept along with emergency oxygen in a central location known to all staff. The expiry dates of drugs and equipment was monitored using on a daily check sheet which enabled the staff to replace out of date drugs and equipment in a timely manner.

The dentists and staff were all qualified first aiders and had annual training in basic life support including use of the AED. An external company had been used to facilitate team training in medical emergencies. Staff described a medical emergency when they had assisted a person who was not a patient, and had helped them.

Staff recruitment

The recruitment policy included the requirement to receive the necessary checks. The practice offered candidates the opportunity of work experience before accepting a contract to find whether the work suited them. This was good practice with respect to equality and diversity as people new to dentistry could evaluate their own preference and suitability.

Checks had been made on all staff to ensure they were safe to work with children and vulnerable adults. The records of the staff member most recently recruited contained their work history, vaccination record, evidence of qualification, details of registration with the GDC, proof of identity and indemnity cover. Not all staff files included the two references from previous employment that are required by the regulations, however, the dentist recollected having gathered a verbal reference that was satisfactory.

Radiography

Individuals were named as radiation protection adviser (RPA) and radiation protection supervisor (RPS) for the practice. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment. These included critical examination packs for each X-ray set along with the three yearly maintenance logs in accordance with current guidelines. A copy of the local rules and inventory of X-ray equipment used in the dental practice was displayed with each X-ray set.

The minutes of a staff meeting held in August 2014 recorded the recognition by the dentists that they needed to carry out an audit to evaluate the quality of radiographs. We observed a sample of six clinical records where dental X-rays had been taken. The clinical records showed that dental x-rays when taken were justified and reported in accordance with IR (ME) R 2000 (Ionising Radiation (Medical Exposure) Regulations 2000). Although the records did not contain a quality assurance grade, all X-rays would have been judged as grade 1 because there were no positioning or processing errors evident. We saw X-ray holders in the treatment rooms. These ensure good placing in the patient's mouth which contributed to good quality images. The X-rays were correctly mounted and labelled in accordance with current guidelines. Although the practice had undertaken an audit of X-rays previously, the provider may wish to note that audit of dental X-rays should be carried out at least annually and a quality assurance score should be recorded in the clinical record.

Dental X-rays were prescribed according to current selection criteria guidelines with the practice having their own written protocol in place. To prevent patients receiving dental X-rays at inappropriate intervals the dentists recorded on the front of the record card when previous X-ray assessments had been carried out. When X-rays were taken, the records showed that the reasons for taking the X-rays and the findings were recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The dentists ensured that valid consent was obtained at all times by the use of signed written consent forms on every occasion even for very simple treatments. This was reinforced by providing written cost estimates;, the clinical records we observed reflected that treatment options had been listed and discussed with the patient prior to the commencement of treatment. The team had audited and improved their recording of verbal consent, when appropriate.

The registered manager had obtained and read the Mental Capacity Act 2005. They explained how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family and other professionals involved in the care of the patient to ensure that the best interests of the patient were met. They had not as yet needed to obtain professional help for a patient. Where patients did not have the capacity to consent, the dentist acted in their best interests and vulnerable patients were treated with dignity and respect.

Monitoring and improving outcomes for people using best practice

Patients' care and treatment was planned and delivered in line with their individual care plan. The dentist described their approach using a typical patient journey through the practice. We looked at a sample of six treatment records including three new patients who were seen the previous day. The patient assessment followed a systematic and structured approach, starting with an assessment of the patient's medical, social and dental history. The records contained details of the patient's presenting condition and history of the complaint. The practice met the general health preventive agenda by recording the smoking and alcohol consumption of the patient and providing advice accordingly.

The clinical history in the treatment records contained details of the condition of the teeth, gums and soft tissues lining the mouth. These were carried out at each dental health assessment and ensured that the patient was made aware of changes in their oral condition. Where patients were diagnosed with more aggressive forms of gum disease for example, a more detailed assessment of the gums was carried out by individual pocket depth charting. Patients would then be provided with more complex care either by the dentist or by referral to one of the dental hygienists working at the practice. The soft tissue screening policy was discussed by the team at their meeting in November 2014, showing they were maintain awareness and keeping up to date with best practice.

Following clinical assessment, the dentists recorded the overall problem or diagnosis along with a treatment plan showing the various treatment options. The details of the treatment including the type of local anaesthesia and filling materials used were also recorded in the clinical notes. The patients were then discharged from care until their next oral health assessment.

Working with other services

Patients were referred to hospital services appropriately. A new patient referral form had been introduced, which included urgent two week referrals for mouth cancer.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

All staff were clear on the importance of emotional support needed when delivering care when treating patients who were very nervous or phobic of dental treatment. Patients, their relatives and carer's were all extremely positive about the care and treatment they had received from the dental team. The practice also kept files of compliments from children as well as adults over a number of years which we were able to observe. Patients wrote in their letters comments that paid tribute to kind and gentle dental care they had received, with a welcoming attitude and friendliness. Patients talked about losing their sense of dread at the prospect of treatment due to the dentists and staffs' patience and unhurried manner.

