ABC Dental Surgery Ltd

169 Lewes Road Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16th June 2015.

Regulations were being met.

We found that this practice was providing safe, effective, caring, responsive and well-led care in accordance with the relevant regulations.

Our key findings were:

The practice was situated on a main road close to Brighton city centre, with nearby links to public transport access. The practice offered general, preventative and cosmetic dentistry. It did not offer sedation services or domiciliary visits.

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 safe in accordance with the relevant regulations. There were effective systems in place in the areas of infection control, clinical waste control, management of medical emergencies in the dental chair and dental radiography. We also found that all the equipment used in the dental practice was well maintained and in line with current guidelines. There were effective systems in place around safeguarding children and vulnerable adults. Staff were recruited and inducted appropriately. The monitoring of health and safety and the response to risks was effective.

Are services effective?

We found that the practice was effective in accordance with the relevant regulations. Services were effective, evidence based and focused on the needs of the patients. There were systems in place for the monitoring and improving of outcomes for patients. Health promotion and illness prevention methods used were relevant and effective. Staff training was relevant to the care needs of patients using the service. There were effective systems in place for the management of patients' consent to care and treatment.

Are services caring?

We found that the practice was caring in accordance with the relevant regulations. There were systems in place to ensure patients were involved in decisions about care and treatment. Patients were treated with respect, dignity, compassion and empathy.

Are services responsive to people's needs?

We found that the practice was responsive in accordance with the relevant regulations. Complaints were managed in a timely and satisfactory manner. There were systems in place to respond to patients' needs, such as a patient presenting in pain. The practice was not accessible to patients with mobility problems but had made alternative arrangements with another dental practice to ensure patients had access to services.

Are services well-led?

We found that the practice was well-led in accordance with the relevant regulations. There was visible and effective leadership. There were relevant and regular audits conducted to identify areas for improvement, which were acted upon. There was a culture of openness and transparency. Feedback from patients, the public and staff was sought and acted upon.

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Detailed findings

Background to this inspection

The inspection was undertaken on 16th June 2015 and was conducted by a CQC inspector and a Specialist Dental Advisor

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members and their qualifications and proof of registration with their professional bodies.

We informed NHS Area Team that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we spoke with the dentist, dental nurse and receptionist. We examined comment cards, supplied by the CQC and completed by 20 patients. We reviewed policies, protocols, procedures and other relevant documentation.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

A medical history record was taken from each patient and updated each time they attended. These were recorded manually, then transferred to the patient record on the practice IT system.

Records we viewed reflected the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that posed a potential risk was recorded and graded.

The practice also kept an adverse incident log in line with their incident management policy. There was documentation related to significant event analysis which outlined methods in which lessons could be learned for the future. There had been no recent incidents.

Reliable safety systems and processes (including safeguarding)

We discussed with staff about the different types of abuse and who to report them to if they suspected abuse was taking place. They were able to describe in detail the types of behaviour a child would display that would alert them to the possibility of abuse or neglect. They also showed an awareness of the issues around vulnerable adults who present with dementia that require dental care and treatment. We examined the practice's safeguarding policy and protocol. The staff we spoke with were clear about their responsibilities in this area. One staff member told us that they would tell the dentist if I thought something was going on. They would discuss it and act, using the practice's protocol. There had been no recent safeguarding concerns or referrals.

Medical emergencies

There was a range of suitable equipment which included an automated external defibrillator (AED), oxygen, oxygen masks, a range of airways and other pieces of equipment available for dealing with medical emergencies. This was in line with the Resuscitation UK Council guidelines. There was also a range of emergency medicines available for dealing with medical emergencies which were generally in line with British National Formulary (BNF) guidelines.

The emergency medicines were all in date and stored securely, with emergency oxygen in a central location known to all staff. The AED was stored in a safe and accessible place. Staff told us they regularly checked the battery to ensure it was in working order, as recommended by the manufacturer, however there was no record of this. A check list monitoring the expiry dates of the emergency medicines was present in the storage cabinet. This ensured that the risk to patients' during dental procedures was reduced and patients were treated in a safe and appropriate manner.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. We observed staff and spoke with the dentist, staff and patients. We noted the practice was compliant with the Department of Health's Decontamination Health Technical Memorandum 01-05 (HTM 01-05). This specifies decontamination requirements for primary dental care.

