Basudev Enterprise Limited

Bedford Dental Practice

Inspection report

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Overall summary

This inspection took place on 3 February 2015 as part of our national programme of comprehensive inspections.

Bedford Dental Service is owned by Basudev Enterprises Limited and provides mainly NHS primary dental care and a small amount of private dentistry to patients in Bedford and surrounding villages. There are four associate dentists supported by two dental hygienists and six dental nurses. The practice opens Monday to Fridays plus Saturday mornings with evening appointments available four days a week. The provider who is the CQC registered manager, Dr Basudev, is referred to throughout this report as the principal dentist. A registered manager is a person who is registered with the Care Quality Commission to manage the service. They 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 our inspection we provided some CQC comment cards for patients to complete about their experience of the practice. A total of 12 comments cards were received and we found that patients had made positive comments about the practice and were very satisfied with the care and treatment they received from the staff. Patients said dentists took time to explain their dental needs to them and treated them with compassion and professionalism. We spoke with five patients on the day of the inspection who also said that staff were respectful and helpful.

Our key findings were:

- There were systems to identify, investigate and analyse patient safety incidents and share learning throughout the team. X-ray equipment at the practice had been serviced, maintained correctly and was only operated by qualified staff. Other items of equipment were serviced and maintained regularly. Staff recruitment procedures were effective.
- The dental care and treatment provided to patients followed current guidelines. Patients were given appropriate information to support decisions about their treatment and oral health. The practice kept detailed clinical records of assessments and treatments plans. There were systems in place to refer patients for specialist treatment and share information appropriately between dental practices. Staff were supported in their continuing professional development (CPD) and were meeting the requirements of their professional registration.
- Patients we spoke with or who completed CQC comments cards told us they had very positive experiences of dental care provided at the practice. Patients had confidence in the staff, were involved in treatment decisions and were treated with kindness and respect.
- A range of dental services were available to NHS patients and a small number of private patients.

Summary of findings

Patients (including those with a disability) had access to treatment including urgent and emergency care when they required it. There was an accessible complaints system in place.

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

- Ensure there is an effective system in place to review the risk assessments at appropriate intervals.
- Infection control systems should be strengthened by reviewing cleaning procedures and infection control policies to ensure they are fit for purpose. Checks completed on all the autoclave machines each day should be recorded to demonstrate that these items are functioning safely.
- Ensure that all policies and procedures within the practice are accessible to staff and fit for purpose.
- Establish systems to ensure that staff are kept informed and involved in service developments and quality improvements.
- Review the opportunities available to all patients to feedback their experience of using the service so that it can be used in a constructive way to benefit the service.
- Review the leadership structure so that the roles and responsibilities of staff are clearly defined and shared within the team.
- Improve safety and security of storage for clinical waste and sharps boxes.

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?

There were systems to identify, investigate and analyse patient safety incidents and share learning. Improvements were required to strengthen cleaning procedures and to ensure that infection prevention and control procedures were relevant and fit for purpose. Decontamination of dental instruments was completed in accordance with guidelines although we saw that clean and dirty zones were compromised because a hand wash sink had been removed. X-ray equipment at the practice had been serviced, maintained correctly and was only operated by qualified staff. Other items of equipment were serviced and maintained regularly. Staff recruitment procedures were effective.

Are services effective?

The dental care and treatment provided to patients followed current guidelines. Patients were given appropriate information to support them to make decisions about the treatment they received and to promote their oral health. The practice kept detailed clinical records of assessments and treatments carried out and monitored any changes in the patient's oral health. The practice had systems in place to refer patients for specialist treatment in a timely manner and that essential information was shared between dental practices.

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

Are services caring?

Patients told us they had very positive experiences of dental care provided at the practice. For example a relative who was supporting a patient with a long-term condition, told us staff put them at ease. Patients had confidence in the staff providing their treatment and told us they were involved in treatment decisions. We found that staff displayed kindness and respect to patients at all times.

Are services responsive to people's needs?

The practice provided a range of dental services to NHS patients and a small number of private patients. Patients were able to access treatment and urgent and emergency care when they required it.We found that patients with a disability or limited mobility were supported to access the service. There were systems in place inviting feedback from patients although this could be made more accessible to patients and used in a constructive way to benefit the service. There was an accessible complaints system in place.

Are services well-led?

