Norfolk Street Dental Surgery Limited

# Norfolk Street Dental Surgery

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 6 December 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**

Norfolk Street Dental Surgery is a well-established dental practice that provides primarily NHS treatment to children and adults. The team consists of one dentist, one dental nurse and two receptionists**.** The practice is situated in a small row of shops and has one dental treatment room, a decontamination room, and a waiting and reception area.

The practice opens from 9am to 5pmon Monday to Fridays and is closed for lunch between 1pm and 2pm.

The practice owner is registered with the Care Quality Commission (CQC) to manage the service. 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.

Before the inspection we sent comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 44 patients who commented positively about the quality of the service and the effectiveness of their treatment.

**Our key findings were:**

- We received consistently good feedback from patients about the caring and empathetic nature of the dentist, and the effectiveness of their treatment.
- There were sufficient numbers of suitably qualified and competent staff. Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.

# Summary of findings

- Patients' care and treatment was planned and delivered in line with evidence-based guidelines, best practice and current legislation. Patients received clear explanations about their proposed treatment and were actively involved in making decisions about it.
- The practice listened to its patients and staff and acted upon their feedback.
- Staff did not receive regular appraisal of their performance and there were no regular minuted staff team minutes.
- Risk assessment was limited, and polices were not kept up to date or made relevant for the practice.

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

- Ensure all unusual events are recorded to aid learning should an incident occur in the future
- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review the practice's recruitment procedures to ensure photographic proof of identification is requested, the need for a DBS check is risk assessed and notes of interviews are formally recorded.
- Review the practice's policies to ensure they are relevant, up to date and discussed with staff.
- Implement an effective process for the on-going assessment and appraisal of all staff employed.

# 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 effective arrangements for essential areas such as infection control, clinical waste, the management of medical emergencies and dental radiography (X-rays). Equipment used in the dental practice was serviced regularly and well maintained. Staff had received safeguarding training and were aware of their responsibilities regarding the protection children and vulnerable adults. However, the identification of possible hazards within the practice was limited and recruitment procedures needed to improve to ensure only suitable staff were employed.

**No action** 

**Are services effective?**

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, and options were explained to patients in a way they understood and staff followed appropriate guidelines for obtaining patient consent. Patients were referred to other services as needed.

The staff were able to access professional training and development appropriate to their roles; however they did not receive formal appraisal of their performance or have development plans in place.

**No action** 

**Are services caring?**

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

We collected 44 completed patient comment cards and obtained the views of a further three patients on the day of our visit. These provided a very positive view of the service and the staff. Patients commented on the cleanliness of the practice, and described staff as empathetic, caring and that they explained their treatment well.

Staff gave us specific examples where they had gone beyond the call of duty to support patients.

**No action** 

**Are services responsive to people's needs?**

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

The facilities and premises were appropriate for the services that were delivered and plans were in place to upgrade and improve the decontamination room. Patients could access treatment

**No action** 

# Summary of findings

and urgent and emergency care when required, and appointment times could be altered to meet individual patients' needs. The practice had made some adjustments to accommodate patients with a disability, although the constraints of space within the practice meant there was no disabled toilet.

Practice information was available in large print, and reading glasses were available to assist patients with visual impairments. There was a complaints system in place which was publicised and accessible to patients. However the practice was not recoding minor concerns that patients raised.

**Are services well-led?**

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

Staff told us that they enjoyed their work and that informal communication systems within the practice were good. They reported that the practice owner valued their involvement and their views were reflected in the delivery of the service. However, there were no formal minuted staff meetings and staff did not receive any appraisal of their performance.

Policies were available to guide staff but some of these needed to be reviewed and made specific to the practice.

**No action** 

# Norfolk Street Dental Surgery

**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.

The inspection was carried out on 6 December 2016 by a CQC inspector who was supported by a specialist dental adviser. During the inspection we spoke with the dentist, one dental nurse and the receptionist. We reviewed policies, procedures and other documents relating to the management of the service. We received feedback from 44 patients about the quality of the service.

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well led?

