Duston Dental Practice

St Crispin's Dental Practice

Inspection Report

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Date of inspection visit: 3 February 2016
Date of publication: 16/03/2016

Overall summary

We carried out an announced comprehensive inspection on 3 February 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.

Are services effective?

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

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

St Crispin's Dental Practice is a general dental practice that was opened in 2011 in the newly developed area of Northampton called St Crispin's. It is situated in a converted stable block, and is a single story practice.

The practice has three treatment rooms and offers NHS and private general dental treatment to adults and children.

The practice is part of a group of two dental practices located within two miles of each other, and has a principal dentist on site, although the registered manager works predominantly at the sister practice to this one.

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.

Prior to the inspection we left Care Quality Commission comment cards and asked patients for feedback on the service. In addition we spoke to patients on the day of our visit. In total 27 people provided feedback about the service.

The feedback we received was entirely positive with patients commenting on the friendliness and helpfulness of the staff.

Summary of findings

Our key findings were:

- Patients commented that the service was prompt and efficient, and staff were professional and polite.
- Essential standards in decontamination as outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health were exceeded.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice had monthly team meetings to discuss the running of the practice, any complaints and learning opportunities.
- Governance arrangements were in place for the smooth running for the practice, including the use of clinical audit to highlight areas that could be improved.
- Staff recruitment checks had been carried out in accordance with schedule three of the Health and Social Care Act 2008. Disclosure and barring service checks had been carried out on all staff to ensure the practice employed fit and proper persons.
- Staff demonstrated a good knowledge of how to raise a safeguarding concern, and the situation in which that may be required.

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

- 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.
- Consider the use of patient information leaflets to aid the process of consent and oral health promotion.
- Consider improved access for the staff to the governance information for this practice.
- Review the practice's protocols for signing, dating and logging the location of sharps bins.

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 exceeded the essential standards in infection control as outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health

Staff demonstrated a thorough knowledge of the situations where they might raise a safeguarding concern for a child or vulnerable adult, and how they would achieve this.

The practice had emergency medicines and equipment for managing medical emergencies in line with the current guidelines with the exception of a full range of sizes of oro-pharyngeal airways (these would depress the tongue and help maintain the airway in an unconscious or semi-conscious patient). Following the inspection these were immediately ordered.

Are services effective?

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

Clinicians used oral screening tools to identify dental disease, and kept accurate and detailed dental care records.

Staff had a good understanding of the Mental Capacity Act 2005, and it's relevance in obtaining full and valid consent for a patient who lacks the capacity to consent for themselves.

The practice had a robust system in place for ensuring that urgent referrals were received by the hospital in a timely manner.

Are services caring?

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

Patients commented that staff were friendly, helpful, polite, professional and always treated patients with dignity and respect.

Staff understood their responsibilities towards the confidentiality of the patient and were able to explain the ways in which patients' personal information is kept private.

Are services responsive to people's needs?

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

The practice offered both early morning and late evening appointments to give flexibility to those patients who may have commitments during normal working hours.

The practice had reconsidered the way in which emergency appointments were scheduled in response to comments from patients. They now operated a successful 'sit and wait' clinic at the end of every morning which they have found has met their patients' needs.

Are services well-led?

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

The practice had polices in place to ensure the smooth running of the service, these were up to date and tailored to the service to ensure their effectiveness.

Summary of findings

Feedback was sought from patients via various pathways, and analysed to look for ways to improve the service.

Clinical audits were employed to highlight areas clinically which could be improved.

St Crispin's Dental Practice

Detailed findings

Background to this inspection

The inspection was carried out on 3 February 2016 by a CQC inspector and a dental specialist advisor.

We requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice principal, the practice manager, assistant practice manager, and two dental nurses. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service, and spoke with patients.

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 robust system in place to reporting, investigating and learning from significant incidents. A policy was accessible in the office that detailed the process for reporting significant incidents, this involved filling in a template which demonstrated that appropriate investigation had been carried out and what could be done to prevent reoccurrence. Learning from these incidents was fed back through the practice meetings so that all staff would benefit.

The practice had a duty of candour policy. This detailed the practice's expectation that staff would deal with the patients in an open and honest way, and that apologies should be issued to patients in a timely way, if appropriate.

The practice received communication form the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the practice manager would disseminate relevant alerts to the staff at the next practice meeting, if there was one soon, or by e-mail for more urgent communications.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager informed us of how they would make such a report, and this was outlined in the practice policy.