The leadership structure was not clearly defined so that the roles and responsibilities of staff could be shared within the team to maintain the smooth running of the service. The effectiveness of systems used to monitor the quality of the service varied. For example staff training and development was well monitored but policies and procedures were not accessible and were not always reviewed appropriately. There were limited opportunities for staff to share ideas or communicate about quality issues and plan improvements.

Bedford Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC.

The inspection took place on 3 February 2015.The inspection team was led by a CQC Inspector with support from a specialist advisor for dentistry.

Prior to the inspection we reviewed the information we already held about the service, requested some basic information from the provider and gathered information from their website. We informed the NHS England area team and the local Healthwatch that we were inspecting the practice; and we did not receive any information of concern from them.

During the inspection we spoke with the principal dentist, two other dentists, the practice manager/lead dental nurse and two other dental practice nurses. We also spoke with five patients prior to or following their appointments.

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

Learning and improvement from incidents

The practice had a process in place for reporting and logging any incidents and this included adverse drug reactions. Incidents were discussed at practice meetings so that learning could be shared. Records of meetings supported this.

Staff were encouraged to be open and report any issues of concern or raise comments to the principal dentist or practice manager. They had a whistleblowing policy and a staff comments book for this purpose. An accident book was also in place and we saw that reported accidents were reviewed and appropriate action was taken.

We spoke with staff who told us they followed steps to ensure there were no errors with wrong site surgery. For example they ensured there was sufficient time allocated for each appointment, they checked radiographs and records and checked with the patient.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the lead for safeguarding concerns and was completing training to an appropriate level. All other staff had completed training for safeguarding children and vulnerable adults through an approved e-learning training course

Details of how to report any concerns were displayed for staff in a place they could easily find the guidance. This referred to local contacts for children and vulnerable adults. The child protection policy and the vulnerable adults policy had last been reviewed over a year ago. There had been no safeguarding concerns relating to patients at the practice.

We found that new staff were required to familiarise themselves with practice policies and procedures as part of their induction process. This was confirmed by a member of staff who had been through a recent induction. The practice had a chaperone policy in place and the dental nurses were familiar with the role and relevant responsibilities.

Quarterly training sessions were in place and these included refresher sessions on protocols if issues had arisen or changes had been made to them.

Infection control

The practice had a designated member of staff to lead on infection prevention and control. They showed us the decontamination area and the processes used to clean and decontaminate dental instruments ready for use. There were clear dirty to clean zones for moving clean and dirty instruments. The dental nurse had to turn back on themselves when dealing with used dental instruments because a hand wash sink had been recently removed from the area. The provider was aware this was not an ideal situation and had made some progress in planning improvements.

Dental nurses we spoke with were knowledgeable about the infection control procedures and told us they had an adequate supply of equipment to meet daily needs. The practice had systems in place for daily and weekly quality testing of the decontamination equipment and records confirmed these had taken place. However, we found one autoclave machine (a device for sterilising dental and medical instruments) did not have a record of the checks completed at the beginning of each day to ensure it was working correctly.

We found that clean instruments were stored in an appropriate area within sealed packaging. The date of sterilisation showed they were all in date and ready for use.

Dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was provided to support this.

An infection control audit had been completed by the practice in November 2014 and an action plan was in place.

The practice was visibly clean and tidy. A cleaning plan and schedule was in place that referred to an employed cleaner. However, staff confirmed that cleaning duties were all performed by the dental nurses who followed the schedules. Cleaning equipment was stored near the decontamination area and followed the recommended colour coding system used by the NHS.

There were clear procedures in place for the disposal of clinical, non-clinical and hazardous waste. Clinical waste bins used in each treatment room did not have plastic

liners which could be an infection risk to staff when emptying and cleaning the containers. Following the inspection the practice agreed to use plastic liners. Sharps bins were stored in an unlocked area when full and awaiting collection from a contractor. Safe procedures were in use for the removal of amalgam and X-ray development fluid.

The Cross Infection Policy was due for a review in July 2015. We found it was not sufficiently detailed to guide staff in safe practice. For example it stated that waste management sacks should be appropriate but gave no detail on the correct colour coding of clinical waste. There was no detailed cleaning policy or guidelines on the frequency of deep cleaning. Another cleaning and disinfection policy was available but it was not tailored to the needs of a dental practice.

The guidelines for decontamination of instruments were displayed on the wall of the decontamination area. These referred to appropriate national guidelines found in Health Technical Memorandum (HTM)2030 and HTM 2010. This should refer to the updated guidance in HTM 01-05.

Equipment and medicines

Portable oxygen cylinders were available and we found the practice had systems in place to check the cylinders were fit for use on a monthly and an annual basis.