There was a glass barrier between the reception desk and the waiting area and a radio on to mask voices and maintain confidentiality at the desk. Patients could relay sensitive and confidential information to the reception staff without being overheard. Staff showed us the marker on the computer used to highlight any problems, such as if a patient was hard of hearing. They would make sure they spoke clearly and face to face with the patient, they did not have a loop system. Many frail older people were registered as patients with this practice.

The practice had offered a prize draw for children to encourage them to express their views. Letters had been received from 58 children between the ages of seven and 17. Young patients said they were pleased the dentists checked their teeth so they would not have horrible teeth when they were older. They said the liked the dentist because he did not like pain, and they liked the way the dentists spoke to the children rather than the adults. They said that staff made the Trinity Dental Centre a happy and enjoyable service and they liked seeing the dentist and being told about their teeth and how well they were doing.

The practice had been proactive and imaginative in gaining an extensive collection of views of their younger patients. The views expressed showed the caring attitude of the dentists and staff.

Involvement in decisions about care and treatment

There was information about private fees and the Health Plan that was offered, displayed on the desk. Copies could be given to patients on request. There were complimentary letters that demonstrated the dentists sought the views of the patient regarding the proposed treatment even when the patient was a younger child. This was confirmed by reviewing patient records which showed patients were given choices and options with respect to their dental treatment in language that they could understand. The letters also demonstrated that patients were treated with respect and dignity at all times.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice used a variety of methods for providing patients' with information. These included a practice website and patient welcome pack given to patients when they joined the practice. The welcome pack and website contained detailed information about the practice philosophy of providing 'kind and gentle dental care', what to expect from the practice's approach, details about professional charges, opening times and how to raise concerns about the level of care provided.

The welcome pack asked patients to complete a comprehensive medical history and a dental questionnaire. This questionnaire enabled the practice to gather important information about their previous dental and social history. They also aimed to capture details of the patient's expectations in relation to their needs and concerns which helped to direct the dentists in providing the most effective form of care and treatment for them.

The practice kept time slots for emergencies each day. We saw a message of thanks from a patient who had attended earlier in the week of our visit. They had been pleased to be provided with emergency treatment speedily.

The practice was sending fliers with information about the payment plan, including changes to the children's plan, to patients with their recall letters, so they could consider their options. There was a notice in the waiting room offering the choice of text or email messages for recalls, instead of a letter.

Access to the service

Staff described how a patient using their disability scooter had been able to drive through the waiting area to the treatment room. New seats had been bought for reception to provide a choice of heights, four higher chairs with arms to help people with restricted mobility. The toilet was spacious and grab rails were provided.

Concerns & complaints

The practice had a complaints policy that had been reviewed in July 2014. The practice manager agreed to check contact details when reviewing the policy and to add the different bodies to be contacted for patients receiving private or NHS treatment.

Information displayed in the waiting room for patients included an invitation to raise any complaints, but simply advised patients to speak to the practice manager. Action the provider could take to improve information for patients would be to add contact details of the organisations that support complainants should they be dissatisfied with the local resolution to any complaint. No complaints had been received during the 14 years this service had been delivered.

The practice had distributed a patient questionnaire covering tidiness and cleanliness, friendliness, promptness, clinical care, understanding as explained, treatments available and their ability to listen to patients. Two of the responses they received gave an evaluation of 'average' but 90 – 97% patients said they found the service was excellent.

Are services well-led?

Our findings

Leadership, openness and transparency

The overall philosophy of the practice was to providing gentle dentistry in a kind and understanding way. This mission statement underpinned practice and was incorporated into the practice information provided to patients including the practice welcome pack and the practice website. The many comments and compliments we observed made by patients demonstrated that the practice and its staff has kept true to its commitment and philosophy at all times over a number of years.

Governance arrangements

The practice had strong and effective clinical leadership which constantly aimed to affirm the practice philosophy. Leadership was provided by the registered manager who was ably supported by an effective practice manager. The practice had achieved membership of the British Dental Association's Good Practice Scheme. This provided an external evaluation of the quality of the service and promoted the adoption of good practice guidelines in relation to clinical governance systems in primary dental care. The practice had also achieved Investor in People status. This provided assurance that the organisation complied with acceptable standards in relation to people management and employment law.

Management lead through learning and improvement

The provider was supporting the staff to deliver care and treatment to a high standard. We were shown examples of minuted regular staff meetings which demonstrated an effective medium for cascading training and information to practice staff. There were certificates in staff files that demonstrated staff had attended appropriate training for their role. The dentists had completed study for their continuous professional development (CPD) including infection control from British Dental Association (BDA) resources, X-rays, handling complaints, legal and ethical issues and dealing with medical emergencies.

Staffing

The practice manager maintained a staff training record to ensure their training was up to date. There was a system of annual appraisal. Records confirmed these had been carried out and showed that the service's vision and mission was discussed, and the staff member's contribution in terms of their role and performance. Staff members' personal requirement for achieving their goals were recorded, with action plans, dated and confirmed. This demonstrated the managers' commitment to supporting staff and encouraging their progress.