Reliable safety systems and processes (including safeguarding)

The practice had systems and policies in place regarding child protection and safeguarding vulnerable adults. Policies were readily available in the staff room with detailed the signs of abuse as well as steps to take should staff suspect abuse. A flow chart detailing how a concern could be raised was displayed on the staff noticeboard, as well as useful contact numbers.

Staff we spoke with had a good understanding of the situations that may precipitate them raising a concern, and how they would go about this. All staff had undertaken safeguarding training appropriate to their role.

The practice had an up to date employers' liability insurance certificate which was due for renewal on 30 June 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Most dentists routinely used rubber dam when carrying out root canal treatment. Rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. Where rubber dam could not be used steps were taken to mitigate the risk.

Medical emergencies

The practice carried medicines for use in a medical emergency in line with the recommendations of the British National Formulary. These were kept in a central and secure location and staff with spoke with were clear on how to access them, and what medication would be required for a range of specific medical emergencies.

The Resuscitation Council UK lists medical equipment that all practices should carry for use in the event of a medical emergency. This included an automated external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The battery and pads were checked regularly to ensure that this would function correctly if required. Records were seen pertaining to these checks.

In addition the emergency kit did not have a full range of sizes of oro-pharyngeal airways (these are plastic tubes in different sizes that can be placed in the mouth of an unconscious or semi-conscious patient to depress the tongue and help keep their airway open). A range of sizes is necessary to effectively keep the airway open. Following the inspection we received information that these had been ordered.

The practice staff underwent six monthly medical emergencies training including basic life support

Staff recruitment

The practice had a staff recruitment policy in place which detailed the pre-employment checks that would be carried out prior to a staff member joining the service. The Health and Social Care Act 2008 (Regulated Activities) Regulations

Are services safe?

2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had a policy to carry out DBS checks on all staff members. DBS checks and all other pre-employment checks were in place for the three members of staff whose staff recruitment files we looked at.

Monitoring health & safety and responding to risks

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place which had been reviewed on 16 November 2015. This policy formed part of the initial induction training of the practice.

A fire risk assessment had been carried out on 23 November 2015. This was underpinned by a fire management policy and all staff had undertaken fire training. Staff we spoke with had a good understanding of their role in an evacuation of the building and were able to point out the muster point.

The practice had carried out a sharps risk assessment which had been reviewed in October 2015. This detailed the systems in place to reduce the risk of sharps injury to staff. This involved the dentists being responsible for disposing of sharps at the point of use. Needle guards were available for dentists to mitigate the risk further. There had been a recent incident of sharps injury, in dealing with this the practice were able to demonstrate effective use of their policy in action.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' This publication by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which had been reviewed in November 2015. This outlined the decontamination process (Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again), hand hygiene, protocols regarding the dental unit water lines and disinfecting impressions.

The practice had a separate decontamination facility and we observed a nurse carrying out the decontaminating process. The practice used a washer disinfector to clean the instruments, which were then inspected under an illuminated magnifier. If visibly free from debris or defect they would then pass through a cycle of the autoclave to sterilise the instruments.

Following sterilisation the instruments were pouched in the designated 'clean' area and dated with the date upon which the sterilisation would become ineffective.

We saw records of checks made to the autoclave and washer disinfector to ensure their effectiveness. Although staff could describe a weekly check they carried out on the washer disinfector to ensure the effective removal of protein contaminants they were not making a specific log of the result. Immediately following the inspection this was implemented.

Sharps bins were appropriately located and not overfilled, however the date they were first in use and location were not written on them This information would be crucial if a trace ever had to be made on the contaminated sharps within the bin. Following discussion with the practice manager this was immediately implemented.

All clinical staff had documented immunity against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A risk assessment had been carried out by an external assessor on 11 January 2016. This had highlighted

actions to reduce the risk of Legionella contamination. We observed that these actions had been implemented by the practice. In addition the practice carried out appropriate flushing and disinfecting of the dental unit water lines in line with the practice policy on the same.

Environmental cleaning was carried out by an external contractor. There were schedules of cleaning in place for the company, and audits were carried out by the company to assure quality. However although the cleaners were making records of what had been cleaned for their company, the practice did not have oversight of this. We discussed this with the practice manager who made arrangements for the completed schedules to be copied to her.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out the full range of dental procedures that they offered.

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Pressure vessel testing had been carried out on the autoclaves and compressor within the last year to ensure they functioned safely.