Electrical safety tests had been completed on the items we checked and a system was in place to ensure these checks took place as required. Servicing of equipment such as the autoclave machines and X-ray equipment were also in place.

Monitoring health & safety and responding to risks

A recent risk assessment had been completed for the safe use and management of sharps. All employers are required to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place. Legislation came into force in 2013 under the European Council Directive 2010/32/EU addressing this issue. When we checked the accident book we found there had been three needle stick injuries to staff in July 2014. This had been followed up with a referral to an occupational health advisor and a safer needle system had been introduced to reduce further risks. No further injuries had since been reported.

Medical emergencies

Emergency medicines were stored in a purpose designed container that could be easily identified by staff in an emergency situation. All of these medicines were in accordance with guidelines from the Resuscitation Council and the British National Formulary (BNF). A checking procedure was in place to ensure that the medicines remained available for safe use.

We found that staff had received recent training in basic life support skills and emergency equipment was ready available for their use. This included an automatic external defibrillator (AED) which had been newly purchased within the last year. This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. In addition, medical emergencies were discussed in staff meetings so that staff could be confident in recognising and dealing with them.

Staff recruitment

The practice employed four dentists, a dental hygienist and 12 dental nurses who also covered reception duties on a rotational basis. One dental nurse was also the practice manager. Where possible staff covered one another's planned and unplanned leave. If this did not provide sufficient levels of staff, agency staff were used although this was a rare occurrence.

We reviewed evidence of the recruitment process used in three personnel files. The records were comprehensive and showed that the relevant checks for example identity, references, qualifications and experience had been reviewed and considered prior to their appointment. In accordance with the practice's own policy, criminal records checks with the Disclosure and Barring Service (DBS) had been completed for all members of staff except for one newly appointed member, whose check was in progress.

In response to its increased patient list, the practice had recently installed an additional treatment room. At the time of the inspection, the practice was trying to recruit another dentist and this was advertised within professional journals.

Radiography (X-rays)

Critical examination packs were in place for each X-ray set and there were maintenance logs completed every three years in accordance with current guidelines. A copy of the

Are services safe?

local rules and an inventory of X-ray equipment used in the dental practice was displayed with each X-ray set. There were arrangements in place for the provider to access specialist support and advice of a radiation protection service.

Records confirmed that staff had completed appropriate training updates. Audits of dental X-rays had also been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

Staff described the patient journey and how this contributed to gaining the consent of the patient to receive treatment. The patient would attend an appointment and following assessment, a treatment plan would be discussed. Information was shared with the patient to enable them to give their informed consent to suggested treatment.

The patient's consent was documented on their treatment plan and copies were supplied to the patient. Staff told us they were mindful that some patients may not have the capacity to make decisions about their own treatment. This would be identified through their medical history and by talking with the patient and carer. The practice would refer to community support services if a capacity assessment was required to ensure treatment was provided in the patient's best interests.

Patients that we spoke with told us they were always supplied with information about the costs involved in their treatment before consenting to go ahead with recommended or agreed treatment pathways.

Monitoring and improving outcomes for patients

The practice kept up to date and detailed electronic records of the care given to patients. The records provided comprehensive information about the patient's current dental needs and past treatment. Clinical records included details of the condition of the teeth, soft tissues lining the mouth and gums. This assessment was repeated at each check-up in order to monitor any changes in the patient's oral health. The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and determine how frequently to recall them.

X-rays were taken at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). Medical history checks were updated at every visit and the paper and electronic records we looked at confirmed this.

Following clinical assessment, the dentists recorded their findings. If a problem was identified or diagnosis made, a treatment plan showing the various treatment options was discussed with the patient and recorded. The details of the treatment included the type of local anaesthesia and filling materials used. The patients were then discharged from care until their next oral health assessment.

Working with other services

In each treatment room dentists had an information pack to identify local NHS and private dental providers so that a referral could be made if they were unable to meet the patient's needs. Electronic referral templates were used to send detailed information to external specialists such as an orthodontist. Once a referral had been completed this was identified in the relevant patient record so that staff could easily see the date of the referral, who had completed it and could check if a response had been received within the timescale of 18 weeks (NHS target).

Health promotion & prevention

The practice followed 'The Delivering Better Oral Health Toolkit' in providing preventative care and advice. We also saw from records that patients were asked about their social, medical and dental history. Smoking cessation and dietary advice was given when appropriate.