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**

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and details of how to report to this agency were available. The practice had an incident reporting policy and there was a specific book available in which to record any. However, we found that no incidents had been recorded in the book, despite staff telling us of a storm that had damaged the building . There was no evidence to show that learning from this event had been recorded and formally shared with staff.

National patient safety alerts were sent to the dentist by the local area team and actioned if required. We found that staff were aware of recent alerts affecting dental practice.

The British Endodontic Society uses quality 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 dentist confirmed he used rubber dams and we noted that a rubber dam kit was available in the practice.

**Reliable safety systems and processes (including safeguarding)**

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies and guidance was easily accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Records showed that all staff had received safeguarding training for both vulnerable adults and children, although this was out of date for the receptionist. The dentist was the lead for safeguarding and was considering undertaking further training for this role. Staff we spoke with understood the importance of safeguarding issues.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which might be contaminated). Only the dentist dealt with sharps and used a single-handed resheathing technique before disposal of used needles and anaesthetic cartridges. Staff spoke knowledgeably about action they would take following a sharps' injury.

**Medical emergencies**

The practice had arrangements in place to deal with medical emergencies. An automated external defibrillator (AED) was available and staff had received training in how to use it. Staff had access to oxygen, along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines, although we noted that the airways and a face mask was out of date for safe use. The dentist checked the emergency equipment annually although has now agreed to ensure this is undertaken on a weekly basis.. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. However, staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice's supply of glucagon (used to treat episodes of severe hypoglycaemia) was not kept in the fridge and we found it had become out of date for safe use as a result.

The practice had mercury and bodily fluid spillage kits to deal with any accidents.

**Staff recruitment**

We checked personnel records for staff which contained evidence of their GDC registration (where relevant), an employment contract, job description, indemnity insurance, references, and a disclosure and barring check (DBS). 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 might be vulnerable. However we noted that one staff member's DBS check had been obtained some months after they had been employed and no measures had been taken to reduce the risk this involved. A record of their recruitment interview was not available to demonstrate it had been conducted fairly and in line with employment practices, and there was no photographic proof of their identity.

# Are services safe?

**Monitoring health & safety and responding to risks**

There were some procedures in place for monitoring and managing risks to patient and staff safety, although there was no comprehensive practice risk assessment in place to help identify potential hazards to staff and patients.

A Legionella risk assessment had been completed by the dentist, and an external company had been commissioned to undertake a full assessment in the coming month. Hot and cold water temperatures were monitored regularly and staff ran dental unit water lines in accordance with national guidance. Water lines were also flushed through each week with a biocide to reduce the risk of legionella bacteria forming. Water samples sent for testing were free of the bacterium.

Firefighting equipment such as extinguishers were regularly serviced although there was no current fire risk assessment available for the practice. Evacuations were not rehearsed so that staff would know what to do in the event of a fire. There was a control of substances hazardous to health file in place containing chemical safety data sheets for most materials used within the practice. However, we noted there were no safety data sheets available for some cleaning products used by the external cleaner.

The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. It included essential contact details of staff and relevant utility companies.

**Infection control**

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness, and the practice had policies in place for key areas such as instrument decontamination, hand hygiene and the use of personal protective equipment. Regular infection control audits were undertaken by the dentist, although these had not been conducted as frequently as recommended by national guidance.

We observed that all areas of the practice were visibly clean and hygienic, including the treatment room, waiting area and toilet. The toilet had liquid soap and a dryer to help maintain good hand hygiene, although there was no bin for the safe disposal of sanitary products. We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The room had sealed flooring and modern sealed work surfaces so it could be cleaned easily.

Equipment used to clean different areas of the practice was colour coded, although it was not stored according to recommended guidelines.

The practice had a dedicated decontamination room that was mostly set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. However the storeroom was in the process of refurbishment to become a decontamination room that complied with best practice guidelines.

The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Staff manually cleaned instruments under water for the initial cleaning process, and suitable personal protective equipment was worn by them. Instruments were then inspected under an illuminated magnifier and placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. Data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

We noted that staff uniforms were clean and their arms were bare below the elbows to reduce the risk of cross infection. All dental staff had been immunised against Hepatitis B.

