Staplehurst Dental Practice Limited

Staplehurst Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 August 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

Staplehurst dental practice provides general dentistry, such as treating tooth decay and gum disease, and other procedures such as tooth straightening. The practice provides private services for approximately 1,000 patients in Staplehurst, Kent and the surrounding area.

The practice staff included a practice manager, a business manager, a dentist, a dental therapist and two dental nurses. Dental services are provided Monday 8am to 7pm, Tuesday 8am to 4pm, Wednesday and Thursday 8am to 5pm and Fridays and Saturdays 8am to 1pm.

The registered manager had recently left the practice and the new practice manager was in the process of registering with the Commission. 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'. 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.

We talked to five patients. They said that the practice offered an excellent service and staff were efficient, helpful and caring. All commented that staff always had time to spend with them. They did not feel that staff were pressured to complete procedures and staff took time to explain what they were doing. They said that staff treated patients with dignity and respect.

Our key findings were:

Summary of findings

The practice was providing safe, effective, caring, responsive and well led care in accordance with the relevant regulations.

- There were effective systems to reduce the risk and spread of infection. We found all treatment rooms and equipment appeared clean.
- There were systems to check all equipment had been serviced regularly, including the suction compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- Dentists regularly assessed each patient's gum health and took X-rays at appropriate intervals.
- The practice ensured staff maintained the necessary skills and competencies to support the needs of patients.
- The practice kept up to date with current guidelines
- Leadership and communication were central to practice values.
- Patients were provided with information and were involved in decision making about the care and treatment they received. We observed staff to be were kind, caring, and worked hard to put patients at their ease.

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

- Review the fixtures and fittings of the decontamination room.

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 for the management of infection control, clinical waste, medical emergencies and dental radiography. Staff had received training in safeguarding and knew the signs of abuse and how to report this. There was a whistleblowing policy and staff were aware of it. The equipment used in the practice was well maintained and in line with current guidelines. There were systems for identifying, investigating and learning from incidents. The staffing levels were safe for the provision of care and treatment provided.

Are services effective?

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

The practice provided evidenced based dental care which was focussed on the individual needs of each patient. Consultations were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and the General Dental Council (GDC). Patients received a comprehensive assessment of their dental needs and their medical history was kept up to date. Staff registered with the GDC had frequent continuing professional development and were meeting the requirements of their professional registration. Consent to care and treatment was obtained from patients and recorded appropriately.

Are services caring?

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

Patients told us that they had found the practice supportive. They said they were listened to, treated with respect and were involved with the discussion of their treatment options which included risks, benefits and costs. There was provision to see patients with urgent dental needs on the day they called and this almost always happened.

Are services responsive to people's needs?

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

Appointment times met the needs of patients. Patients with mobility issues were directed to other local dentists as the practice could not accommodate them. The practice was very responsive in supporting patients who were particularly anxious or nervous including providing time for these patients to meet the practice team before any consultation. The practice handled complaints openly and transparently. The complaints procedure was readily available to patients and the practice responded to complaints and learned from them.

Are services well-led?

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

The practice had effective clinical governance and risk management systems. There was a pro-active approach to dealing with safety issues and the practice learned and made improvements. The practice management were approachable and supportive of staff. Staff felt that they could raise concerns with any member of the management team. The practice sought the views of staff and patients and had implemented suggestions such as the provision of an intercom system within the practice.

Staplehurst Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection of Staplehurst Dental Practice on 4 August 2015. Our inspection team was led by a CQC Lead Inspector. The team included a Dentist specialist advisor.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England and the local Healthwatch, to share what they knew. We did not receive any information of concern.

