Reza Ardalan and Homayoun Bagherzadeh

Oliver's Battery Dental Surgery

Inspection Report

94 Oliver's Battery Road South
Winchester
Hampshire
SO22 4EZ
Tel: 01962 877 877
Website:www.oliversbatterydentalsurgery.com

Date of inspection visit: 4 April 2016
Date of publication: 27/05/2016

Overall summary

We carried out an announced comprehensive inspection on 4 April 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 regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Oliver's Battery Dental Surgery has four dentists, seven dental nurses, five of whom are qualified and registered with the GDC and two who are in training, and three receptionists. A self-employed dental hygienist also worked from the practice. All of the dentists and dental nurses are qualified and registered with the General Dental Council (GDC). The practice's opening hours are 8am until 5pm Monday to Friday.

Oliver's Battery Dental Surgery is a dental practice providing mainly NHS and some private treatment and caters for both adults and children. The practice is situated in purpose built premises. The practice had three dental treatment rooms. Decontamination for cleaning, sterilising and packing dental instruments is carried out in a separate room. There is a reception and waiting area. All of the dental treatment rooms were on the ground floor enabling access for patients who found stairs difficult.

One of the dentists was the registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. Supporting the Registered Manager is a practice manager and a business support manager.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 46 completed cards and received feedback on the day of the inspection from eight patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was good.

We carried out an announced comprehensive inspection on 4 April 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a second inspector.

Our key findings were:

- The practice had a practice manager who administered the clinical governance systems and processes within the practice.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had effective safeguarding processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The practice had enough staff to deliver the service.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff we spoke to felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from eight completed CQC comment cards gave us a positive picture of a friendly, caring and professional service.
- All complaints were dealt with in an open and transparent way by the practice manager responsible for administration if a mistake had been made.

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

- Review working arrangements for the dental hygienist so they do not work alone.
- Review arrangements for translation services.
- Review references request template to include the name of the company providing them.
- Review arrangements for recording clinical meetings, so that there is a written record of what is discussed.

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 care which was safe in accordance with the relevant regulations.

The practice had reliable arrangements in place for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Evidence was not available on the day of inspection to demonstrate that all staff had received safeguarding training. The provider provided this information within 48 hours of the inspection which showed that all staff had received relevant training. All staff were aware of their responsibilities regarding safeguarding children and vulnerable adults.

The practice had a staff recruitment policy and staff recruitment checks for staff who started to work since the service registered with the Care Quality Commission included evidence of a Disclosure and Barring Service check, a full employment history, evidence of satisfactory conduct in previous employment and registration with professional bodies.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 46 completed patient comment cards. These provided a completely positive view of the service; we received feedback on the day of inspection from eight patients who also reflected these findings. All of the patients commented that the quality of care was good. They were treated with compassion and put at ease. They felt listened to and involved in their treatment.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in how the practice was run. Patients could access treatment and urgent care when required. The practice provided patients with written information about how to prevent dental problems and on the indicative costs of dental treatment. All dental treatment rooms were based on the ground floor enabling ease of access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

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

Summary of findings

Staff were supported and managed at all times and were clear about their lines of accountability. They felt the provider valued their involvement, were engaged and their views were reflected in the planning and delivery of the service. Care and treatment records were complete, legible, accurate, and kept secure. Staff were supported to meet their professional standards and follow their professional code of conduct.

Audit processes were effective and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. There were systems in place to support communication about the quality and safety of services and what actions had been taken as a result of concerns, complaints and compliments.

Oliver's Battery Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection of Oliver's Battery Dental Surgery on 4 April 2016. The inspection was carried out by a lead inspector and a second inspector.

We informed NHS England area team that we were inspecting the practice, however there were no immediate concerns from them.

During our inspection visit, we reviewed policy documents and staff records. We spoke with members of staff, including the practice manager and dentists. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and computer system that supported the patient treatment records. We reviewed comment cards completed by patients prior to our visit and received feedback from eight patients on the day. Patients gave positive feedback about their experience at the practice.

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

We spoke with practice manager about the reporting of incidents that could occur in a primary dental care setting. We saw that a system was in place. The practice reported that they had had no significant events in the previous 12 months and the last recorded incidents occurred in 2014. Incident recording forms were available which allowed for action points to be noted. The practice said that when needed learning was shared with the rest of the team.