The segregation and storage of clinical 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 in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste and waste consignment notices were available for inspection.

**Equipment and medicines**

The equipment used for sterilising instruments was checked, maintained and serviced in line with the

# Are services safe?

manufacturer's instructions. All other types of equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, portable appliance testing had been completed in May 2016; the practice's autoclave had been serviced in November 2016, and its compressor in September 2016.

We found that there were plenty of instruments available for each clinical session to take account of decontamination procedures. Stock control was good and medical consumables we checked in the storeroom were within date for safe use.

Prescription pads were held securely, however there was no logging system in place to account for the prescriptions issued. The batch numbers and expiry dates for local anaesthetics were recorded in a book.

**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 Supervisor and the Radiation Protection Advisorand the necessary documentation pertaining to the maintenance of the X-ray equipment.

Included in the file was the critical examination packs for each X-ray unit, the local rules and evidence that the health and safety executive had been notified. Rectangular collimation was used to confine the scatter of x-ray beams.

Training records showed that the dentist had received training for core radiological knowledge under IRMER 2000 Regulations. Regular radiographic audits were completed, although there was no evidence of an action plan following the audits to ensure that any issues identified were addressed.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

Patients who completed our comment cards told us they were happy with their treatments and that the dentist never conducted unnecessary work.

We found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Our discussion with the dentist and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. Assessments included an examination covering the condition of the patient's teeth, gums and soft tissues. Antibiotic prescribing, wisdom tooth extraction and patients' recall frequencies also met national guidance. Dental care records were of a good standard, although we found that intra and extra oral assessments could be recorded in a little more detail. We saw evidence that patients' the medical histories were updated at every check-up visit.

We saw a range of clinical audits that the practice carried out to help them monitor the effectiveness of the service. These included clinical record keeping, dental radiographs and infection control.

**Health promotion & prevention**

Patients were asked about their smoking and alcohol intake as part of their medical history and dental care records we reviewed demonstrated that the dentist had given oral health advice to patients, and prescribed high fluoride toothpaste and fluoride application if required.

The practice did not sell any oral hygiene products and there were no leaflets easily available to patients about maintaining good oral health. There was no information for patients wanting to give up smoking and staff were unaware of local smoking cessation services

**Staffing**

There was a stable and established staff team at the practice. Staff told us the staffing levels were suitable for the small size of the service and the dentist always worked with a dental nurse. The practice shut completely when staff took annual leave. Both the dental nurse and patients told us they did not feel rushed during appointments and the dentist saw about 20-25 patients a day.

Files we viewed demonstrated that staff were appropriately qualified, trained and had current professional validation and indemnity insurance. The dental nurse told us she regularly attended British Dental Association training meetings at Addenbrookes clinical school to keep her knowledge and skills up to date. However, none of the staff had received an appraisal so it was not clear how their performance was assessed, or their training needs identified.

**Working with other services**

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. No log of the referrals made was kept so they could be could be tracked, although urgent referrals for suspected oral malignancy were hand delivered to guarantee their safe arrival.

**Consent to care and treatment**

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Dental staff we spoke with had a clear understanding of patient consent issues.

The dentist we spoke with understood the importance of providing patients with treatment options and describing the risk and benefits of each one. This was something that many of the patients who completed our comment cards praised the dentist for, stating they were impressed by the amount of information he provided.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Before the inspection, we sent comment cards so patients could tell us about their experience of the practice. We collected 44 completed cards that provided a very positive view of the practice. Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as professional, caring and empathetic to their needs. Patients mentioned in particular the care and time the dentist took to explain their treatments, and the possible alternatives to them.

Staff gave us examples of where they had gone out their way to support patients. For example, they kept an eye on parking times and fed the meter for patients if needed; the practice closed to allow staff to attend the funerals of long standing patients whom they had known well; and ensured that separating couples were not booked for appointments in close proximity.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients. However, staff assured us they could offer a room to any patient who wanted to speak privately and a mobile phone was available to make telephone calls away from reception. The receptionist told us she was careful not to give out patients' personal details when speaking on the phone. Patients' notes were held securely in locked fireproof filing cabinets.

