

## 406 Dental

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## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 15 December 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**

406 Dental provides some NHS, but mainly private treatment for both adults and children. The practice is based in a converted terraced property. The practice has three dental treatment rooms, a decontamination room, reception area, two waiting rooms and a staff room.

Treatment is provided on the ground and first floor. The ground floor is wheelchair accessible with a ramp to access the front of the property. On street parking is available.

The practice employs two dentists, two dental hygienists, four dental nurses, two of whom are trainees and a decontamination staff member. The clinical team are supported by a practice manager and reception staff.

The practice's opening hours are 9:00am to 7.30pm Monday, 9am to 5:30pm Tuesday, Wednesday, Thursday and 8am to 2pm Friday.

The practice is a member of a 'Good Practice' accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

The practice manager is 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'.

# Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

## **Our key findings were:**

- The practice was well organised, visibly clean and free from clutter.
- An Infection prevention and control policy was in place. We saw the sterilisation procedures followed recommended guidance.
- The practice had systems for recording incidents and accidents.
- Practice meetings were used for shared learning.
- The practice had a safeguarding policy and staff were aware on how to escalate safeguarding issues for children and adults should the need arise.
- Staff received annual medical emergency training. Equipment for dealing with medical emergencies reflected guidance from the resuscitation council.

- Dental professionals provided treatment in accordance with current professional guidelines.
- Patient feedback was regularly sought and reflected upon.
- Patients could access urgent care when required.
- Dental professionals were maintaining their continued professional development (CPD) in accordance with their professional registration.
- Complaints were dealt with in an efficient and positive manner.

## **There was an area where the provider could make improvements and should:**

- Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

Infection prevention and control procedures followed recommended guidance from the Department of Health: Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions.

Medicines were stored appropriately, both for medical emergencies and for regular use and were in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff we spoke with were knowledgeable about safeguarding systems for adults and children.

The practice had processes for recording and reporting any accidents and incidents.

Risk assessments (a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) were in place for the practice.

No action



### Are services effective?

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

Dental professionals referred to resources such as the National Institute for Health and Care Excellence (NICE) guidelines and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations.

Staff obtained consent, dealt with patients of varying age groups and made referrals to other services in an appropriate and recognised manner.

Staff who were registered with the General Dental Council (GDC) met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD).

No action



### Are services caring?

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

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 48 responses all of which were very positive, with patients stating they felt listened to and received the best treatment at that practice.

Dental care records were kept securely on computer systems which were password protected and backed up at regular intervals.

No action



# Summary of findings

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

## **Are services responsive to people's needs?**

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

The practice had dedicated slots each day for urgent dental care and every effort was made to see all emergency patients on the day they contacted the practice.

Patients had access to telephone interpreter services when required and the practice had wheelchair access.

**No action**



## **Are services well-led?**

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

We found there were strong support systems in place to ensure the smooth running of the practice.

There were dedicated leads in infection prevention and control and safeguarding as well as various policies for staff to refer to.

The practice manager kept all staff files, training logs and certificates and ensured there were regular quality checks of clinical and administration work.

The results and action plans from audits were not clearly detailed or shared with staff. We discussed this with the practice manager who agreed that this process could be improved.

Staff were encouraged to provide feedback on a regular basis through staff meetings and informal discussions.

Patient feedback was also encouraged verbally and online. The results of any feedback were discussed in meetings for staff learning and improvement.

**No action**



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## 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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection took place on 15 December 2016 was led by a CQC inspector and supported by a dental specialist advisor.

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

During the inspection, we spoke with the practice manager, dentists, dental hygienist, dental nurses, decontamination

staff and reception staff. We also reviewed policies, procedures and other documents. We also obtained the views of five patients on the day of our visit. We reviewed 48 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

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

There was a system in place to learn from and make improvements following any accidents, incidents or significant events.

We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff were aware of their responsibilities under the Duty of Candour. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

There was a system to receive and distribute patient safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). (The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness). All alerts were shared throughout the practice and actioned accordingly.

### Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority's safeguarding team, social services and other agencies including the Care Quality Commission. All members of staff had received level two training. They demonstrated to us their knowledge of how to recognise the signs of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them. This included and identified the practice's safeguarding lead.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments). Only the dentists were permitted to re-sheath needles where necessary in order to minimise the risk of inoculation injuries to staff.

### Medical emergencies

Staff had received up to date training in medical emergencies. The practice had made improvements following a practice training session by ensuring that the door to the patient toilet could be opened from the outside in an emergency.

All equipment and emergency medicines were present in line with the Resuscitation Council UK guidelines. This included an automated external defibrillator (AED) [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm].

We saw records that showed the emergency medicines and equipment were checked regularly and all stock was within the expiry date

Staff knew the location of the emergency equipment which was easily accessible.

### Staff recruitment

The practice recruitment policy was in line with the requirements of schedule 3. Staff recruitment files where relevant contained evidence of a Disclosure and Barring Services (DBS) check. (The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they might have contact with children or adults who may be vulnerable), evidence of conduct in previous employment, identification and eligibility to work in the United Kingdom, evidence of relevant qualifications and skills and hepatitis B immunisation status.

### Monitoring health & safety and responding to risks



## Are services safe?

A health and safety policy and risk assessments were available and up to date. There was a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found that risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

The practice had a number of risk assessments in place which included assessing the safety of boxes used to transport contaminated instruments to the decontamination room, the decontamination of dental impressions in the treatment room, an assessment of risk to trainee dental nurses and the risks of using latex, as a result the practice had introduced a latex free policy.

A fire risk assessment had been undertaken in April 2016. There were fire detection systems in place which were checked weekly. Staff carried out regular fire drills and the practice manager carried out an evaluation of how well staff had reacted.

### Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission which included Hepatitis B. The policy also described processes for the possibility of sharps' injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste. The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. This document and the practice policy and procedures on infection prevention and control were accessible to staff.

We looked at the facilities for cleaning and decontaminating dental instruments. The practice had a designated decontamination rooms in accordance with HTM 01-05 guidance. There was a dedicated staff member who had received appropriate training to carry out decontamination, they showed us how instruments were decontaminated. They wore appropriate personal

protective equipment (including heavy duty gloves and a mask) while instruments were decontaminated and inspected with an illuminated magnifier prior to being placed in an autoclave (sterilising machine).

We saw instruments were placed in date stamped pouches after sterilisation to indicate when they should be reprocessed if left unused.

There was evidence of daily, weekly and monthly tests being performed to check the steriliser was working efficiently and a log was kept of the results. We saw evidence the parameters (temperature and pressure) were regularly checked to ensure equipment was working efficiently in between service checks.

We observed how clinical waste items were disposed of and stored. The practice had a contract with a clinical waste contractor. We saw the different types of waste were appropriately segregated and stored at the practice. This included clinical waste and safe disposal of sharps.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of which was in line with guidance.

We looked at the treatment rooms where patients were examined and treated. The rooms and equipment were visibly clean. Separate hand wash sinks were available with good supplies of liquid soap and alcohol gel. Patients were given a protective bib and safety glasses to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

A Legionella risk assessment had been carried out in 2011 and the recommendations of the report had been implemented. This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease. (Legionella is a germ found in all potable water entering domestic and commercial premises). Dental nurses ran the water lines in each treatment room at the beginning of each session, flushed the dental water unit lines with an approved disinfectant and monitored cold and hot water temperatures in the sentinel taps each month. The lead dental nurse showed us the records of monitoring the hot and cold water in the sentinel taps and demonstrated how the DUWL were flushed.



## Are services safe?

There was a good supply of environmental cleaning equipment which was stored appropriately. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spreading.

### Equipment and medicines

There were systems in place to check equipment had been serviced regularly, including the dental air compressor, autoclaves, fire extinguishers, medical emergency oxygen and the X-ray equipment. We were shown the servicing certificates.

An effective system was in place for the prescribing, administration and stock control of the medicines used in clinical practice such as local anaesthetics and antibiotics. These medicines were stored safely for the protection of patients. Local anaesthetic cartridges were removed from the packaging and kept in warming devices in the surgery. The dentists told us they would stop the use of these and keep local anaesthetic in the original package until required.

