Care Quality Commission

A D V Canterbury Limited

Burgate Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 29 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

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

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

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

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

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

Background

Burgate dental practice is a dental practice located in Canterbury Kent. The premises are situated on the ground and first floors. The treatment room is on the ground floor as is the reception area and waiting room. Upstairs are a staff room / kitchen, a dedicated decontamination room and a toilet.

The practice provides private dental services to adults and children. The practice offers a range of services including routine examinations and treatment, veneers, crowns and bridges and implants.

There is a principal dentist (who is also the owner), two dental hygienists, two dental nurses and a practice manager. The practice had engaged a consultant over the last year to help to professionalise the administration of the business.

The practice opening hours are Monday, Tuesday, Wednesday and Friday 9am to 5pm.

The principal dentist is the registered provider and has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection took place over one day and was carried out by a CQC inspector.

Sixteen patients completed CQC comments cards about the service. Patients were positive about the care they received from the practice. They were complimentary about the sympathetic attitude of the staff. Several comments mentioned that the practice equipment and treatments were very up to date.

Summary of findings

Our key findings were:

- There were effective systems to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, X-ray units and autoclave (steriliser), were checked for effectiveness and had been regularly serviced.
- The practice had clear procedures for managing comments, concerns or complaints.
- Patients said that they felt they were listened to and that they received good care from a helpful and sympathetic team.
- Staff understood the importance of obtaining informed consent prior to treatment. And showed an awareness of the needs of higher-risk groups, including young people and those with impaired decision-making capacity.
- Staff maintained the necessary skills and competences to support the needs of patients.
- Staff were well supported and were committed to providing a quality service to their patients.
- Staff had received training appropriate to their role and were supported in their continued professional development.

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

Formally record the annual appraisals that were carried out with 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 policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There were effective systems to reduce and minimise the risk of infection. The practice were able to respond in the event of medical emergencies. Equipment and medicines were checked and were in line with current guidance. The practice had maintained all of the equipment such as the autoclave and X-ray units in line with current guidance.

Are services effective?

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

The practice monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed up on referrals made to other health professionals. Staff had engaged in continuous professional development (CPD) and were meeting all of the training requirements of their registration with 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 positive feedback from patients through comments cards and by checking the results of the practice's patient survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice treatment area was all on one level with access into the building for patients with mobility difficulties and families with prams and pushchairs. The team had access to telephone translation services if necessary.

Are services well-led?

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

The practice manager and the dentist worked closely together to co-ordinate the day to day running of the practice. Staff were aware of plans for the future and of the ethos of the practice. The practice used quality assurance processes to assist them to maintain the quality of the service.

Care Quality Commission

Burgate Dental Practice

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.

This was an announced inspection and was carried out on 29 March 2016 by a CQC inspector who had access to remote advice from a specialist dental advisor.

We informed the local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection we spoke with the dentist, a dental nurse, the practice manager and a consultant who the practice had engaged to help professionalise the running of the business. We looked around the premises, reviewed operational polices and inspected staff recruitment files.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system to manage significant events, safety concerns and complaints and staff showed a good understanding of the procedures. There had not been any reported significant events within the last year.

There was also an accident reporting book. The practice filed completed accident forms separately to protect the privacy of people involved. None of the accidents or incidents recorded were sufficiently serious to warrant reporting under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) or to the Care Quality Commission.

The dentist received national and local safety alerts by email. We saw how these were received, stored and acted on.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which were up to date. The policies were based on professional guidance and had been adapted to meet local requirements. They contained the contact details for the local authority safeguarding team both in and out of normal working hours. This information was displayed prominently and all staff were aware of the procedure to follow.

The dentist was the safeguarding lead and the staff understood this. All staff had completed safeguarding training to the appropriate level. Staff we spoke with were confident when describing potential abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedure for whistleblowing if they had concerns about any staff member's performance. Staff told us they would be confident about raising such issue with the dentist or with other members of staff.

The British Endodontic Society uses guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment. The dentist said that they always used a rubber dam when carrying out this type of work.

The practice had processes to make sure that they did not make avoidable mistakes such as extracting the wrong tooth. The dentist told us they always checked and re-checked the treatment plan and re-examined the patient. They said they took particular care with this where they were extracting a tooth on the recommendation of another dentist (such as when carrying out orthodontic extractions). The processes were double checked with the dental nurse assisting them. The dentist was aware that carrying out incorrect dental treatment of any kind would be reportable to CQC.

Medical emergencies

The practice had arrangements to deal with medical emergencies. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff were trained in its use. The practice had the emergency medicines as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date, stored securely with emergency oxygen and were accessible to staff. All emergency equipment was regularly checked. The medical oxygen cylinder was checked daily. All the medicines and equipment we checked was in date and ready for use.

Staff recruitment

The practice's written procedures contained clear information about all of the checks required by regulation for new staff. The practice had not recently recruited any new staff. The practice was in the process of recruiting an associate dentist, to support the principal dentist, and was correctly following the processes. The staff recruitment files were well organised and contained the relevant information such as educational certificates, photographic identification, General Dental Council (GDC). There were records of professional indemnity (if applicable) and evidence of Hepatitis B vaccination status.