During our visit we spoke with a range of staff (the dentist, the practice manager, the business manager, the dental therapist and a dental nurse) and spoke with five patients. We reviewed practice documentation.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system for the reporting, recording and monitoring of significant events or safety incidents. All staff had responsibility for reporting significant or critical events and staff we spoke with understood this.. There was a range of policies for various events such as a breach of confidentiality or an information technology failure and we saw staff reported and reacted to these events to keep patients safe. We saw that where there had been a significant event it had been recorded, there were documented details of the event, how learning was implemented and actions taken to reduce the risk of it happening again. The guidance available to staff did not define what constituted a significant event. When we spoke with staff there was no common understanding of the definition of a significant event. We found incidents that, though they had been well managed and without detriment to the patients or staff, had not been recorded as significant events so the opportunity for all staff to learn from them was reduced.

National patient safety alerts were disseminated electronically as well as in paper form to practice staff and alerts relevant to the practice were discussed at staff meetings.

Reliable safety systems and processes (including safeguarding)

There were policies and procedures to support staff to report safeguarding concerns. The practice had a named person responsible for safeguarding issues. All staff we spoke with told us they were up to date with training in safeguarding and records confirmed this. Staff were able to describe the different types of abuse patients might experience, how to recognise them and report them. They were aware who was the safeguarding lead for the practice. There were contact details of relevant safeguarding bodies available so that staff could report any allegations of abuse of vulnerable adults or children. Staff told us that there had been no safeguarding concerns during the last year.

There was a whistleblowing policy. Staff we spoke with were aware of the procedures and who to contact outside the practice if they felt that they could not raise issues internally. However they felt confident that any issue they raised would be taken seriously.

Staff maintained their professional registration for example, professional registration with the General Dental Council. We looked at the practice records of two clinical members of staff which confirmed they were up to date with their professional registration. However there was no systematic process to monitor this. The practice was aware of this and remedial action was part of a longer plan to improve governance within the practice.

Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. All patient records that we examined had an up to date medical history including any allergies and any medicines being taken. A questionnaire to update their history was completed each time a patient attended.

Medical emergencies

There were arrangements to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including medical oxygen. There was no automated external defibrillator (AED), a device used to attempt to restart a person's heart in an emergency. The practice planned to purchase one and had received quotes from several different suppliers. Staff were aware of the location of two places nearby which had AEDs and would use this as a contingency until a device was supplied. The emergency medicines available included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff knew the location of the equipment and medicines. Equipment and medicines were checked regularly.

Staff recruitment

The practice had policies and other documents that governed staff recruitment. There were comprehensive staff files that contained evidence that appropriate checks had been undertaken, for example proof of identification, references and professional qualifications.

All relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check) or an assessment of the potential risks involved in using those staff, together with action taken to mitigate the risk, without DBS clearance.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and accompanying procedures. This information was available to staff on the practice computer system. There was a record of identified risks and action plans to manage or

reduce risk. For example, the risk of accident from loose wires beneath the reception desk. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety such as the appointment of a fire marshal. Fire extinguishers had been recently serviced and staff knew how to respond in the event of a fire.

We saw that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). This was managed using a proprietary software system and the information was available to all staff through the practice's computer system. Each substance used at the practice that had a risk was recorded and graded as to the risk to staff and patients. There were measures to reduce such risks such as the wearing of personal protective equipment and safe storage.

There were various contact lists that provided information on who to contact if certain events such as power failure, adverse weather or information technology failure. However these had not yet been drawn together in a single document accessible to all staff.

Infection control

The premises were generally clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control. The practice had an identified infection control lead, who had had specific training to help them carry out this role. All relevant members of staff were up to date with infection control training.

There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste. There were sufficient supplies of cleaning equipment, appropriately stored. The practice had a cleaning schedule that covered all areas of the premises. It detailed what areas should be cleaned, how frequently and what equipment to use.

We looked at the treatment rooms and waiting areas. The treatment rooms were fitted with hard flooring so that spillages were easily cleared up. All surfaces of the dental chairs were intact and covered in non-porous material. Effective cleaning of the dental chairs was therefore possible. Antibacterial hand wash, paper towels and posters informing staff how to wash their hands were available at all clinical wash-hand basins in the practice.

