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Kew Road Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 July 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.

The inspection took place over one day and was undertaken by a Care Quality Commission (CQC) inspector and dental specialist adviser. We spoke with staff and reviewed policies and procedures and dental care records. Seven patients gave us feedback about the service.

Kew Road Dental is situated on Kew Road and located in the London Borough of Richmond. The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including dental hygiene, inlays and dental implants.

The practice opening times are as follows: Monday 9am-6pm; Tuesday 9am-7pm; Wednesday 9am-6pm; Thursday 9am-7pm; Friday 9am-3pm; Saturday 10am-2pm; Sunday closed.

Facilities within the practice include one treatment room, a dedicated decontamination room, and a reception area. There are a further two rooms in the practice that are not currently being used. The principal dentist told us that they were in the process of being developed into treatment rooms as part of the practice's renovation plans.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), a trainee dental nurse and a receptionist.

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 that provided feedback said 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:

- Maintain accurate, complete and detailed records relating to employment of staff. This includes keeping appropriate records of references taken.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.

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 the 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 control and maintenance of equipment used at the practice. The practice assessed risks to patients and managed these well. In the event of an incident or accident occurring, the practice documented, investigated and learnt from it. The practice followed procedures for the safe recruitment of staff, this included carrying out Disclosure and Barring Service (DBS) checks, and obtaining references.

Are services effective?
We found that the 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 wisdom tooth removal 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.

Staff were supported by the practice in maintaining their continuous professional development (CPD) and were meeting the requirements of their professional registration. Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

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

Feedback was very positive about the service provided by the practice. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality. Staff told us that treatments, risks and benefits were discussed with each patient to ensure the patients understood what treatment was available so they were able to make an informed choice.

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 appointments and emergency appointments were scheduled in for each day. 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 had a suggestion box located in the practice reception area.

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

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

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Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on10 July 2015. This inspection was carried out by a CQC Inspector and a specialist advisor.

We received feedback about the service from seven patients. We also spoke with three 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. Staff were able to describe the types of incidents that would be recorded and logged in the incident logging process. There had been no incidents 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. The practice had not had any 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 that covered adult and children's safeguarding. The policy was dated April 2015 and was scheduled to be reviewed in April 2016. The policy included procedures for reporting safeguarding concerns and contact information for the local safeguarding teams. Staff we spoke with had completed safeguarding training and were able to explain their understanding of safeguarding issues. The practice had not had any situations which needed to be referred for consideration by safeguarding teams.

The practice had safety systems in place to help ensure the safety of staff and patients. For example they had infection control, and health and safety policies, COSHH procedures and had carried out risk assessments. Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service.

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. Dental care records contained patient's medical history that was obtained when people first registered with the practice and was updated at regular intervals. The dental care records we saw were well structured and contained sufficient detail enabling another dentist to know how to safely treat a patient. For example, they contained details of soft tissue checks.

The practice followed national guidelines such as use of 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 most of the recommended medicines but did not contain adrenaline injections. The provider told us they would order the adrenaline injection for the kit. 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. However we found they did not have an automated external defibrillator (AED), in line with Resuscitation Council UK guidance. [An AED is a portable electronic device that analyses the heart's rhythm and if necessary, delivers an electric shock, known as defibrillation, which helps the heart re-establish an effective 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) checks. We saw that the provider had carried out checks for staff who worked in the practice. However, we found that the practice did not always maintain accurate, complete and detailed records relating to employment of staff. For example the principal dentist told us that on occasion a verbal reference was obtained for a member of staff but this was not recorded.

Monitoring health & safety and responding to risk

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 continually being updated and reviewed to ensure the safety of patients and staff members. This included risk assessments for building environment, fire, legionella,

Are services safe?

manual handling and risk from the use of equipment. The assessments identified risks and actions the practice should take to mitigate risks. For example a May 2015 manual handling risk assessment recommended that the practice staff receive manual handling training and this had been acted upon.

However, the practice did not have a comprehensive business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service.

