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Highfield Dental Practice

Inspection Report

Highfield Dental Practice
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Overall summary

We carried out an announced comprehensive inspection on 20 October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Highfield Dental Practice is located in the London Borough of Bromley and provides NHS and private dental services.

Facilities within the practice include three treatment rooms, X-ray room, a dedicated decontamination room and a reception area.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), two associate dentists, four dental nurses, two trainee nurses, three receptionists and a practice administrator. The practice is open 8.30 am– 5.30pm Monday to Friday.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we reviewed 31 completed CQC comment cards and spoke with four patients on the day of the inspection. The patients who provided feedback were positive about the care and treatment they received at the practice. They told us they were involved in all aspects of their care and found the staff to be friendly and helpful and they were treated with dignity and respect.

Our key findings were:

Summary of findings

- There were effective processes in place to reduce and minimise the risk and spread of infection.
- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- Patients were involved in their care and treatment planning.
- There was appropriate equipment for staff to undertake their duties and equipment was well maintained.
- Patients told us that staff were caring and treated them with dignity and respect.
- There were processes in place for patients to give their comments and feedback about the service including making complaints and compliments.
- There was a clear vision for the practice. Governance arrangements were in place for the smooth running of the practice.

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

- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the practice's protocols for medicines management and ensure all medicines are stored safely and securely.

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.

There were systems in place to help ensure the safety of staff and patients. These included policies for safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and maintenance of equipment used at the practice. The practice assessed risks to patients and managed these well. We found that staff were trained and there was appropriate equipment to respond to medical emergencies. In the event of an incident or accident occurring, the practice documented, investigated and learnt from it. However, improvements could be made in the staff recruitment procedures.

Are services effective?

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

The practice followed guidance issued by National Institute for Health and Care Excellence (NICE) for example, in regards to prescribing antibiotics and dental recall intervals. Patients were given appropriate information to support them to make decisions about the treatment they received. The practice kept detailed dental care records of treatments carried out and monitored any changes in the patient's' medical and oral health. Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

Staff were supported by the practice in maintaining their continuing professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

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

We reviewed 31 completed CQC comments cards completed by patients prior to our visit and spoke with four patients on the day of the inspection. The feedback received was very positive about the service provided by the practice. We observed that staff treated patients with dignity and respect. 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.

Patients had good access to routine and emergency appointments at the practice. There was sufficient well maintained equipment to meet the dental needs of their patient population. There was a complaints policy clearly publicised in the reception area. We saw that the practice responded to complaints in line with their complaints policy. Patients were given the opportunity to give feedback through the practice website and regular surveys of patients. There were arrangements to meet the needs of people whose first language was not English.

Are services well-led?

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

Summary of findings

There was a clear vision for the practice that was shared with the staff. There were good governance arrangements and an effective management structure. There were regular meetings where staff were given the opportunity to give their views of the service. Appropriate policies and procedures were in place, and there was effective monitoring of various aspects of care delivery. Patients were given the opportunity to provide feedback about the practice through questionnaires.

Highfield Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 20 October 2015. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months. We also reviewed further information on the day of the inspection.

We received 31 CQC comment cards completed by patients and spoke with four patients on the day of the inspection. We also spoke with four members of staff. We reviewed the policies, toured the premises and examined the cleaning and decontamination of dental equipment.

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 suitable processes around reporting and discussion of incidents. We saw there was a system in place for learning from incidents. Staff told us this would mainly be through discussion at team meetings. Staff were able to describe the type of incidents that would be recorded and the incident logging process. There had been no incidents reported over the past 12 months.

Staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Staff were able to describe the type of incidents that would need to be recorded under these requirements. There had been no RIDDOR incidents over the past 12 months.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead and staff knew who they should go to if they had a safeguarding concern. The practice had a safeguarding policy. The policy had last been reviewed in March 2015 and was scheduled to be reviewed again in 2016. Staff had completed child and adult safeguarding training that was updated on a regular basis. The practice had details of the local safeguarding teams. There had been no safeguarding incidents that needed to be referred to the local safeguarding teams in the last year.

The practice had safety systems in place to help ensure the safety of staff and patients. This included for example having infection control protocols, procedures for using equipment safely and health and safety at work procedures.

Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example use of autoclave, biological agents, display screen, manual handling and the building environment risk assessments. We noted that the practice had acted upon what had been identified in the risk assessments. For example a sharps risk assessment specified that re-sheathing could only be done by dentists with a special device.

During our visit we found that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. During the course of our inspection we checked dental care records to confirm the findings. Dental care records contained patient's medical history that was obtained when patients first registered with the practice and was updated on the patient's electronic records. The dental care records we saw contained sufficient detail enabling another dentist to know how to safely treat a patient. For example, they contained details of any allergies patients had.

The principal dentist said they used floss and an apex detector and not a rubber dam for root canal treatments. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.].