Personal protective equipment (PPE) including disposable gloves, aprons, face masks and visors were available for staff to use. All clinical staff wore uniforms dedicated for use whilst at work.

We looked at the decontamination room and went through the decontamination procedures with staff. There was a procedure, which met the current guidance, for moving instruments between surgeries and the decontamination area to help prevent the spread of infection. There was a system to help ensure that reusable items of equipment were only used for one patient before being decontaminated and sterilised. Dental instruments were cleaned and decontaminated in a dedicated decontamination room.

The facilities were compliant with the essential standards for decontamination. There was only one sink in the decontamination room there was no second hand washing sink. Some surfaces, such as the windowsill were used for storage which made cleaning more complex. The layout of the room did not allow staff, easily, to work in zones moving from the dirty area through to the clean though staff did show us how they achieved this.

Staff demonstrated the process for cleaning and sterilising instruments. This followed current guidance. An illuminated magnifier was used to check for any debris or damage throughout the cleaning stages. Staff wore appropriate personal protective equipement throughout the procedure. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests. We checked these and the equipment was in working order and being effectively maintained

We looked at the dental instruments which had been decontaminated prior to reuse. Instruments were stored in sterile pouches which were marked with expiry dates. All the instruments we saw in the treatment rooms were within their expiry dates.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. There were procedures to help ensure that water used in the practice complied with purity standards. The

Are services safe?

practice had had an assessment of the risk of legionella (a germ found in the environment which can contaminate water systems in buildings) carried out in July 2015 but had not yet received the report from the specialist company involved.

Equipment and medicines

Staff said that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. There were equipment logs that showed that equipment (including clinical equipment) was tested, calibrated and maintained in accordance with the manufactures' schedules. There was an engineer booked to test the portable electrical equipment on 10 August 2015.

Medicines were stored securely in areas accessible only by practice staff. The practice kept records of the ordering and receipt of medicines. There were records showing the batch numbers and expiry dates of medicines. Staff told us that the expiry dates of medicines were always checked before staff administered them to patients. Medicines that we checked were within their expiry date and fit for use. Appropriate temperature checks for refrigerators used to store medicines had been carried out and records maintained.

Radiography

Radiography was carried out at the practice safely and followed current legislation. There was an inventory of radiography equipment and the equipment had been regularly checked by service engineers. There were clear lines of responsibility and accountability recorded in the local rules for each X-ray unit. (The local rules set out who is responsible for the oversight and safety of radiography in the practice and what to do in the event of an equipment failure).

X-rays were justified, graded and reported on in clinical notes. There had been a limited audit of radiography in the last year but the quality of the radiography work was recorded in the patients' clinical notes.

The practice had a comprehensive radiation protection file where information was stored to show how the practice complied with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R2000). The file contained the names and contact details of the radiation protection advisor and the radiation protection supervisor.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for people using best practice

Dentists regularly assessed each patient's gum health and took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken as well as an examination of a patient's soft tissues (including lips, tongue and palate) and their use of alcohol and tobacco. The dentist used an appropriate scoring method to record their assessment of any gum disease.

The practice was up to date with current guidelines in order to continually develop and improve their systematic clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to wisdom teeth removal and in deciding when to recall patients for examination and review. The practice used guidelines and accredited processes from other specialist bodies such as the British Academy of Cosmetic Dentistry to inform practice.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and used the Department of Health 'Delivering Better Oral Health; a toolkit for prevention'. For example the practice prescribed high concentration fluoride tooth pastes to patients at high risk of dental decay.

The practice asked new patients to complete a health questionnaire which included information on their medical health, consent and data sharing guidance. Patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice. Information in the waiting areas promoted good oral health and included information on tooth sensitivity.

Staffing

There was an induction programme for staff to follow which helped to ensure they were skilled and competent to deliver safe and effective care and support to patients. There was an immediate induction programme to help to ensure staff understood the critical polices and safety aspects, for example of the building itself. There was a three month induction programme that covered issues such as the practices' goals, vision and ethos and the new staff's longer term needs such as training.