### Radiography (X-rays)

We checked the practice's radiation protection records as X-rays were taken and developed at the practice. We found there were arrangements in place to ensure the safety of the equipment. We saw local rules relating to each X-ray machine were available.

We found procedures and equipment had been assessed by an independent expert within the recommended timescales. The practice had a radiation protection adviser and had appointed a radiation protection supervisor.

In order to keep up to date with radiography and radiation protection and to ensure the practice is in compliance with its legal obligations under Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000, the General Dental Council recommends that dentists undertake a minimum of five hours continuing professional development (CPD) training During each five year CPD cycle. We saw evidence that the dentists were up to date with this training.

Dental care records we reviewed showed the practice was justifying, reporting on and grading X-rays taken.





# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The dentists told us they regularly assessed each patient's gum health and took X-rays at appropriate intervals. Dental Care Records showed a comprehensive examination of a patient's soft tissues (including lips, tongue and palate) had been carried out and the dentists had recorded details of the condition of patients' gums using the basic periodontal examination (BPE) scores. (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). In addition they recorded the justification, findings and quality assurance of X-ray images taken.

The dentists carried out an oral health assessment for each patient which included their risk of tooth decay, gum disease, tooth wear and mouth cancer. The results were then discussed with the patient (and documented in the patient record) along with any treatment options, including risks, benefits and costs.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to wisdom teeth removal and in deciding when to recall patients for examination and review.

### Health promotion & prevention

The practice placed an emphasis on oral disease prevention and the maintenance of good oral health as part of their overall philosophy. A range of leaflets and posters in the waiting room contained information for patients such as smoking cessation advice and maintaining children's oral health.

Staff we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice. This was also recorded in the dental care records we reviewed.

### Staffing

There was an induction and training programme for staff to follow which ensured they were skilled and competent in

delivering safe and effective care and support to patients. We reviewed the newest member of staff's induction file and evidence was available to support the policy and process had been followed.

Staff had undertaken training to ensure they were kept up to date with the core training and registration requirements issued by the General Dental Council. This included areas such as responding to medical emergencies and infection control and prevention.

There wasn't a formal appraisal system in place but we saw evidence of discussions with staff to identify training and development needs. The dentists did not receive an appraisal but they attended regular peer review events and meetings. They told us they would arrange appraisals.

### Working with other services

Referrals for patients when required were made to other services. The practice had a system in place for referring patients for dental treatment and specialist procedures such as orthodontics and minor oral surgery. Staff told us where a referral was necessary, the care and treatment required was fully explained to the patient. There was a system in place to record and monitor referrals made to ensure patients received the care and treatment they required in a timely manner.

### Consent to care and treatment

The practice ensured informed consent from patients was obtained for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. We asked the dentists to show us some dental care records which reflected this. Patients were given time to consider and make informed decisions about which option they wanted. This was reflected in the comments we received from patients.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated a good understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were



## Are services effective? (for example, treatment is effective)

respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and

treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.



## Are services caring?

### Our findings

#### **Respect, dignity, compassion & empathy**

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 48 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

We observed all staff maintained privacy and confidentiality for patients on the day of the inspection. Practice computer screens were not overlooked in reception and treatment rooms which ensured patients' confidential information could not be viewed by others. If further privacy was requested, patients were taken to a private room to talk with a staff member.

Staff had radios in the practice, they asked patients and made a note of when patients preferred to be treated without the radio on.

We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored electronically and computers were password protected to ensure secure access. Computers were backed up and passwords changed regularly in accordance with the Data Protection Act.

We saw evidence for all staff in information governance training. Staff were confident in data protection and confidentiality principles.

#### **Involvement in decisions about care and treatment**

The practice provided clear treatment plans to their patients that detailed possible treatment options and costs. Posters showing NHS and private treatment costs were displayed in the waiting area. The practice's website provided patients with information about the range of treatments which were available at the practice.

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. We looked at dental care records with clinicians which confirmed this and patient comments aligned with these findings.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

We saw the practice waiting area displayed a variety of information including the practice opening hours, emergency 'out of hours' contact details, complaints and safeguarding procedures and treatment costs. Leaflets on oral health conditions and preventative advice were also available.

