Edres Limited

Queen Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 January 2017 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

Queen Street Dental Practice is a small well-established dental practice that provides private treatment to adults and children. The practice has about 400 registered patients. The team consists of one part-time dentist, one part-time dental nurse and receptionist (who is the dentist's wife, and a qualified dentist). The practice has one a treatment room, a separate room for the decontamination of instruments and a reception and waiting area. It opens three days a week from 8.45am to 5.30pmon Wednesdays, Thursdays and Fridays.

The dentist is registered with the Care Quality Commission (CQC) as the registered manager. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run

Our key findings were:

- The practice had systems to help ensure patient safety. These included responding to medical emergencies, maintaining equipment and managing radiographs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was visibly clean and well maintained. Infection control and decontamination procedures were good, ensuring patients' safety.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- Patients were treated in a way that they liked and spoke highly of the caring and empathetic nature of the dentist. They told us they were actively involved in decisions about their treatment.

Summary of findings

- The practice listened to its patients and staff and acted upon their feedback.

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

- Review training needs to ensure that all staff receive relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Review the practice's sharps handling procedures to ensure it complies with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had good arrangements for essential areas such as infection control, clinical waste, the management of medical emergencies and dental radiography (X-rays). Equipment used in the dental practice was well maintained and recruitment procedures ensured only suitable staff were employed. Staff were aware of their responsibilities in safeguarding children and adults, although had received no accredited training in this. The practice did not receive safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and medical emergency training needed to be updated.

No action

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, options and costs were explained to patients in a way they understood and staff followed appropriate guidelines for obtaining patient consent. Patients were referred to other services as needed.

No action

Are services caring?

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

We spoke with a small sample of patients following our inspection who spoke very highly of the dentist, and his caring and empathetic nature. They told us they were involved in decisions about their treatment, and did not feel rushed in their appointments. Staff gave us specific examples where they had gone beyond the call of duty to support patients. The dentist responded to patients in dental pain and drove to see them from London if needed.

No action

Are services responsive to people's needs?

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

Despite the practice only being open three days a week, patients told us it was easy to get an appointment at a time suitable for them and getting through on the phone was easy. The practice had made some adjustments to accommodate patients with a disability and the treatment room was accessible to wheelchair users.

There was a clear complaints' system and the practice responded appropriately and empathetically to issues raised by patients. Complaints were used to improve the service.

No action

Summary of findings

Are services well-led?

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

The practice had a number of policies and procedures to govern activity and held regular staff meetings. Staff received regular performance reviews and told us they enjoyed their work. They described a family like and supportive environment in which to work. The practice proactively sought feedback from staff and patients, which it acted on.

No action 

Queen Dental Surgery

Detailed findings

Background to this inspection

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

The inspection was carried out on 10 January 2017 by a CQC inspector who was supported by a specialist dental adviser. During the inspection, we spoke with three dentists, two dental nurses, the practice manager and a member of reception staff. We reviewed policies, procedures and other documents relating to the management of the service and spoke to patients following our inspection.

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

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and details of how to report to this agency were available. The practice also had policies regarding the reporting of significant events, and a specific form on which to record them. In addition to this, the practice kept a small notebook to record any accidents; although we were told none had occurred in recent years.

There was no system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned, and staff were unaware of recent alerts affecting dental practice.

Reliable safety systems and processes (including safeguarding)

None of the staff we spoke with had received accredited safeguarding training, although staff we spoke with demonstrated they understood the importance of safeguarding issues and their knowledge of reporting procedures and external agencies involved in the protection of children and vulnerable adults was good. Policies and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Contact details of relevant agencies involved in protecting vulnerable people were on display in the reception area and in the treatment room, making them easily accessible to staff. The dental nurse was aware of agencies she could contact if she had concerns about a colleague's practice.

Files showed that disclosure and barring checks had been competed for staff to ensure they were suitable to work with children and vulnerable adults.

Staff spoke knowledgeably about action they would take following a sharps injury and we viewed at sharps' injury protocol available in the practice's filing room (although this would be better placed in areas where sharps are used). We noted that sharps' bins were securely attached to the wall in treatment rooms to ensure their safety, and had been assembled correctly, signed and dated. A sharps risk assessment had been completed, although not all of its recommendations had been implemented. Only the dentist handled used needles, but he did not use a safer sharps' system as recommended by the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. 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. The dentist confirmed that he routinely used rubber dams to ensure patient safety.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies found in dental practice. There was an automated external defibrillator and staff had received training in how to use it, although this was out of date at the time of our inspection. Staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date. Staff had access to oxygen along with other related items in line with the Resuscitation Council UK guidelines. However, we found there was no airways equipment to assist patients with breathing difficulties in an emergency.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice and those we checked were in date for safe use. The dentist told us he checked all emergency equipment and medicines each month, although no record was made of these checks.

