Oasis Dental Care (Central) Limited

Oasis Dental Care Central - Waltham Cross

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 March 2017 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

Oasis Dental Care Central – Waltham Cross is a mixed dental practice providing mainly NHS and some private treatment for both adults and children. The practice is situated in a converted commercial property and provides services over two floors; there is a reception and waiting area on the ground floor and a waiting area on the first floor. The practice had five dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments.

The practice is open 8.00am to 7.00pm Monday to Thursday and 8.30am to 5.30pm Friday, Saturday 8.30am to 1.00pm and Sunday 8.30am to 1.30pm. The practice has five dentists who work a variety of hours and are supported by seven dental nurses, two reception staff and a practice manager. There are also two part time dental hygienists.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 11 patients. These provided a completely positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

Our key findings were:

- We found that the practice ethos was to provide high quality general dental care in a relaxed and friendly environment.
- Effective leadership was provided by senior clinicians at the practice and an empowered practice manager.
- The practice manager and lead nurse were proud of the practice and their team. Staff felt well supported and were committed to providing a quality service to their patients.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were effective and the practice followed published guidance.
- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these that the practice used for shared learning.
- The practice had enough staff to deliver the service.
- The practice placed an emphasis on the promotion of good oral health and provided regular oral health instruction to patients.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- All complaints were dealt with in an open and transparent way by the practice manager if a mistake had been made.

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?

No action

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

The practice had effective arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

We reviewed 11 completed CQC patient comment cards. These provided a positive view of the service the practice provided. Patients felt they received excellent care in a calm and reassuring environment from staff who were friendly and accommodating. On the day of our inspection we observed staff to be caring, friendly and very welcoming. Staff spoke with enthusiasm about their work and were proud of what they did. Staff we spoke with demonstrated they cared about their patients and were focussed on their individual wellbeing and treatment needs.

Are services responsive to people's needs?

No action

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services. The practice had a ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

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 manager, lead dental nurse and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had effective clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the practice manager. All the staff we met said that the practice was a good place to work.

No action 

Oasis Dental Care Central - Waltham Cross

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 17 March 2017 and was conducted by a lead CQC inspector and a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members and proof of registration with their professional bodies.

During the inspection, we spoke with the practice manager, dentists, lead dental nurse, reception staff and reviewed policies, procedures and other documents. We reviewed 11 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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 manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had adverse incidents reporting policy and standard reporting forms for staff to complete if something went wrong. The policy contained clear information to support staff to understand the wide range of topics that could be considered an adverse incident.

The practice received important information relating to patient safety in the form of the organisation's 'Weekly Check Up' in-house magazine. This is a national system implemented to cascade national and local alerts to all practices in the group. There was a process in place to ensure all members of the dental team received copies of relevant information. The practice manager explained that they discussed any urgent actions with the team immediately.

Reliable safety systems and processes (including safeguarding)

We spoke with the lead dental nurse about the reporting of incidents that could occur in a primary dental care setting. This included needle stick injuries and medical emergency incidents. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice had undertaken a sharps risk assessment and had implemented a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. The practice used special needle guards when used needles were recapped to prevent needle stick injuries. It was also practice policy that the discarding of the used needle was the dentist's responsibility. A dental nurse was also able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked how the practice treated the use of instruments that were used during root canal treatment. A dentist we spoke with explained that these instruments were single use only. They explained that root canal treatment was carried out where practically possible using a rubber dam. (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). We found that a rubber dam kit was available in each treatment room. Patients were assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

We spoke with staff about the different types of abuse that could affect a patient and who to report them to if they came across abuse of a vulnerable child or adult. They were able to describe in detail the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. They also had an awareness of the issues around vulnerable elderly patients who present with dementia that require dental care and treatment. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse. We observed that information was available which contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillators (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 received annual training in how to use this. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely in a central location known to all staff.

The expiry dates of medicines and equipment were monitored using weekly check sheet's that enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. We found that all staff had received update training in 2016.

Are services safe?

Staff recruitment

There were effective recruitment and selection procedures in place. We reviewed the employment files for four staff members. Each file contained evidence that satisfied the requirements of relevant legislation. This included application forms, employment history, evidence of qualifications and photographic evidence of the employee's identification and eligibility to work in the United Kingdom where required. The qualification, skills and experience of each employee had been considered as part of the recruitment process.

Appropriate checks had been made before staff commenced employment including evidence of their professional registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service had been carried out. 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 might have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The Oasis organisation had a dedicated health and safety team that had developed their national systems and processes in respect of health and safety. This team visited practices in the group regularly to ensure compliance with health and safety practise. It was observed that the practice had a detailed general risk assessment looking at a variety of environmental risk factors in the practice and specific risk assessments related to the provision of dental services. The practice had a fire safety risk assessment that had been carried out by a specialist company in May 2016

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found that risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice manager had delegated the responsibility for infection control procedures to the lead dental nurse. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We saw that audits of infection control processes in May and November 2016 confirmed compliance with HTM 01 05 guidelines.

We noted that the five dental treatment rooms, waiting areas, reception areas and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms, the decontamination room and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice.

The lead dental nurse who was responsible for infection control described the end-to-end process of infection control procedures at the practice. They described the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the work surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental unit water lines.