We reviewed four staff files. Staff development was addressed, for example there was a training needs assessment for individuals. Staff were up to date with their continuing professional development requirements (CPD). They were encouraged to maintain their CPD and their skill levels. There was an effective appraisal system which was used to identify training and development needs as well as personal objectives. Staff said that they had found the appraisal process to be useful and motivational.

Working with other services

The practice specialised in cosmetic dentistry and referrals to other providers were made when appropriate. When a referral was necessary, the type of care and treatment required was explained to the patient and they were given a choice of other healthcare professionals who could provide that service. The practice contacted the other provider by telephone to check that the referral was appropriate and could be undertaken by the other provider. Once this was agreed the practice confirmed the arrangement with an e-mail setting out the full details of the consultation and the type of treatment required. When the patient had received their treatment they were discharged back to the practice.

The system worked well but there was no formal process of following up referrals to ensure that the patient had been seen within the expected timeframe.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment. When patients needed treatment a treatment plan was developed. The plan included photographs of the work that needed to be carried out as well as the options, risks, benefits and costs. The plan was printed and checked by the person who was to carry out the work before being shared and discussed with the patient. Patients were given time to make informed decisions about the treatment they chose to receive..

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and

Are services effective?

(for example, treatment is effective)

make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice had not been involved in any such decision making. The lead dentist had received specific training in the provisions of the Act. Other staff had undertaken e-learning which allowed them to understand when the provisions of the Act might apply and draw this to the attention of the lead dentist.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. All the patients we spoke with told us they were satisfied with the care provided by the practice. We listened to staff taking calls from and speaking with patients. They were considerate and attentive to patients' needs.

We saw that all consultations and treatments were carried out in the privacy of treatment rooms. Treatment rooms were private so that patients' privacy and dignity was maintained during any examination or treatment. We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff in the reception area were careful to ensure that any conversation they had with patients, for example on the telephone, could not be heard by patients waiting to be seen in person.

The practice had documents that guided staff in order to keep patients' private information confidential for example, the data protection policy and the information governance policy. All staff had signed a confidentiality agreement which was retained in their staff file. The practice obtained written permission from patients to share information about them with others. Patients' records were in electronic and paper form. Records that contained confidential information were held in a secure way so that only authorised staff could access them.

Involvement in decisions about care and treatment

Patients we spoke with told us that health issues and medication were discussed with them and they felt involved in decision making about the care and treatment they received. A theme running through all the feedback we received from patients was that there was always enough time to discuss treatments in depth with the dentist or dental therapist. They also told us they felt listened to and supported by staff.

Patients were provided with written treatment plans that explained the treatment required and outlined any costs patients were required to pay. The plans were accompanied by photographs showing the treatment needed. There were also photographs and video recordings from other patients, who had had similar procedures, setting what that treatment had achieved in their case. Staff told us that they rarely carried out treatment the same day unless it was considered urgent. This allowed patients time to consider the treatments available and make an informed choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice delivered personalised care to patients that took into account their individual needs. Each morning there was a staff meeting where the needs of each patient discussed and arrangements made to meet them. For example ensuring that where patients went from the dental consultation directly to the dental hygienist the appointments system was set up to facilitate this.

When patients were particularly anxious about receiving dental care, the practice offered an afternoon where patients could come and meet the practice. There was no treatment or examination planned. Patients were simply offered the opportunity to meet members of staff so that they could reassure themselves and become familiar with the surroundings.

Staff told us that the practice always scheduled enough time to assess and undertake patients' care and treatment needs. Staff said they did not feel under pressure to complete procedures and had enough time available to prepare for each patient. This was corroborated by patients who consistently commented how much time was afforded them for consultations.

Tackling inequity and promoting equality

The premises were on the first floor and had not been designed to meet the needs of patients with mobility issues or patients with prams and pushchairs. Staff told us that they would refer such patients to other nearby practices and had a list that patients could choose from.