Infection control

The principal dentist was the infection control lead. The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. The policy had been drafted in April 2015 and was scheduled for review in April 2016. The policy detailed procedures related to decontamination, handling clinical waste management and personal protective equipment. In addition there was a copy available for staff of the Department of Health guidance document, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'

There was a separate room for the decontamination of instruments. The room had a clearly labelled 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 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 records of the daily, weekly and monthly checks that were carried out on the autoclave to ensure it was working effectively. All records we saw showed that it was in working order.

We saw evidence that staff had been vaccinated against Hepatitis B to protect patients from the risks of contracting the infection. The practice had blood spillage and mercury spillage kits. There was a contract in place for the safe disposal of clinical waste and sharps instruments. Clinical waste was stored away from public access and collected on a regular basis.

The surgery was visibly clean and tidy. There were stocks of PPE (personal protective equipment) for both staff and patients such as gloves and aprons. We saw that staff wore appropriate PPE, and the nurse carried out regular checks on this. Hand washing solution was available.

A legionella risk assessment had been completed in April 2014 and the results were negative for bacterium [legionella is a bacterium that can grow in contaminated water]. The practice used distilled water in all dental lines. The water lines were flushed daily and weekly and alpron tablets were used once a week to purify the water.

There was a cleaning plan, schedule and checklist, which we saw were completed. Cleaning equipment and materials were stored appropriately in line with Control of Substances Hazardous to Health (COSHH) Regulations 2002. COSHH is the law that requires employers to control substances that are hazardous to health.

Equipment and medicines

We found that 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 the 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.

The practice had clear guidance regarding the prescribing, recording, dispensing, use and stock control of the medicines used in the practice. The systems we reviewed were complete, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as recorded. Medicines were stored appropriately with batch numbers and expiry dates recorded. All prescriptions and the prescription log were stored securely. Local anaesthetic is also a medicine and was stored appropriately.

Radiography (X-rays)

The practice maintained suitable records in the radiation protection file demonstrating the maintenance of the x-ray equipment. The principal dentist was the radiation protection supervisor (RPS) for the practice. An external contractor covered the role of radiation protection adviser. Detailed X-ray audits were undertaken at least on an annual basis, the last audit was undertaken in November

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2014. The audits looked at issues such as the maintenance of X-ray equipment, quality of images and the radiography training staff had undertaken. This was done to ensure X-rays that were taken were of the required standard. We saw that the practice had local rules relating to the X-ray machine**.** The rules had not specified that the principal dentist was the radiation supervisor; staff told us that this information would be added to the rules and they would be re-printed. We saw there were CPD records related to dental radiography for all staff that undertook radiography tasks. This included Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000training.

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 guidance. 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 also showed compliance with 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.

We reviewed ten medical records and saw evidence of comprehensive detailed assessments that were individualised. This included having an up to date medical history (which was reviewed regularly), details of the reason for visit, medical alert flashes, discussions on options 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 questions about smoking and alcohol intake. Appropriate advice was provided by staff to patients based on their medical histories. However we found that the practice was not contributing to the dental preventive agenda by providing diet, smoking cessation and oral health advice. The principal dentist told us this was something they would do in the future.

Staffing

Staff told us they had received appropriate professional development and training and 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 practices. This was to ensure that patients received high quality care as a result. The practice used a variety of ways to ensure development and learning was undertaken including both external and in-house training. Examples of staff training included core issues such as health and safety, fire safety, safeguarding, medical emergencies and infection control. Staff that were involved in radiography had completed IR (ME) R 2000 training. We reviewed the system in place for recording training attended by staff working within the practice. We saw that the practice maintained a matrix that detailed training undertaken and highlighted training that staff needed to undertake. We also reviewed information about continuous 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 hospitals' specialist dental services for further investigations and treatment; this included urgent two week referrals for mouth cancer. The practice completed referral forms or letters to ensure others service had all the relevant information required. 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 received feedback from seven patients. The practice had a consent policy dated April 2015. The patient feedback we received showed patients were clear about 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 reviewed dental care records and noted signed consent forms for treatment and details of treatment options patients had been given. Staff had received Mental Capacity Act 2005 (MCA) training and understood the practice consent policy. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff 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 received feedback from seven patients. All the feedback we received was positive. Staff were described as reassuring, welcoming and helpful. Patients said staff treated them with dignity and respect during consultations. All the patients who responded to the patient survey we saw said that they felt staff at the practice were friendly and approachable.