We noted that the treatment room, waiting area, reception and toilet were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet, hand washing protocols were also displayed in each of these areas. We spoke with the staff member responsible for the day to day infection control systems and processes within the practice. They, along with a colleague, undertook environmental cleaning duties, which were detailed in a dedicated cleaning schedule.

The staff member explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of legionella bacteria which included frequent flushing of the water lines. Legionella is a bacterium found in contaminated water which is potentially dangerous. A legionella risk assessment had been carried out by an appropriate contractor. The contractor carried out assessments on an annual basis. The latest report stated no risks had been identified. These measures ensured that patients' and staff were protected from the risk of infection due to legionella.

Are services safe?

There was a dedicated decontamination room which was well ventilated, with two instrument sinks for washing and rinsing. We noted all work surfaces were sealed to prevent infection. We examined records related to the maintenance of the steriliser, including steam penetration and a record of required temperature and pressure levels. These were all in order.

Staff demonstrated to us the decontamination process from taking dirty instruments through to the point they were ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing followed by the use of an ultra-sonic bath as part of the initial cleaning process.

We inspected the drawers of the treatment room that was in use on the day of our visit in the presence of staff. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched. It was clear which items were single use and these items were clearly new. The treatment room had the appropriate routine personal protective equipment available for staff and patient use.

When instruments had been sterilized they were pouched and stored appropriately until required. The staff member also demonstrated to us systems were in place to ensure that the autoclave and ultra-sonic cleaning bath used in the decontamination process were working effectively. These included protein residue tests and the foil test for the ultrasonic bath and the automatic control test for the autoclave. We examined the data sheets used to record the essential daily validation checks of the sterilisation cycles. These were complete with no gaps in the record.

We observed that sharps containers were properly maintained and was in accordance with current guidelines. The practice sharps injury protocol was clearly understood when talking with staff. The staff member explained it was the dentist's responsibility to dispose of used needles who confirmed this. However, we did note that the sharps box was kept on the floor and not wall-mounted or in a place inaccessible to patients. The dentist corrected this during our visit.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. The practice used a contractor to remove clinical waste from the practice which was stored in a separate, locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

Equipment and medicines

We examined documentation related to the maintenance and servicing of equipment in use at the practice. These were in line with the manufacturers' guidelines. We examined the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations(2000). These were in order. The dental compressor was serviced regularly in line with current regulations. X-ray machines were the subject of regular, recorded visible checks. A specialist contractor calibrated and reviewed all X-ray equipment to ensure they were operating safely. The most recent report was compliant with the Ionising Radiation Regulations (1999). A maintenance contract was in place for the replacement of the emergency oxygen ensuring that the contents and the metal oxygen cylinder did not deteriorate over time. We noted that all relevant equipment had undergone regular PAT (portable appliance testing), which was recorded.

Radiography (X-rays)

We were shown a radiation protection file which was completed in line with the Ionising Radiation Regulations (1999) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation related to the maintenance of the x-ray equipment. These included critical examination packs for each x-ray set along with the three yearly maintenance logs and a copy of local protocols. Also present in the file was training records of the dentist in relation to IRMER requirements. We saw a copy of the most recent radiological audit. The clinical records we saw showed dental x-rays were justified, reported on and quality assured on each occasion. This showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Staff recruitment

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for three staff members. We noted staff had undergone procedures required by the provider, including

Are services safe?

Disclosure and Barring Service (DBS) checks before being allowed to work with patients. There were also copies of blood borne virus risk assessments, staff references, staff contracts and job descriptions in staff files. The provider also had systems in place to ensure staff maintained registration with the appropriate professional bodies. We noted, on commencing employment, all staff underwent a formal induction period. The records showed this process was structured around allowing staff to familiarise themselves with the practice's policies, protocols and working practices. Staff 'shadowed' more experienced staff until such time as they were confident to work alone. One staff member told us that they felt very well supported. They said that they could always ask and would be helped.

Monitoring health and safety and responding to risks

The practice undertook a variety of risk assessments to ensure the safety and welfare of patients who used the service. We noted an environmental risk assessment was conducted regularly which was used to identify risks to patients and staff at the practice. The results of these were discussed at team meetings and action taken where necessary. The practice also undertook regular fire risk assessments. We examined the provider's health and safety policies. The staff we spoke with were aware of these and acted accordingly.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with General Dental Council (GDC) guidelines. Staff described to us how they carried out assessments. Patients completed a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw the medical history was updated at subsequent visits. We noted the reason for the patients visit was recorded. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and possible signs of oral cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included the discussion of general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient notes were updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A review of a sample of ten dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. These were carried out at each dental health assessment. The records we saw showed that dental X-rays were justified, reported on and quality assured every time. Patients who required any specialised treatment were referred to other dental specialists as necessary. Their treatment was then monitored after being referred back to the practice.