The drawers of two treatment rooms were inspected by us, we found these were well-stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment such as protective gloves and visors available for staff use.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). The lead dental nurse described the method in use by the practice which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was available for inspection. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument reprocessing. This room was organised, clean, tidy and clutter free. The dental nurse demonstrated the

Are services safe?

decontamination process including cleaning, inspection, sterilisation, packaging and storage of instruments. This followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifier they were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized, they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The lead nurse also demonstrated the automatic control and steam penetration tests that are used to ensure that the autoclaves used in the decontamination process were working effectively. The records of these tests were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and this was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients and the public could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in May 2016.and the practice compressor had been recently serviced. The practices' X-ray machines had been serviced and calibrated in February 2017. Dental treatment records we reviewed showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored securely for the protection of patients. The practice had in place a prescription logging system to account for the prescriptions issued. This prevented inappropriate prescribing or loss of prescriptions. We observed that the practice had appropriate first aid equipment.

Radiography (X-rays)

We were shown a well-maintained 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 and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown an X-ray audit for each dentist which had been carried out in 2016. Dental care records we reviewed where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

In order to keep up to date with radiography and radiation protection and to ensure the practice is in compliance with its legal obligations under Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000, the General Dental Council recommends that dentists undertake a minimum of five hours continuing professional development training every five years. We saw evidence that the dentists were up to date with this training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The dentist we spoke with described how they carried out patient assessments using a typical patient journey scenario. The practice used a pathway approach to the assessment of the patient. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. The assessment also included details of their dental and social history. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and signs of mouth cancer. Patients were then 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 then discussed with the patient and treatment options explained in detail.

Where relevant, individualised preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. The clinical records observed were well-structured and contained sufficient detail about each patient's dental treatment. This included details of 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 that is used to indicate the level of examination needed and to provide basic guidance on treatment need).These were carried out at each dental health assessment. The records we saw showed dental X-rays were justified, reported on and quality assured every time. Details of the treatment were also documented and included local anaesthetic details including type, the site of administration and batch number and expiry date.

Health promotion & prevention

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth and gums. A dental hygienist was available on certain days to provide a range of advice and treatment in the prevention of dental disease. The dentist we spoke with explained that tooth brushing and interdental cleaning techniques were shown to patients and dietary, smoking and alcohol advice was given to them when appropriate. Dental care records we reviewed all demonstrated that dentists had given tooth brushing instructions and dietary advice to patients.

Staffing

The practice manager told us that the practice ethos was that all staff should receive appropriate training and development. There was an induction and training programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients. The practice used a variety of ways to support staff development including in-house training and staff meetings as well as attendance at external courses and conferences.

Staff had undertaken training to ensure they were kept up to date with the core training and registration requirements issued by the General Dental Council. This included areas such as responding to medical emergencies and infection control and prevention and child protection and adult safeguarding. We confirmed that the dental nurses received an annual appraisal which were carried out by the practice manager. This was used to identify training and development needs.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers. This ensured that patients were seen by the right person at the right time.

Are services effective?

(for example, treatment is effective)

A referral letter was then prepared and sent to the hospital with full details of the dentists findings and was stored on the practices' records system. When the patient had received their treatment, they would be discharged back to the practice for further follow-up and monitoring. A copy of the referral letter was always available to the patient if they wanted this for their records. The practice manager reported that there were no patient complaints relating to referrals to specialised services.

Consent to care and treatment

The practice ensured informed consent from patients was obtained for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. We asked the dentist to show us some dental care records which reflected this. Patients were given time to consider and make informed decisions about which option they wanted. This was reflected in the comments we received from patients who also told us the staff were happy to answer any questions they may have.

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. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in their best interests.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We reviewed 11 completed comment cards which provided a very positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients felt they received excellent care in a calm and reassuring environment from staff who were friendly and accommodating. During the inspection, we observed staff in the busy reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly. All the staff we spoke with described treating patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

Staff spoke with enthusiasm about their work and were proud of what they did. This demonstrated to us they cared about their patients and were focussed on their individual wellbeing and treatment needs.

Involvement in decisions about care and treatment

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we reviewed that the dentists recorded the information they had provided to patients about their treatment and the options open to them. It was also observed that the practice scanned signed treatment plans including the cost of treatment into the patients dental care record.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The practice had an empowered practice manager who was responsible for the day to day running of the practice.

Oasis owns a chain of dental practices throughout the UK and had developed an effective on line intranet based clinical governance system that we observed. Staff were able to access a wide range of policies and protocols covering all aspects of clinical governance, information governance and human resources in relation to dentistry. We observed one such area in relation to the use of safer sharps. This resource contained the policy, downloadable risk assessment forms and protocols should a member of staff sustain a contaminated sharps injury. The company had made a short training video covering all aspects of sharps handling and a demonstration of how to use the single delivery system for giving a patient a local anaesthetic. We viewed this video and found that it was very clear and informative.

Leadership, openness and transparency

Effective leadership was provided by the practice manager and senior clinicians. The practice ethos focussed on providing high quality patient centred dental care in a relaxed and friendly environment. The comment cards we reviewed reflected this approach.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. There was a no blame culture within the practice and staff told us they felt comfortable about raising concerns with the practice manager. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice manager was proactive and aimed to resolve problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that all staff received an annual appraisal. There was also a system of peer review in place to facilitate the learning and development needs of the dentists.

The practice had a rolling programme of clinical and non-clinical audits which included infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

The practice regularly invited feedback from patients in the form of surveys and comment cards for the NHS Family and Friends test (a national programme to allow patients to provide feedback on the services provided).

The practice held regular staff meetings each month where they discussed a range of topics in order to learn and improve the quality of service provided. Staff members told us they found the meetings were a useful opportunity to share ideas.