We observed interaction with patients and saw that staff interacted well with patient speaking to them in a respectful and considerate manner. The practice phone was located and managed at the reception desk. The practice staff told us if patients wanted to discuss something in private they could take them to another room. Patients manual records were kept in a lockable cupboard only accessible to staff. Electronic records were password protected. There was a confidentiality policy dated April 2015. Staff we spoke with understood the importance of confidentiality and keeping patients' data secure and private.

Involvement in decisions about care and treatment

We saw that the practice had a website that included information about dental care and treatments, costs and opening times. The reception area contained information leaflets about the types of treatment available at the practice. Patients who provided feedback told us they were satisfied with the information they had been provided in regards to their dental care and the treatment choices. They told us the dentist explained the findings from investigations and they felt involved in their treatment. Patients told us they were given time to make an informed choice.

Staff told us that treatments, risks and benefits were discussed with each patient to ensure the patients understood what treatment was available so they were able to make an informed choice. The principal dentist told us they would explain the planned procedures to patients and used aids to show patients visually what their teeth/ oral cavity required. Patients feedback confirmed what staff had told us. Patients said they were always involved in decisions about their treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see a dentist. The feedback we received from patients confirmed that they felt 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. We saw that patients were given double appointments when it was deemed necessary

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services that included access to telephone translation services. The building was accessible to people in wheelchair via a temporary ramp used by the practice. The receptionist spoke two languages that reflected the community where the practice was based.

Access to the service

The practice displayed its opening hours were displayed on the practice website. The practice had clear instructions for patients requiring urgent dental care when the practice was closed. These instructions were on the telephone answering machine, as well as being on their website. Patients we received feedback from told us they had good access to the service.

Concerns & complaints

The practice had effective arrangements in place for handling complaints and concerns. The practice had a complaints policy and information for patients about how to complain was available in the reception area. The policy was scheduled to be reviewed in 2016. The policy included contact details of external organisations that patients could contact if they were not satisfied with the provider's response to a complaint. This included the General Dental Council and The Patient Advice and Liaison Service (PALS**).** There had been no complaints in the last twelve months.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements and an effective management structure. Appropriate policies and procedures were in place, and there was effective monitoring of various aspects of care delivery. The practice had arrangements for identifying, recording and managing risks. The practice had regular meetings involving all staff. Staff told us these meetings were used as an opportunity to share useful information. However, we found that minutes of these meetings were not taken.

The principal dentist undertook quality audits at the practice. This included audits on health and safety, x-rays, manual handling and records. We saw that action plans had been drafted following audits and actions taken as necessary. For example a 2015 infection control audit had identified the need to increase the number of hand dispensers at the practice and this had been acted upon.

Leadership, openness and transparency

Staff we spoke with said the vision of the practice was shared with them. Staff said they felt the leadership of the surgery was open and created an atmosphere where all staff felt included. They described the culture encouraged candour, openness and honesty. We saw that staff had appraisals at least once a year. This gave staff the opportunity to discuss their development and training needs with the principal dentist.

Management lead through learning and improvement

Staff told us they had good access to training. The principal dentist monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuous 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 dental care records and X-rays, and audits of infection control and radiography.

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

There was a suggestion box in reception with comment cards for patients to complete. The practice website contained a feedback form for patients to provide feedback on the service. The website contained testimonials from patients who had commented on the service they received from the practice. There were no formal methods for staff to give feedback on the service provided but staff told us they could go directly to the principal dentist with any ideas or feedback they had.