Staff were knowledgeable about how to book interpreter services for patients whose first language was not english though they said that this was very rarely required.. The practice provided Mental Capacity Act 2005 training. Staff we spoke with and records confirmed this.

Access to the service

Appointment times and availability met the needs of patients. The practice was open on Monday 8am to 7pm, Tuesday 8am to 4pm, Wednesday and Thursday 8am to 5pm and Fridays and Saturdays 8am to 1pm. Patients with emergencies were assessed and seen the same day if treatment was urgent. Patients could contact the practice at any time in an emergency using a designated mobile phone number where they could receive advice and guidance if required.

Patients we spoke with said that they could always get an appointment at a suitable time. There were extended appointments for patients with additional needs. Patients were able to get appointments at short notice when this was needed.

Concerns & complaints

There was a complaints policy which guided staff through the handling of formal and informal complaints from patients. There was information for patients about how to make a complaint in the practice. Timescales for dealing with complaints were clearly stated and details of the staff responsible for investigating complaints were given.

The practice had received two complaints in the last 12 months. We looked at both in detail. We saw that the complaints were thoroughly investigated. The complainant received a response to their complaint and this included an apology if it was appropriate. The practice learned from the complaints it received and implemented appropriate changes for example, one complaint had centred on the use of a particular phrase by one of the staff. At a subsequent practice meeting there was learning about the use of words and how people can interpret them in certain ways.

Are services well-led?

Our findings

Governance arrangements

Staff members told us they felt supported by the practice manager and principal dentist and were clear about their roles and responsibilities. There were documents that set out the practice's governance strategy and guided staff, for example safeguarding, recruitment and confidentiality policies. The practice used a proprietary software system to measure their performance against various standards. For example they used this tool to prioritise the system for reviewing policies and other activities.

There was a leadership structure with named members of staff in lead roles. For example, a dental nurse had lead responsibilities for infection control. The practice manager was responsible for the day to day running of the practice with oversight from the lead dentist. There was a business manager who had certain objectives and these were reviewed with the lead dentist quarterly. The practice had an ethos of caring for and respecting patients. Several staff members told us this meant ensuring that patients did not receive treatment that they did not want or did not need.

The practice had carried out a number of audits, for example there had been an audit of clinical record keeping. This had showed that the practice was compliant with the required minimum standards. However there had been no audit report and action plan or follow up audit to complete the audit cycle which would demonstrate learning and improvement within the practice.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, a fire risk assessments, control of substances hazardous to health and legionella (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Leadership, openness and transparency

The practice manager and business managers were visible in the practice and staff told us that they were always approachable and always took time to listen to all members of staff. Staff told us they felt well supported by colleagues and management at the practice. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs.

All staff were involved in discussions about how to run and develop the practice. There was a staff meeting each week to involve them in the running of the practice. Staff said that they valued these meetings and were able to provide evidence of beneficial changes that had come from suggestions made at the meetings. For example, the means of recalling patients, whether by e-mail or text and duration between recalls was agreed at the meetings. The practice had also installed an intercom system, so that dentists and nurses could call other staff to assist them, as result of discussions at these meetings.

Management lead through learning and improvement

The practice valued learning. There was a culture of openness to reporting and learning from incidents. All staff were supported to update and develop their knowledge and skills. Records showed that staff training took place during some staff meetings, for example, how to use emergency equipment and the management of medical emergencies.

Staff members we spoke with had had annual appraisals and valued the process. We saw that learning needs had been identified during the process and steps taken to book training for staff. Other staff had joined more recently and had not had formal appraisals, however they had had discussions about their goals and the practice's ethos with managers.

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

The practice took into account the views of patients and those close to them via feedback from patient surveys, as well as comments and complaints received when planning and delivering services. We saw that the practice reacted positively to feedback and where this identified training or other learning acted upon this, for example in providing communication training.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would always feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt very involved and engaged in the practice to improve outcomes for both patients and staff.