The Disclosure and Barring Service carries out checks 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. The practice had obtained DBS checks (standard or enhanced) for all staff at the appropriate level.

Monitoring health & safety and responding to risks

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. There was a fire risk assessment. There were fire extinguishers, strategically placed, throughout the building. They had been checked and serviced in accordance with the manufacture's guidelines. There were regular fire evacuation drills.

The requirements of the Control of Substances Hazardous to Health 2002 (COSHH) regulations were met. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. The actions required to mitigate risks were described and staff were aware of them. COSHH products were securely stored. Staff were aware of the COSHH file and accessed it for guidance.

There were arrangements to refer patients to another nearby practice, should the premises become unfit for use. Emergency arrangements had been considered and there was a business continuity plan with key contacts, such as for electrics or plumbing, which could be referred to in the event of service failures.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. The dentist had overall responsibility for infection prevention and control (IPC), one of the practice nurses was responsible for the day to day management of IPC.

We saw that dental treatment room, decontamination room and the general environment were clean, tidy and clutter free. Patients said that the practice maintained a good standard of cleanliness. The practice employed a cleaner for general cleaning, the cleaning equipment was safely stored.

During the inspection we observed that the dental nurse cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had an adequate supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. The decontamination room and treatment room all had designated hand wash basins separate from those used for cleaning instruments.

The practice had a well-defined system which separated dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. Different boxes, which were clearly marked, were used for the dirty and clean instruments.

There was a separate decontamination room. The dental nurse showed us the full process of decontamination including how staff manually scrubbed and rinsed the instruments. They were checked for debris using an illuminated magnifying glass. An ultrasonic bath was used first and then instruments were placed in the autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. Clean instruments were packaged and date stamped according to current HTM01-05 guidelines. Dentist and nurses checked to make sure that packs, which had gone past the date stamped on them, were not used. Any packs not used by the date shown were processed through the decontamination cycle again.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. We looked at the paperwork they used to record and monitor these checks. These were fully completed and up to date. We saw maintenance information showing that the practice maintained the decontamination equipment in accordance with the manufactures guidelines.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. Legionella is a bacterium which can contaminate water systems. We saw that staff carried out

regular checks of water temperatures as a precaution against the development of Legionella. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice carried out audits of infection control every six months using the format provided by the Infection Prevention Society. The practice also completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries. There were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp instrument including the contact details for the local occupational health department.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary required waste consignment notices. There were spillage kits for cleaning hazardous substances such as mercury.

Equipment and medicines

We looked at the practice's maintenance schedule. This showed that they ensured that each item of equipment was maintained in accordance with the manufacturer's instructions. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies. All electrical equipment had been subject to portable appliance testing by an qualified person.

Prescription pads held by the practice were securely stored. The batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. Temperature sensitive medicines were stored in a fridge and the staff kept a record of the fridge temperatures.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor. There were maintenance records which showed that the X-ray equipment had been serviced within the correct timeframes. The file contained a copy of the local rules (a record of the working practices staff at the practice must follow to ensure safety when working with radiation). The local rules were displayed in the treatment room.

The practice carried out monitoring of the quality of each X-ray taken to demonstrate that the dental X-rays were graded and quality assured every time. We looked at the radiological quality audit. This assessment systematically analysed the quality of X-rays to identify areas for improvement and to establish that undiagnostic images taken fell below the expected 10% parameter.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

All of the patients' comment cards were positive about the practice. Several described how the practice kept up to date with the latest professional developments. Others mentioned the practice's emphasis on prevention of dental problems.

There had been a number of clinical and other audits carried out during 2015 to help the practice monitor and improve the quality of the service. These included quality of clinical record keeping, quality of dental radiographs, and infection prevention control procedures. These audits all showed good results and little or no remedial action had been required.

The practice had undertaken an audit of the availability of patient appointments and identified areas for improvement. As a result the practice was recruiting an associate dentist so as to increase the number of appointments available on a weekly basis.

The dentist described how they carried out dental assessments. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. The medical history was updated at every visit, especially before any treatment was commenced.

There was an examination of the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The dentist was aware of various best practice guidelines including those from the National Institute for Health and Care Excellence and the Faculty of General Dental Practice. They discussed with us how they put this guidance into practice in relation to recall intervals, antibiotic prescribing, wisdom tooth extractions and X-ray frequency.

Health promotion & prevention

The practice used the Public Health England "Delivering Better Oral Health" guidelines and were proactive in providing preventative dental care as well as providing restorative treatments. We were told that dentists talked with patients about smoking cessation and eating a healthy diet where required. Comment cards remarked on the quality of health prevention advice that the staff gave.

Staffing

All the staff were well established having been with the practice for a considerable number of years. All employed staff had had discussions with the dentist about training and personal development needs. Staff said that there was scope for development and that their training needs were met. However the annual assessment process was not formally recorded. We saw that the consultant the practice had engaged had developed a new process for formalising the arrangements. This was to be implemented in the financial year 2016/2017.