Glucagon is an emergency medicine which is given to diabetics in the event of a hypoglycaemic attack (low blood sugar). It needs to be stored within two to eight degrees Celsius in order to be valid until the expiry date. We found that the medicine was not kept in the fridge, but with the other emergency medicines. The expiry date had been appropriately amended to account for its being kept at room temperature.

Prescription pads were kept securely, and issued to dentists one at a time.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice used exclusively digital X-rays which meant that images were able to be viewed almost instantaneously, as well as providing a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which detailed the responsible people involved in taking X-rays as well as appropriate testing and servicing of each X-ray machine.

Dental care records demonstrated that clinicians were reporting the justification for taking an X-ray as well as logging the quality of the X-ray taken and what the image showed.

In this way the effective dose of radiation to the patient was kept as low as reasonably possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with three dentists and we were shown patient care records to illustrate our discussions**.**

Comprehensive medical history forms were given to patients to sign at every new appointment, and checked verbally at every visit to the practice. In this way the practice was kept abreast of changes to patients' medical histories that could affect their treatment.

Records showed assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums. Higher figures would trigger further investigation, referral to a dental hygienist, or to an external specialist.

Dentists demonstrated a thorough understanding of the national guidelines available to aid diagnosis and treatment. This included the National Institute of Health and Care Excellence (NICE) guidelines pertaining to wisdom teeth extractions, recall intervals and antibiotic prescribing for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it). Also the Faculty of General Dental Practitioners guidance on when X-rays were required and necessary. We found that this guidance was mostly being followed by the dentists.

It was demonstrated through dental care records we were shown that dentists were keeping accurate and detailed records of the discussions and treatment carried out.

Health promotion & prevention

Medical history forms that patients were asked to fill in included information on alcohol and nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease. However the practice did not have oral health leaflets that would offer an opportunity for the patient to take the information home and revisit the advice given.

The practice employed a dental nurse who was trained as an oral health educator. In this role she was able to talk to patients individually about their oral health needs as well as giving smoking advice.

We found a good application of guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice demonstrated appropriate staffing levels, and skill mix to deliver the treatments offered to the patients.They utilised the skills of their extended duties dental nurse in delivering oral health instruction to patients.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Referrals for suspect oral lesions would be made to the hospital via a pre formatted template that could be e-mailed securely, and backed up by a phone call to the hospital to ensure the referral had arrived. In this way the practice could be assured of the timeliness of a referral if urgent.

Consent to care and treatment

The dentists we spoke with were able to describe to us how full valid, and informed consent was achieved through a process of discussion, listening, detailing options and the risks and benefits of each. Dental care records verified these comprehensive conversations. The practice did not however, have a range of treatment specific patient information leaflets, which would be helpful in the consent process.

Are services effective?

(for example, treatment is effective)

Patients were asked to sign their written treatment plan to confirm their consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent, understanding that capacity should be assumed even if the patient has a condition which may affect their mental capacity, and when it may be necessary to make decisions in a patient's best interests.

Staff we spoke with had a good understanding of the situation which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence and relies on the assessment of a child's understanding of the procedure and the consequences of having/not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed patients being treated in a friendly and kind manner. Feedback we received from patients commented how the staff were able to put at ease nervous patients, and were caring and helpful.

Staff we spoke with explained how confidentiality was maintained in the practice. The reception area was set away from the waiting room. There was also a radio playing in the waiting room, this ensured that a patient at the desk would not be overheard by patients in the waiting room.

In addition the computer screens were located below the level of the counter top, thereby obscuring them from the view of patients at the desk. Dental care records were computerised and password controlled, and the computers would log off automatically if left idle.

Confidentiality was underpinned by a data protection and information governance policy which were available for staff to reference in hard copy in the policies file.

Involvement in decisions about care and treatment

Patients that we spoke with felt fully involved in decisions about their treatment. Dental care records shown to us gave a detailed description of discussions held between the clinician and patients regarding the treatments options available to them, risks and benefits.

Costs were discussed with patients before treatment started, and NHS and private price lists were displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We examined the appointments book and found that adequate time had been allocated per patient for discussion and treatment. We received feedback from patients that appointments always ran on time.

We discussed the arrangements for patients with a dental emergency. In response to feedback from patients that had indicated a difficulty in getting a prompt appointment in the event of an emergency. The practice had implemented a triage traffic light system to prioritise patients in pain, and offered a 'sit and wait' appointment to those patients whose need was not so great.