The practice had dedicated slots each day for emergency dental care and every effort was made to see all emergency patients on the day they contacted the practice. Reception staff had clear guidance to enable them to assess how urgently the patient required an appointment.

We looked at the appointment schedules and found that patients were given adequate time slots for different types of treatment.

### Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place to support staff in understanding and meeting the needs of patients. The policy was updated annually.

The practice had made reasonable adjustments to prevent inequity to any patient group. The practice had carried out a disability access audit. A disability access audit is an assessment of the practice to ensure it meets the needs of disabled individuals, those with restricted mobility or with pushchairs. Staff had access to a translation service where

required and there were disability aids within the practice such as a selection of reading glasses and a hearing loop. Staff could access interpretation services should the need arise.

### Access to the service

The practice's opening hours were:

9:00am to 7.30pm Monday, 9am to 5:30pm Tuesday, Wednesday, Thursday and 8am to 2pm Friday. These were displayed in their premises, in the practice information leaflet and on the practice website.

The patients we spoke with felt they had good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

### Concerns & complaints

The practice had a complaints policy which provided guidance to staff on how to handle a complaint. The policy was detailed in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and as recommended by the GDC.

Information for patients was available in the waiting areas. This included how to make a complaint, how complaints would be dealt with and the time frames for responses.

Staff told us they raised any patient comments or concerns with the practice manager immediately to ensure responses were made in a timely manner.

The practice received one verbal complaint in the last twelve months. We saw records that showed the complaints had been effectively managed and also shared with the whole practice to enable staff learning.

# Are services well-led?

## Our findings

### Governance arrangements

The practice manager provided us with the practice policies, procedures, certificates and other documents. We viewed documents relating to safeguarding, whistleblowing, complaints handling, health and safety, staffing and maintenance. We noted policies and procedures were kept under review by the practice manager on an annual basis and updates were shared with staff to support the safe running of the service.

The practice manager kept all staff files, training logs and certificates and ensured there were regular quality checks of clinical and administration work. The practice had an approach for identifying where quality or safety was being affected and addressing any issues. Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members.

We looked at the Control of Substances Hazardous to Health (COSHH) file which contained detailed risk assessments for substances used in a dental practice, their practice risk assessment, health and safety risk assessment and fire risk assessment. Each was in accordance with the relevant legislation and guidance. The practice had dedicated leads and various policies to assist in the smooth running of the practice.

There were business continuity plans in place and we saw evidence that these were followed. For example during a recent computer system failure. There were arrangements in place with other local practices to provide cover where necessary.

### Leadership, openness and transparency

The overall leadership was provided by the registered manager. The ethos of the practice was clearly apparent in all staff as being able to provide the best service possible.

Staff told us they were aware of the need to be open, honest and apologetic to patients if anything was to go wrong; this is in accordance with the Duty of Candour requirements.

### Learning and improvement

A regular audit cycle was apparent within the practice although the findings were not always shared with staff. An audit is an objective assessment of an activity designed to improve an individual or organisation's operations.

Clinical and non-clinical audits were carried out by various members of staff. Topics included appointment cancellations, radiography, infection prevention and control and record keeping audits. The results and action plans were not clearly detailed or shared with staff. We discussed this with the practice manager who agreed that this process could be improved.

Improvement in staff performance was monitored by personal development plans and informal discussions which were documented by the practice manager. The records we reviewed were filled with sufficient details and action plans.

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

The practice had systems in place to seek and act upon feedback from staff members and people using the service.

Staff and patients were encouraged to provide feedback on a regular basis either verbally, online, and using the suggestion boxes in the waiting rooms. Patients were also encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on the services provided. The most recent FFT in the preceding four months showed 100% of 33 patients who took the survey were likely or extremely likely to recommend others to the practice. The practice also carried out their own survey with quarterly analysis. Both survey results were displayed in reception to show patients how their views have been considered.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the practice manager. Staff meetings were held every six weeks and staff were encouraged to contribute to the meeting agenda. Several staff members had been employed at the practice for many years, we observed high levels of staff satisfaction. We reviewed the minutes of staff meetings, topics discussed included the repair of equipment, continuing professional development and the potential provision of a second handrail.