There was evidence that members of the clinical team had completed appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), oral cancer and other specific dental topics. The staff files contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status.

Non clinical staff also participated in training such as basic life support, safeguarding and information technology.

We noted that there had been no recent update of fire safety training however this was booked to for all staff on 29 April 2016.

Working with other services

The practice had written procedures for receiving and making referrals to other services and a process for following up referrals. The practice could show that it referred patients to other services when necessary and made evidence based decisions about this.

Consent to care and treatment

The practice had a consent policy which was up to date and based on professional guidance. Some comment cards mentioned the range of information and options that the dentist provided.

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

Are services effective?
(for example, treatment is effective)

particular decisions. The practice did not generally provide complex treatment for patients where this was likely to apply. However, the dentist had completed MCA training and staff were aware of the basics of the Act and its general implications for dentistry.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients who had completed Care Quality commission (CQC) comment cards were complimentary about the care and treatment they received at the practice. Patients told us that the practice was welcoming and that the staff were caring and compassionate. They said that staff listened to them and tried to accommodate their needs.

From our discussions with staff it was clear that the staff knew their patients well. There was enough time allowed between appointments so that patients could be put at their ease. The staff spoke about patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity.

During the inspection we saw members of the team dealing with patients on the telephone and at the reception desk. They were polite and helpful.

Involvement in decisions about care and treatment.

Some patients who completed CQC comment cards specifically commented on being involved in decisions about treatment and the professionalism of all staff at the practice. The dentist told us and records confirmed that the care and treatment options were discussed with the patients. This included the risks, benefits and costs of treatment.

The dentist emphasised how important it was to give patients enough time to consider which treatment option, if any, that they wanted. The dentist said that they always gave this time.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided information about all the types of treatment available and their costs, this was also on display in the waiting rooms and in the practice leaflet. The treatment information was also available on the practice's website.

Care and treatment was planned and delivered by trained, registered and qualified staff. A detailed medical history was taken for each patient; we saw that this was updated at each consultation. There was a system that notified the staff of any particular health risks, such as allergies, when the patient's record was accessed. This helped to ensure that patients with health conditions were given the most appropriate treatment for their needs.

Tackling inequity and promoting equality

The practice had access to a telephone translation service if necessary. There was level access into the building with a treatment room on the ground floor. The practice was house within a listed building and the practice had made the treatment room as accessible as possible within the constraints of the listing.

Access to the service

The practice was open from 9am to 5.00pm Monday, Tuesday, Wednesday and Friday. The practice was closed on Thursday and at the weekend. The practice aimed to provide same day emergency access during opening hours and planned for this. For example on the first day of opening following a bank holiday weekend there were extra appointments available to accommodation emergencies as experience had shown that these were often needed. Information about the out of hour's service was available in the practice, on the answer phone message and on the website.

Concerns & complaints

The practice had a complaints process which was available on the practice website as well as in print at the practice. This contained information about relevant external bodies that patients could contact about their concerns if they were not satisfied with how the practice dealt with them.

We looked at information available about comments and compliments and complaints. There had been no complaints received during the period under review. There was a comments book in the reception and patients had made many positive comments about the quality of the service.

Are services well-led?

Our findings

Governance arrangements

There was a full range of operational policies, procedures and protocols to govern activity. The practice regularly reviewed these. Staff had signed the policies to show they had read and understood them. The staff we spoke with were aware of the policies, procedures and protocols, and knew how to look them up if necessary.

The practice conducted audits to monitor and assess the quality of the services. These audits had been repeated regularly to evidence that improvements had been made where gaps had been identified. Records we looked at related to audits for infection control, the quality of X-rays taken and record keeping.

There were daily weekly and monthly checks as appropriate. For example daily checks of the treatment room and the emergency medical oxygen and weekly checks of the emergency medicines.

Leadership, openness and transparency

The practice had a strong leadership structure which was led by the dentist. Staff were experienced, suitably qualified and worked closely as a team. We saw an effective team working in a relaxed but professional way. Staff told us that they felt supported and encouraged to raise any issues of concern or suggestions for improving working practices.

The practice had regular team meetings which were used to share information and to discuss changes to professional practice or local procedures.

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

There was a comments book in reception. Further feedback was collected through a rolling patient survey. Patients were asked to comment on their experiences, areas included; waiting times for scheduled appointments, listening skills of staff and the quality of the information provided. There were about 40 completed survey forms each month. The results showed that, generally, patients were very satisfied with the service.

Where the survey had identified areas for improvement, such as the need for more hygienist's appointments, these had been addressed.

Learning and improvement

The practice recognised the value of developing the staff team through learning and development. We found that the clinical staff had all undertaken the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC). The practice staff went as a team to mandatory training such as basic life support or safeguarding.

The practice held a monthly staff meeting and staff were encouraged to participate. The dentist also worked one day a week at another dental practice carrying work of a special interest. This exposed the dentist to new and/or different ways of working which were shared with staff at the monthly meeting.