The practice put aside an hour daily for emergency patients so that all patients in pain could be seen on the day if they called in the morning. Patients with urgent needs were fitted in at any time.

The practice offered late evening opening (until 7 pm) twice a week, and early morning appointments (from 7.45 am) Monday to Friday. This offered flexibility for patients who may have commitments during normal working hours.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs. This was underpinned by an equality and diversity policy which was dated 12 November 2015.

We discussed with staff how they could assist patients for whom English was not their first language or had other communication difficulties. They explained how extra appointment time could be allocated, in order to allow the clinician time to explain things, draw diagrams and be sure that the patient understands.

Access to the service

The practice was on ground level, and had been designed internally to have good disabled access. In addition to which two of the treatment rooms had double doors that could be opened out to increase access to extra-wide wheelchairs or mobility scooters. Staff we spoke with described how they would respond to the individual needs of their patients in this regard.

Out of hours arrangements had been put into place so that patients could access dental care at any time. There was a local practice that offered a service to 8pm every week night, which patients could access outside practice hours. After this time patients were directed to contact the NHS 111 service.

The practice was shut on a Friday afternoon, and at this time one of the dentists from this, or its sister practice would be available on the phone to speak to patients and arrange to see them if necessary.

Concerns & complaints

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

We saw that apologies were issued to the patient in a timely manner if appropriate, and complaints were regularly discussed at the monthly team meetings.

Information for patients on how to make a complaint to the service was displayed in the waiting area. This document also indicated how to take a complaint further should they not receive a satisfactory response from the practice.

Are services well-led?

Our findings

Governance arrangements

The practice had a principal dentist who worked solely in this practice. A practice manager who spent time at this practice and its sister practice and an assistant practice manager who was based at this practice. Clear lines of responsibility and accountability were evident. In addition the management team had delegated lead roles to other staff in the practice such as infection control lead. However the designated cross infection leads did not routinely work at this practice. Following discussion with the practice manager a cross infection lead for this practice has been appointed.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance and whistleblowing. These had all been reviewed within the last year.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice including sharps and fire safety.

Most of the records to support the management of the service were held at the provider's other site. Although there was a folder of some of the policies on this site, staff may have benefitted from access to other governance information such as servicing arrangements. We discussed this with the practice manager who will review their policy in this regard.

The practice had monthly team meetings where discussions were held on training, complaints and significant events. These were held at the sister practice and representatives for this practice attended and they fed back informally to the remainder of the team. In addition the minutes of these meetings were e-mailed to all staff following the meeting, and we saw copies of the minutes were displayed on the staff noticeboard for reference.

Group learning such as basic life support was carried out at the sister practice with the whole team.

Leadership, openness and transparency

Staff reported an open and honest environment where the opinions of all staff were taken into account. This was underpinned by the practice's policy on candour which highlighted the practice's expectation of honesty.

Staff we spoke with expressed that they felt comfortable approaching any member of the management team either formally or informally.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. This was available for all staff to reference in the policy folder.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audits were used to identify areas that could improve and highlight how those improvements could be made. We saw recent audits in cross infection control and radiography, although we found that the infection control audit had been completed for the two sites in one overarching audit.

This did not allow for the different set ups between the practices and would not allow for specific actions to be highlighted for the individual services. Following our inspection an infection control audit was carried out specifically for this practice, and actions highlighted to further improve the clinical quality in this area.

A clinician specific record keeping audit was carried out in November 2014. This had highlighted areas for each clinician to improve the detail and quality of their dental care records.

In addition to this the practice treatment rooms were subjected to unannounced spot checks to confirm that standards were being met. These were completed on a template and fed back to the clinicians involved.

Staff felt supported in their roles and commented on the ready availability of training to further their careers. The practice subscribed to online training systems on behalf of all of the staff. Staff underwent regular appraisals in order to identify their training needs and wishes, as a result of these a personal development plan was drawn up, which could be followed.

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

Are services well-led?

The practice sought to obtain feedback from patients from several pathways. They had the NHS friends and family test cards for patients to fill in. In addition the practice would regularly check for new feedback via the NHS choices website, and online search engine reviews. They have a link to a feedback questionnaire that is attached to all e-mails that the practice sends out. We saw evidence that feedback was analysed and fed back to staff, and we were given examples of situations where patient feedback has elicited a change with in the practice.

Staff feedback is welcomed formally, through practice meetings, or informally across this close knit team.