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received basic life support training which included cardiopulmonary resuscitation (CPR) training. The practice had a medical emergency kit which included emergency medicines and equipment. The kit contained the recommended medicines as recommended by the Resuscitation Council UK and the British National Formulary (BNF). We checked the medicines that were in the kit and we found that all the medicines were within their expiry date. The emergency equipment included oxygen and an automated external defibrillator (AED), in line with Resuscitation Council UK guidance. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Staff recruitment

The practice had a policy for the safe recruitment of staff. In order to reduce the risks of employing unsuitable staff the provider is required to complete a number of checks. They must obtain a full employment history, check the authenticity of qualifications, obtain two references, including one from the most recent employer, and complete an up to date Disclosure and Barring Service (DBS) check. We checked six recruitment records. We found that the practice had obtained DBS checks for the dentists but not for the dental nurses. All the dental nurses had been working at the practice for over five years. The most recent post recruited to was a receptionist position and the principal dentist told us they would obtain a DBS for this

member of staff, and all new members of staff in the future. However, we found that the practice did not always maintain a record of references for all staff. The principal dentist said they had sometimes taken a verbal reference but not recorded it.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A health and safety policy was in place. The practice had a risk management process which was regularly updated and reviewed to ensure the safety of patients and staff members. For example, we saw risk assessments for display screen equipment (DSE), radiation, building environment, health and safety and use of sharps. The assessments included the controls and actions to manage risks. For example a 2015 manual handling risk assessment had recommended that staff receive manual handling training and we saw this had been acted upon.

The practice had a business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service. The plan had been reviewed in March 2015 and was scheduled to be reviewed again in March 2016. The plan covered what to do in the event of issues such as loss of electricity supplies and the computer system breaking down. The plan detailed arrangements for using facilities at another practice in event of a loss of water supply.

Infection control

The practice had an infection control policy that outlined the procedure for issues relating to minimising the risk and spread of infections. This included details of procedures for hand hygiene, clinical waste management and personal protective equipment. A copy of the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, which is a guidance document from the Department of Health, was available for staff to refer to. The principal dentist was the infection control lead.

There was a separate area for the decontamination of instruments. There was a clear flow from dirty to clean areas to minimise the risks of cross contamination. Staff gave a demonstration of the decontamination process which was in line with HTM 01-05 published guidance. This included carrying used instruments in a lidded box from the surgery, cleaning instruments suitably and using an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); placing in the autoclave pouching and then date stamping.

We saw that daily, weekly and monthly checks that were carried out on equipment used in the practice including the autoclave, to ensure they were working effectively.

We saw evidence that staff had been vaccinated against Hepatitis B to protect patients from the risks of contracting the infection.

There was a contract in place for the safe disposal of clinical waste and sharps instruments. Clinical waste was stored appropriately away from the public. The waste was collected weekly by a clinical waste contractor.

The surgery was visibly clean and tidy. There were stocks of PPE (personal protective equipment) such as gloves and aprons for both staff and patients. We saw that staff wore appropriate PPE. Hand washing solution was available.

An infection control audit had been undertaken in June 2015. A legionella risk assessment had been completed in August 2015 and the results were negative for bacterium [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. The practice used distilled water in all dental lines. The water lines were flushed daily and weekly.

There was a cleaning plan, schedule and checklist, which was regularly checked by the practice staff. Cleaning equipment and materials were stored appropriately in line with Control of Substances Hazardous to Health 2002 (COSHH) regulations.

Equipment and medicines

We found the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments and X-ray equipment. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process where electrical appliances are routinely checked for safety. All the equipment at the practice had annual maintenance checks.

The practice had clear guidance regarding prescribing medicines .Prescription pads were stored in a lockable cupboard and stock was monitored. However we found

Are services safe?

medicines stored in a cupboard which did not have a lock on it. The cupboard was in a kitchen used by staff. The principal dentist told us that immediate action would be taken to put a lock on the cupboard.

Radiography (X-rays)

The principal dentist was the radiation protection supervisor (RPS). An external organisation covered the role of radiation protection adviser. The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in clinical areas where X-rays were used. We saw an email that confirmed the practice had contacted the Health and Safety Executive (HSE) that they were carrying out radiation work. Evidence was seen of radiation training for staff undertaking X-rays. A comprehensive radiograph audit had been carried out in 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were assessed and care and treatment was delivered in line with current legislation. This included following the National Institute for Health and Care Excellence (NICE) guidance, for example in regards to wisdom tooth extraction and dental recalls. The practice staff also showed awareness of the Delivering Better Oral Health Tool-kit. 'Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

During the course of our inspection we checked dental care records to confirm the findings. We saw evidence of detailed assessments that were individualised. This included having an up to date medical history on the electronic records, details of the reason for visit, medical alerts, and a full clinical assessment with an extra- and intra-oral examination. An assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool. [The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.] Information about the costs of treatment and treatment options available were also given to patients.

Health promotion & prevention

Patients' medical histories were updated regularly which included, where applicable, questions about smoking and alcohol intake. Appropriate advice was provided by staff to patients based on their medical history. We saw the practice displayed preventive care advice on tooth brushing and oral health instructions as well as fluoride application, alcohol use, and dietary advice in their reception area.