Health promotion & prevention

Staff told us they adopted a collaborative approach when treating patients. This meant helping the patient to maintain a healthy, functional and comfortable mouth. Advice on smoking cessation and alcohol consumption reduction was included in this. The practice did not employ or use the services of a dental hygienist. This work was undertaken by the dentist.

Staff described how they used models and pictures to assist in getting across the preventative message to patients, for example when patients present with gum disease.

Dental care records showed staff had given tooth brushing instructions and dietary advice to his patients. Staff were aware of the Department of Health evidence based toolkit to support dental practices in improving their patient's oral and general health.

Staffing

We looked at the practice's policies, staff files and staff training records and associated documentation. We found they contained relevant and up to date information. There was a system in place to record staff training and development needs in accordance with General Dental Council requirements on continuing professional development.

There were regular staff meetings held. We looked at the minutes of these meetings and saw staff were given the opportunity to discuss professional issues. Staff were able to access training in subjects relevant to the needs of the patients they were treating. These included the dental radiography, safeguarding vulnerable adults and children, endodontic (root canal) treatments and essentials of communication. Staff we spoke with were satisfied with the training opportunities on offer.

We noted the dentist was supported by an appropriately qualified dental nurse. The practice did not offer conscious sedation services, specialist oral surgery or domiciliary visits.

Working with other services

The dentist referred patients to other practices or specialists if the treatment required was not provided by the practice. We saw they explained to patients when a referral was necessary and gave a choice of other dentists who were experienced in undertaking the type of treatment required. A referral letter was then prepared and sent to the practice with full details of the consultation and the type of

Are services effective?

(for example, treatment is effective)

treatment required. When the patient had received treatment they were discharged back to the practice for further follow-up and monitoring. There were no complaints concerning referrals to other services.

Consent to care and treatment

We looked at the provider's consent to care and treatment and consent to outside referral policies. Patients told us the dentist always discussed treatment options with them after initial examination. Our observations confirmed this. We noted that staff had recently undergone training in relation to the Mental Capacity Act (2005).

Staff explained how they would manage consent issues with a patient who was unable to fully understand the implications of their treatment. We were told if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They told us they would involve relatives, carers and health professionals to ensure that the best interests of the patient were served as part of the process in line with Mental Capacity Act (2005).

We looked at a recently completed patient satisfaction survey. We noted that all of patients asked were satisfied or highly satisfied in areas of treatment discussion and involvement in decision making. We saw that patients' written consent had been sought and obtained in a variety of areas, including general treatment, tooth extraction and photography. Each patient received written information, outlining proposed treatment, which was signed as read and agreed by the patient. We asked about matters of consent in relation to children registered at the practice. We were told children were accompanied by a parent or guardian, from whom written consent was always sought. One staff member told us they needed parental consent for children and that they wouldn't treat them without it. The staff we spoke with understood their responsibilities in relation to the care of people who did not have the capacity to consent to treatment. The documentation we looked at and the observations we made showed appropriate consent had been sought for treatment. This was done either face-to-face during a consultation or by letter sent from the practice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The staff we spoke with were clear about their responsibilities in relation to ensuring people's dignity and privacy were maintained. One staff member told us that they knew how important that was and that they didn't share information with anyone unless it was essential.

We looked at a recently completed patient satisfaction survey. We noted that all of patients asked were satisfied or highly satisfied in areas concerning the maintenance of privacy, confidentiality and dignity.

We noted when reception was left unstaffed from time to time, confidential patient information was not left on display.

Involvement in decisions about care and treatment

Staff were aware of the importance of involving patients in decisions about care and treatment. Our discussions and observations indicated patients could withdraw consent at any time. They had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan.