Reliable safety systems and processes (including safeguarding)

We spoke to the practice manager about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist. The practice manager was also able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked how the practice treated the use of instruments which were used during root canal treatment. A dental nurse explained that these instruments were single use only. They explained that root canal treatment was carried out where practically possible using a rubber dam (a rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

There was a nominated member of staff who acted as the practice safeguarding lead. This individual acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse. Evidence was not available on the day of inspection to demonstrate that all staff had received children and adult safeguarding training. The provider provided this information within 48 hours of the inspection which showed that all staff had received relevant training. Information was available that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator, (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice also had an oxygen cylinder and other related items such as manual breathing aids and portable suction available in line with the Resuscitation Council UK guidelines.

All emergency medicines and oxygen were in date. The expiry dates of medicines and equipment were monitored using a weekly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. The training was last carried out in February 2016.

Staff recruitment

The practice had a staff recruitment policy in place. We looked at the recruitment records for the three staff recruited since the practice registered with the Care Quality Commission. All recruitment records had the information required by the regulations, such as evidence of satisfactory conduct in previous employment, proof of identity and checks of professional qualifications. We found that when references were requested as evidence of satisfactory conduct in previous employment, there was no information which confirmed the person or company approached for a reference.

Monitoring health & safety and responding to risks

Are services safe?

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a well maintained Control of Substances Hazardous to Health (COSHH) file. Other assessments included fire safety, radiation, general health and safety issues affecting a dental practice and water quality risk assessments.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice manager was responsible for infection control procedures within the practice. It was demonstrated through a description of the end to end process and a review of practice protocols that Health Technical Memorandum (HTM) 01 05 (national guidance for infection prevention control in dental practices) Essential Quality Requirements for infection control was being met. It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines.

It was noted that the three dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including wall mounted liquid soap and gels and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

We asked a dental nurse to describe to us the processes for infection control at the practice. They 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 drawers of a treatment room were inspected in the presence of staff. These were well stocked, clean, well ordered and free from clutter. Instruments were either pouched or stored in covered trays if the instruments were used that day. This was in accordance with current guidelines. There were appropriate single use items available and these were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) she described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in March 2016. The recommended procedures contained in the report were being carried out and logged appropriately. This included regular testing of the water temperatures of the taps in all rooms in the building. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination area for instrument processing. Displayed on the wall were protocols to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available in this room. A dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process, followed by use of the washer disinfector. The instruments were then inspected and were placed in an autoclave (a machine used to sterilise instruments). There were two autoclaves. When instruments had been sterilised they were pouched or stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. There were systems in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice which was stored in a separate locked location within the practice prior to collection by the waste

Are services safe?

contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Environmental cleaning was carried out in accordance with the national colour coding scheme and cleaning schedules were available for inspection.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclaves had been serviced and calibrated in the past year. The practices' X-ray machines had been serviced and calibrated annually in accordance with current guidelines. Portable appliance testing (PAT) for all electrical appliances had been carried out annually. A sample of dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients.

Radiography (X-rays)

We were shown a well maintained radiation protection file 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 (RPA) and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. At this location dentist with an approved dental radiography qualification acted as the Radiation Protection Supervisor. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A copy of the last radiological audit in March 2016 demonstrated that a high percentage of radiographs were of grade one standard. A sample of dental care records where X-rays had been taken showed that when dental X-rays were taken they were justified, reported on and quality assured. The practice also carried out a six monthly overview of the quality of all dental X-rays taken and the most recent audit showed that in this period less than 2% in total for the six month period were unacceptable, which was within their target range. The practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke to two dentists on the day of our visit. They described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products. 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.

As review of a sample of 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 where appropriate during a dental health assessment.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were health promotion leaflets available in the practice to support patients look after their general health. A dental hygienist was available on a private basis to provide scaling and polishing and other preventive advice and treatments.

Staffing

There were enough support staff to support the dentists during patient treatment. All of the dental nurses supporting the dentists were qualified dental nurses. The practice manager told us that the practice ethos was that all staff should receive appropriate training and development. This included training in cardio pulmonary resuscitation, infection control, child protection and adult safeguarding and other specific dental topics. We noted that the dental hygienist who worked at the practice usually worked alone. The practice manager said that they usually had an extra dental nurse on duty and they would arrange for this member of staff to work with the dental hygienist when needed to be in line with current guidance.

Working with other services

The practice manager explained how the dentists would work with other services if required. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. Systems had been put into place by local commissioners of services and secondary care providers whereby referring practitioners would use bespoke deigned referral forms. This helped ensure that the patient was seen in the right place at the right time. We saw a selection of these forms which included referrals for oral surgery problems, suspected mouth cancer cases, orthodontics and patients who required special care dental services as a result of physical and mental impairment. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

The dentists we spoke with had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients and explaining in a way and language that patients could understand. Costs were made clear in the treatment plan and in the dental treatment record. The dentists always used the NHS treatment plan form known as the FP17 DC form when carrying out any treatment over and above an examination and treatment under private contract. We reviewed a number of records which confirmed this approach had taken place.