Staffing

Staff told us they had received appropriate professional development and training; the records we saw reflected this. The practice maintained a programme of professional development to ensure that staff were up to date with the latest protocols & procedures. The practice used a variety of ways to ensure development and learning was undertaken including both face to face and e-learning. Examples of staff training included mandatory modules such as health and safety, safeguarding, medical emergencies and infection control.

We reviewed the system in place for recording training that had been attended by staff working within the practice. We saw that the practice maintained records that detailed training undertaken and highlighted training that staff needed to undertake. We also reviewed information about continuing professional development (CPD) and found that staff had undertaken the required number of CPD hours.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist hospitals for complicated oral surgery. Dental care records we looked at contained details of the referrals made and the outcome from the referrals that were made.

Consent to care and treatment

Patients who used the service were given appropriate information and support regarding their dental care and treatment. We reviewed 31 CQC comment cards and spoke with four patients. Patients said they were given clear treatment options which were discussed in an easy to understand language by practice staff. Patients understood and consented to treatment. This was confirmed when we checked dental care records and noted signed consent forms for treatment and details of treatment options patients had been given.

Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA 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 particular decisions for themselves. Staff were aware of how they would support a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient and carers to ensure that the best interests of the patient were met. This meant where patients did not have the capacity to consent, the dentist acted in accordance with legal requirements and that vulnerable patients were treated with dignity and respect.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed 31 CQC comment cards and spoke with four patients. All the feedback we received was positive. Staff were described as caring, friendly and helpful. Patients said staff treated them with dignity and respect during consultations. We observed staff interaction with patients and saw that staff interacted well with patients, speaking to them in a respectful and considerate manner.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area that gave details of fees. We spoke with the principal dentist and dental nurses on the day of our visit. There was a culture of promoting patient involvement in treatment planning which meant that all staff ensured patients were given clear explanations about treatment. Staff told us that treatments, risks and benefits were discussed with each patient to ensure that patients understood what treatment was available so they were able to make an informed choice. The dentist told us they would explain the planned procedures to patients using visual aids when necessary. Patients were then able to decide which treatment option they wanted.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Staff told us there was enough time to treat patients and that patients could generally book an appointment in good time to see a dentist. Patients we spoke with confirmed they could get appointments when they needed them.

There were vacant appointment slots to accommodate urgent or emergency appointments. We observed that appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services this included access to telephone translation services for patients whose first language was not English and a stair lift for people with mobility problems.

Access to the service

The practice displayed its opening hours on the practice website. Opening times were also displayed at the front of the practice. The practice was open Monday to Friday 8.30 am– 5.30pm, with the practice closing at 5.00pm on Fridays. There were clear instructions for patients requiring urgent dental care when the practice was closed. These instructions were on the telephone answering machine.

Concerns & complaints

The practice had effective arrangements in place for handling complaints and concerns. There was a complaints policy, and information for patients about how to complain was available in the reception area. The policy had last been reviewed in 2015 and was scheduled to be reviewed in 2016. The policy included contact details for three external organisations that patients could contact if they were not happy with the practice's response to a complaint. We were told that there had been no complaints received in the last year.

Are services well-led?

Our findings

Governance arrangements

The provider had governance arrangements in place for the effective management of the service. This included having a range of policies and procedures in place including health and safety, complaints and infection control. There was a clear management structure in place with identified staff leading on specific roles such as on infection control and safeguarding. Staff told us they felt supported and were clear about their areas of responsibility. Comprehensive risk assessments had been undertaken to cover various aspects of the service delivery.

Staff told us meetings were held monthly to discuss issues in the practice and update on things affecting the practice. We saw that these meetings were used as an opportunity to let staff know about the ongoing business of the practice. For example we saw that the safeguarding policy was discussed at a April 2015 meeting.

Dental care records we checked were stored as hard copies and electronically. Hard copy records were stored in a locked cabinet and electronic records were password protected.

The practice manager undertook quality audits at the practice. This included audits on infection control, radiography and patient waiting times. We found that action plans were drafted following the completion of audits. For example we saw that a July 2015 patient waiting time audit suggest a clock be kept in the surgeries to help dentist monitor time more effectively.

Leadership, openness and transparency

We spoke with the principal dentist, the receptionist and a dental nurse. Staff said they felt the owner of the practice had created an atmosphere where all staff felt included. Staff told us they were comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so. They described the culture encouraged candour, openness and honesty.

The practice was also keen to ensure that all of their staff provided highly-skilled care. There was a system of periodic staff appraisals and supervision to support staff.

Learning and improvement

Staff told us they had good access to training. The practice manager monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC).

The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as on X-rays and patients satisfaction. We looked at a sample of these and found audits were being undertaken regularly.

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

The practice had gathered feedback from patients through their own patient feedback surveys. For example staff were asked to give feedback on their treatment and the service as a whole during a 2014 patient survey. We found that the practice acted upon the feedback they received. For example the practice had updated their range of magazines following feedback in the survey.