The dental assessment included assessment for the risk of tooth decay and the condition of soft tissues of the mouth. This was demonstrated through discussion with the dentist and reviewing dental records.

Patients who required it could have fluoride varnish treatments and high concentration fluoride toothpaste to provide better protection against tooth decay.

There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene, healthy eating especially for children and the early detection of oral cancer.

Staffing

The principal dentist completed all staff appraisals on an annual basis and this process was used to identify any training needs. Staff were able to raise any concerns they had about their role and identify training and development needs**.** Job descriptions were in place so that role expectations were clear. Mandatory training included basic life support, safeguarding and infection control. Records showed staff were up to date with this learning.

Are services effective?

(for example, treatment is effective)

The principal dentist confirmed that a period of induction was arranged for new staff to support them in the first few weeks of working at the practice**.** An induction checklist was in place and a detailed resource file was available for their use. Staff had access to a range of policies and procedures to support them in their work.

All clinical staff were required to maintain a five year period of continuous professional development as part of their registration with the General Dental Council. Records showed that professional registration was up to date for all staff and we saw evidence of on-going continuous professional development.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. The registered manager was available one day a week at the practice and available by phone or email at other times.

We saw brief records of two team meetings that had taken place within the last six months but these were not established on a regular basis. Staff told us they had a daily morning meeting with the practice manager. If any issues were raised that required further follow up notes were made in the meeting book for discussion with the principal dentist/registered manager. For example practical issues about the decontamination of dental instruments.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We noted that staff greeted patients with respect and made them welcome. When staff arranged patient appointments we heard them ask patients about their preferred time and check the suggested times and dates were suitable for them.

We saw that staff were considerate when discussing personal information with patients that could be overheard by others in the waiting room. They spoke in low tones and did not repeat personal information that could be overheard when speaking to patients by phone. Staff told us they used a spare room for private conversations with patients if it was needed.

At the reception desk, a member of the public requested the date of a family members next appointment. They were informed they could not share confidential information and advised the person to ask their relative to call in themselves.

We received a total of 12 CQC comments cards completed by patients during two weeks leading up to the inspection. The cards were all very positive showing that patients valued the service they received. Patients said that staff were helpful, they had confidence in the treatment provided and that they were treated with dignity and respect.

We also spoke with five patients who attended the practice during the inspection. They all told us they were happy with the service they had experienced, staff were caring and they had not had a need to complain. One patient was visiting in a supportive role to their relative who had a mental health condition. They told us the dentist was very patient and put their relative at ease.

Involvement in decisions about care and treatment

Feedback from the patients we spoke with confirmed that patients were involved in making decisions about their care and treatment. They all told us staff at the practice were open about treatment costs which were always explained by staff before the treatment started. One patient told us they had been given treatment plan options and they had negotiated a payment plan with their dentist that they were happy with.

There was information displayed in the reception and waiting room about the costs of treatment. There were other information leaflets to promote dental health and hygiene.

We found that when patients required a referral for more specialist treatment, they were given a choice of local providers who were available to meet their clinical needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice offered a range of general dental services such as examinations, fillings, root canal treatments and cosmetic dentistry such as teeth straightening and implants. The practice treated mostly NHS patients and opened weekdays from 9am until 7pm three days a week with longer opening until 8pm one evening a week and earlier closing on a Friday at 5pm. The practice also opened Saturday mornings. Patients were asked to give the practice 24 hours notice of a cancelled appointment although some non attendance still occurred. This had reduced since the introduction of a system to remind patients about their appointment details by email or text messaging.

Patients received information about obtaining emergency care out of hours if they telephoned the practice. This information was not available on the practice website.

Tackling inequity and promoting equality

The practice had a ramp at the front door so that patients with poor mobility or those who used a wheelchair could access the building more easily. Treatment areas were all on the ground floor with level access and there was a toilet suitable for patients with a disability.

The practice had recently completed a refurbishment of their reception desk and waiting area. The reception desk was at one height and staff told us they walked around the desk so they were able to speak with patients who used a wheelchair for whom the desk was too high.

Staff at the practice were able to speak several other languages and this met the needs of many local patients from other cultural backgrounds. In addition, a patient from an Eastern European background had recommended the service to others within their community and often attended with them to help translate their needs if they required this support.

If a patient had any special needs such as a disability or being very nervous of visiting the dentist staff would add this to their health records. This meant that reminders about that persons' individual need popped onto the screen as staff accessed their records.