Both dentists we spoke with explained how they would take consent from a patient who suffered with any mental

Are services effective?

(for example, treatment is effective)

impairment which may mean that they might be unable to fully understand the implications of their treatment. They told us how he would manage such patients. The dentists explained if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting area and we saw that doors were able to be closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy. Patients' dental care records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage.

Patients told us (through discussion and comment cards) that they found the practice caring and supportive. They said they were listened to, treated with respect and were involved in discussions about their treatment options, which included risks, benefits and costs. We observed that staff were helpful, kind and considerate to the needs of individual patients.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients which detailed possible management options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area.

We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This information was recorded on the standard NHS treatment planning forms for dentistry.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Services were planned and delivered to meet the needs of patients. The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice had a clear understanding of who their population were and understood their needs including, making appointments long enough to carry out investigations and treatment.

Most examination appointments were at least 15 minutes long and filling appointments were at least 20-30 minutes long. We did not see evidence of routine double booking of patients. This only occurred when patients were asked to come and sit and wait if they were in pain. Generally the practice had dedicated urgent slots as well as asking patients to come and sit and wait.

Tackling inequity and promoting equality

There was level access to the practice and all treatment rooms were on the ground floor. The practice had a hearing loop for patients who had impaired hearing and part of the reception desk was lower so patients who were wheelchair users could speak directly to reception staff. Translation services were available and the practice had a card which patients could point to identify their first language.

Access to the service

Appointments were available Monday to Friday between 8am and 5pm. Appointments could be made in person or by telephone. We asked eight patients if they were satisfied with the practice opening hours and they confirmed they were. The practice supported patients to attend their forthcoming appointment by having a reminder system in place. This included a SMS text message.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

The practice had a complaints policy which had been reviewed in April 2016. The policy set out set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient after a ten day investigation period. The aim was to achieve full resolution within 21 days of a complaint being received. This was seen to be followed. We saw a complaints log which listed six complaints received since April 2015. Records confirmed the complaints had been resolved with a satisfactory outcome.

We asked eight patients if they knew how to complain if they had an issue with the practice. Six patients said they would know how to complain and two were not sure. Information about how to make a complaint was seen in the practice leaflet and on display in the patient waiting areas.

Are services well-led?

Our findings

Governance arrangements

Oliver's Battery Dental Surgery had suitable systems and processes in place to provide an overview of how the practice was operating. The practice was a 'Good practice Scheme' member and used protocols to monitor the quality of service provision and health and safety checks. For example, there was a daily reception checklist detailing what needed to be in place to ensuring the smooth running of the business.

We found a system of policies, protocols and procedures in place covering the clinical governance criteria expected in a dental practice. We found that procedures in relation to clinical governance were well maintained by the practice manager. There were many examples of attention to fine detail with respect to record keeping and validating processes and protocols. This included the reporting of incidents, completing risk assessments and maintaining policies and protocols in relation to infection control, radiation protection and medical emergencies.

Leadership, openness and transparency

It was apparent through our discussions with the dentists and nurses that the patient was at the heart of the practice with the dentists adopting a holistic approach to patient care. We found staff to be hard working, caring and committed to the work they did. Dentists were able to analyse their own performance as well as being able to obtain support and guidance from their colleagues and the providers who were also a practicing dentist.

Policies and procedures were seen to be in place to support a culture of openness and transparency in respect of the new statutory duty of candour which was introduced for dentists registered with CQC from 1 April 2015.

Learning and improvement

We found that there were examples of learning and improvement taking place in the practice. This included the auditing of infection control procedures and clinical record keeping. We saw a high level of compliance with infection control procedures and record keeping standards were maintained to a satisfactory standard.

Employees were supported to access training and to maintain their registration with the General Dental Council (GDC), where relevant.

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

The practice had gathered feedback from patients through the NHS Friends and Family test, NHS Choices, compliments and complaints. For example, following patient feedback the practice only requested payment at the time a patient came to the surgery for treatment and not prior to treatment. We saw that there was a robust complaints procedure in place, with details available for patients in the practice leaflet and in the waiting area.

All of the staff we spoke with told us they felt included in the running of the practice. They went on to tell us how the dentists and practice manager team listened to their opinions and respected their knowledge and input at meetings. We were told that staff turnover and sickness was low. Staff told us they felt valued and were proud to be part of the team. They said that as a result of their feedback an extra member of staff had been employed to provide cover for breaks and sickness. Staff received regular appraisals and we noted this had been planned for the forthcoming year. There were regular staff meetings, but improvements were needed in minuting these. Tutorials were held at the end of each working day to discuss clinical care.