We looked at a recently completed patient satisfaction survey. We noted that all of patients asked were satisfied or highly satisfied in areas concerning involvement in decision making.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

We spoke with staff and examined documentation concerning the provider's response to patients' needs. We examined the provider's emergency appointment policy and spoke with staff. We were told that patients were prioritised at the point of contact with the practice. Patients presenting in pain or those already undergoing a course of treatment at the practice were seen the same day. All others were seen within 24 hours or as soon as practically possible. We looked at the practice's appointment system and saw this in operation. We noted the appointment system was flexible enough to cope with emergency situations. There was no double booking of appointments. Our examination of returned patient satisfaction questionnaires showed a high degree of satisfaction in waiting times, both for routine and emergency appointments.

Tackling inequality and promoting equality

We spoke with staff about tackling inequality and examined the practice's equality and diversity policy. We were told the practice served an area with relatively high social need. We noted all general dentistry services were provided by the NHS at the practice. There was a wide variety of leaflets and information available concerning costs and the criteria for exemption from charges.

Access to the service

The practice was not accessible for people with restricted mobility and for those who used a wheelchair. However, the practice had made arrangements to ensure patients could receive services at a nearby step-free dental practice, either on a permanent or temporary basis. The practice was situated in a built-up area. Parking, both free and charged was available nearby and the practice stood on a major bus route with frequent services.

We noted the practice was situated in a highly multi-cultural area. We asked how patients needs, whose first language was not English, were met. We also examined the practice's policy for dealing with language barriers. We noted the practice had access to and used the Sussex Interpreting Service. In addition, the practice had access and links to Action Deafness to ensure patients with auditory problems could access services safely and effectively.

Concerns and complaints

The practice took account of complaints and comments to improve the service and explained how complaints would be dealt with. The patients we spoke with felt they could make a complaint if they needed and would be listened to. We examined the complaints policy and procedures and found they included clear guidelines on how and by when issues should be resolved. They also contained the contact details of relevant external agencies, such as the Dental Complaints Service and the General Dental Council. The policy was also displayed in the waiting area. There had been one recent complaint made. We looked at documentation related to this and found the complaint had been resolved in a timely and satisfactory manner. The management of complaints was reviewed regularly in team meetings and remedial action taken where necessary. Our conversations with staff indicated a culture of openness in which people, their representatives and staff could raise issues of importance to them. We also examined 48 recently returned NHS Friends and Family Test cards. We noted that all of the patients who returned these would be likely or highly likely to recommend the practice to others.

Are services well-led?

Our findings

Governance arrangements

We were told the day to day running of the practice was the responsibility of the practice manager. There was a clear management structure, with staff acting as dedicated leads in areas such as infection control and safeguarding children and vulnerable adults. There were clear and relevant risk assessments in place, in areas such as environmental cleaning, the safety and suitability of premises and infection control. The provider also had a dedicated COSHH file (care of substances hazardous to health). We examined the file and saw it was reviewed and updated regularly.

Leadership, openness and transparency

Our observations and discussions with staff indicated a high level of communication within a small team. This was backed up by regular staff meetings, the minutes of which were produced for internal and external scrutiny. The staff we spoke with appeared highly motivated. They told us they felt valued and supported and could contribute ideas and suggestions without fear of discrimination. Our conversations with patients confirmed the perception of an open provider.

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

The practice regularly sought the views of patients who used the service via questionnaires. We examined a recently completed patient satisfaction survey. We also looked at 48 returned NHS 'Friends and Family' Test cards and 20 comment card returned directly to the Care Quality Commission. All of those examined showed a high degree of satisfaction in all areas, including cleanliness, waiting times and staff attitudes. The practice also captured the views of patients informally following their visit to the practice.

Management through learning and improvement

We found that there were a number of clinical and non-clinical audits taking place at the practice. These included record keeping, waste pre-acceptance and X-ray quality. We looked at a small sample of all of them. The latter was carried out by the dentist qualified to do so and this involved grading the quality of the X-rays to ensure they had been taken correctly. Where areas for improvement had been identified action had been taken. There was evidence of repeat audits at appropriate intervals and these reflected that standards and improvements were being maintained. For example infection prevention audits were undertaken every 6 months in accordance with current guidelines. The practice had a system in place to monitor medicines in use at the practice. We found that there was a sufficient stock of them and they were all in date. Records had been kept of the checking process. Audit findings were discussed and action taken at team meetings.

We asked if all relevant staff were registered with the General Dental Council and adequately indemnified. We were shown documentation to confirm this. Our conversations with staff indicated a clear understanding of their professional responsibilities and accountability. The practice operated a formal appraisal system, including one-to-one interviews where staff were able to raise issues of importance to them. The staff we spoke with were satisfied with this arrangement.