All consultations were carried out in the privacy of the treatment room and we noted that the door was closed during procedures to protect patients' privacy.

**Involvement in decisions about care and treatment**

Feedback we received from patients clearly indicated that the dentist was good at explaining treatments and involving them in decisions about their care. A plan outlining the proposed treatment was given to each patient so they were fully aware of what it entailed and its cost.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice was located in a central area of Cambridge, close to a number of bus routes. There was parking for bicycles directly outside the building and some car parking to the rear of the property. There was a helpful folder in the waiting area, giving patients details of how the practice would manage confidential information, a list of the treatment fees, and information about NHS dentistry in general.

The practice was open Monday to Friday from 9 am to 5pm. Although the practice did not offer any extended hours opening, patients commented that appointments were easy to get and emergency slots were available each day for patients in dental pain. The practice's answering machine gave details of an emergency out of hours contact telephone number, although details were not displayed outside the practice should a patient come when it was closed.

**Tackling inequity and promoting equality**

Information about the practice was available in large print to help patients with visual impairments and staff told us they offered morning appointments to patients observing Ramadan to ensure they had eaten and hydrated adequately before their treatment. The practice had made some adjustments to help prevent inequity for patients that experienced limited mobility. There was level access entry to the practice and the treatment room was on the ground floor. However, the treatment room door was not wide enough to accommodate wheelchair users and constraints of space within the practice meant there was no disabled toilet available. There was no portable hearing loop available despite a number of patients with hearing aids, or easy riser chairs in the waiting area for patients with mobility needs.

No information was available about translation services for patients who did not speak English.

**Concerns & complaints**

The practice had an appropriate complaints procedure in place that included the timescales within which they would be dealt and other agencies that patients could contact. Information about how raise a complaint was available in the patients' information folder and staff spoke knowledgeably about how they would handle a patient's concerns.

It was not possible to assess how the practice managed its complaints as we were told none had been received in the last few years. However, the receptionist reported that patients did sometimes complain about the length of wait they had once they had arrived for their appointment and the cost of their treatment. No record was made of these concerns so it was not clear how they were being monitored or the action taken in response.

# Are services well-led?

## Our findings

**Governance arrangements**

The dentist had responsibility for the day-to-day running of the practice, supported by a dental nurse and receptionist. There were some policies and procedures in use to support the management of the service and guide staff, although many of these were generic and not specific to the practice. Many were also undated so it was not clear whether or not they were up to date and still relevant to the practice. There was no system in place to formally discuss these policies and ensure that staff fully understood their application.

Staff told us that communication in the practice was good, even though no formal recorded staff meetings were held. The dental nurse told us that a formal meeting was scheduled to take place on 20 December 2016 and would now be held regularly.

None of the staff had received an appraisal of their performance so it was not clear how their working practices were assessed or their training needs identified. None had personal development plans in place.

**Leadership, openness and transparency**

Staff told us they enjoyed their work and the small size of the practice which meant informal communication systems were good. They reported there was an open culture and they had the opportunity to raise issues with the dentist. For example, the dental nurse told us she had felt comfortable advising the dentist to chat less to patients, so that other appointments could keep to time.

Both the dentist and dental nurse we spoke with had a good understanding of their obligations under the duty of candour and the practice had recently implemented a policy in relation to it. We found staff to be open and honest about the shortfalls within the practice, and they were clearly keen to address the issues we found during our inspection.

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

The practice had introduced the NHS Friends and Family Test as a way for patients to let them know how well they were doing. The results of these were monitored each month by the dental nurse, and shared with the team. We reviewed results for the previous six months which showed consistently that patients would recommend the practice.

We found good evidence that the practice listened to patients. As a result of feedback the practice had implemented suitable reading material for its teenage patients, and obtained a mobile phone so that it could text patients appointment reminders

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the dentist. Their suggestions to improve the service had been implemented, for example allowing patients to park in front of their cars in the car park, obtaining reading glasses for patients to borrow and displaying a sign informing patients they could request water.