Access to the service

The practice did not hold any dedicated appointments for emergency needs and told us they were able to accommodate such requests on the same day or during evening appointment times. Standard dental check up appointments were for 15 minutes and each dentist made decisions about the length of time patients would require for any follow up treatment.

We spoke with a temporary patient who had contacted the practice the previous day because they required emergency treatment. They were provided with a convenient appointment the following morning.

Concerns & complaints

The practice manager was responsible for dealing with any concerns or complaints with support from the principal dentist. A complaints policy was in place that recognised concerns or complaints in any format and followed the NHS complaints guidelines. We asked to see the complaints log and found that three had been received recently and were being investigated. The principal dentist told us he gave feedback to any staff members involved following the investigation although there were no examples at the time to evidence this.

Patients we spoke with had not had a need to raise a complaint and told us they would raise any concerns directly with staff.

Staff had not received any training in handling complaints although arrangements were in place for them to do this through an e-learning programme.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership, openness and transparency

Whilst there were some delegated roles such as an infection control lead and a senior dental nurse, the principal dentist took responsibility for leading on clinical, management and quality monitoring roles with support from the senior dental nurse. He also had this responsibility at a second dental practice and divided his time between the two as well as continuing to do some clinical work. The shortfalls identified during this inspection indicate the need for leadership roles to be more clearly defined and carried out by suitable team members.

Staff told us they felt supported and enjoyed working at the practice. They reported that the senior dental nurse and dentists were approachable. The arrangements for sharing information across the practice required some improvement because staff had limited opportunity to discuss issues together as a team. However, dental nurses told us they had informal chats with the senior dental nurse at the start of their working day and could report back to them at any time during the day.

Governance arrangements

We spoke with the principal dentist who described some of the systems that were in place to improve the quality of the service. He had recently completed a training course and said this learning was helping him to develop a better governance structure and this was work in progress.

The practice completed audits on a regular basis. Examples included clinical records, infection control, radiography and patient waiting times. These were used to improve the service.

The practice had a risk assessment in place dated 2012. It covered risks such as hazardous substances, legionella, fire and display screen equipment. The risk assessments required updating.

There were comprehensive COSHH records (Control of Substances Hazardous to Health) in place that were updated regularly so staff had guidance on safe usage of products provided in the practice.

There was a system in place for managing complaints and incidents. Staff told us that relevant learning was discussed at staff meetings however these meetings had not been held on a regular basis and meeting records were brief. The principal dentist told us he planned to improve this by meeting with staff on a monthly basis and using the meeting to reflect on issues and promote staff learning. This was evidenced through preparation undertaken for the next planned meeting which would include complaints and feedback and training on new policies.

Most policies and procedures were in place although there was no clear system for organising them to ensure they were readily accessible or regularly reviewed. Policies for infection prevention and control and environmental cleaning were not sufficiently detailed to give staff the guidance they needed to ensure safe care.

The principal dentist is a member of the local dental network and this forum is used to improve dental service standards and share good practice. For example, the practice introduced referral procedures that were recommended by the NHS England area team for dentistry.

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

Staff told us the principal dentist and practice manager were approachable if they wanted to share ideas or issues of any concern. Two staff meetings had taken place since September 2014 and although these were not held on a regular basis the brief records of the meetings showed staff had been able to contribute their ideas. The dental nurses told us they also had daily discussions with the senior dental nurse and felt involved in suggestions on how the practice could improve.

The practice had an online feedback form that could be completed by patients and a comments box was available in the waiting room. However, we found there was no formal process in place to review the comments or act upon suggestions received from patients. The principal dentist told us they contacted individuals in relation to their feedback but they did not share comments received or the actions considered by the practice with the wider patient group. Patient feedback had not been used to continually improve the service.

Management lead through learning and improvement

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Each dentist worked with a qualified or trainee dental nurse. The dental nurses rotated their duties so that they worked with each dentist in turn as well as covering reception duties and this helped to share learning and experience.

Certificates in staff files demonstrated that staff had attended appropriate training for their role. The dentists had completed study for their continuous professional development (CPD) and all staff had current registration with the General Dental Council (GDC).

All staff received annual appraisals and had a personal development plan in place. The principal dentist was able to describe an example of unacceptable performance in cleaning dental instruments. This was addressed with the dental nurses by meeting with them, discussing the concerns and implementing a system that required each dental nurse to sign when the cleaning process was completed. This meant they each took accountability for the work they had completed and poor quality could be tracked to individual members of staff.