Staff recruitment

We checked personnel records for staff which contained evidence of their GDC registration and qualifications where required, references and a disclosure and barring check (DBS). 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. Notes of staff recruitment interviews were not kept to demonstrate they had been conducted fairly.

Are services safe?

We spoke with the dental nurse who told us her recruitment had been thorough and that she had received a good induction to her new role.

Monitoring health & safety and responding to risks

There was a health and safety policy available with a poster, which identified local health and safety representatives. The practice had completed a full health and safety risk assessment, which covered a range of potential hazards in the practice including autoclaves, biological agents, display screen equipment and radiation.

A legionella risk assessment had been carried out in July 2016 and we noted that its recommendations had been implemented by the practice. Regular flushing of the dental unit water lines was carried out in accordance with current guidelines, water temperatures were monitored monthly and the practice used a biocide in the water line to reduce the risk of legionella bacteria forming.

A fire risk assessment for the practice had been completed in December 2016 but this was very basic and had failed to identify a number of hazards we saw such as the storage of oxygen. Firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** However regular evacuation drills were not completed with patients to ensure staff knew what to do in the event of a fire.

The dental nurse worked completely on her own at the practice on Mondays and Tuesdays and no risk assessment had been completed to identify any potential risks to her safety on these days. The dentist assured us one would be completed.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for products used within the practice, although some data information sheets were missing for commonly used household cleaning products.

The practice had a business continuity plan in place for major incidents such as the loss of utilities, a copy of which was kept off site by the dentist.

Infection control

The practice had infection control policies in place to provide guidance for staff on essential areas such as waste disposal, blood spillage, hand hygiene and the use of personal protective equipment.

The nurse was responsible for all cleaning in the premises and we viewed the daily and weekly cleaning checklists that she completed. All areas of the practice we viewed were visibly clean and hygienic, including the waiting area, toilet, reception and window blinds. Cleaning equipment used in different areas of the practice was colour coded according to national guidance to reduce the risk of cross contamination.

We checked the treatment room and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. Posters reminding staff of how to wash their hands correctly were on display by the hand wash sink. The room had sealed flooring and modern sealed work surfaces so they could be cleaned easily. Drawers were clean and uncluttered, although we noted some uncovered and loose items in them that risk becoming contaminated in the long run.

The practice had a separate room for the decontamination of dental instruments. A dental nurse demonstrated to us the decontamination process and we noted that she wore appropriate personal protective equipment during the procedure including heavy-duty gloves, visor and apron.

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. We noted that the nurse used an inner bowl to clean the instruments, rather than the full sink for increased safety, and that she was not using an appropriate detergent to clean them. Following inspection with an illuminated magnifier, the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. Logs used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. The practice used an appropriate contractor to

remove clinical waste from the practice and waste consignment notices were available for inspection. Clinical waste was stored upstairs in a secure location prior to collection.

All dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, however the dentist wore a laboratory coat with full-length sleeves and the nurse wore a long sleeved top under her scrubs which compromised infection control.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. Other equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, portable appliance testing had been undertaken in December 2016; a pressure vessel inspection had taken place in July 2016 and the dental chairs and suction unit had been serviced in September 2016.

The practice did not have a separate fridge for medicines, which required cool storage, and we found medical consumables stored alongside food in the staff kitchen. The temperature of the fridge was not monitored to ensure it operated effectively. Staff had access to a mercury spillage kit but there was no kit available to deal with bodily fluid spills. The dentist assured us he would order one immediately.

Our review of dental care records showed that the batch numbers and expiry dates for local anaesthetics were always recorded. The dentist was aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines. Prescriptions for patients were printed out as needed but there was no system in place to track them effectively.

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 and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. The critical examination report and a copy of the local rules were available in the file.

Regular radiographic audits were completed and dental care records we viewed showed that dental X-rays were reported on and justified, although not regularly graded.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

All patients to the practice were asked to provide their medical history including any health conditions, current medication and allergies. These were updated every two years, and not annually as recommended, although patients were asked to verbally confirm any changes in their health at each visit. This ensured the dentist was aware of patients' present medical condition before undertaking any treatment.

Our discussion with the dentist showed that that he was aware of, and worked to, guidelines from National Institute for Heath and Care Excellence (NICE) and the Faculty of General Dental Practice for best practice in care and treatment. Dental care records we reviewed demonstrated that NICE guidance was followed for patients' recall frequency, wisdom tooth extraction and antibiotic prophylaxis, although record in keeping in general could have been more detailed. We found that routine dental examinations for gum disease and oral cancer had taken place. Dental decay risk assessments had been completed for patients.

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping, the quality of dental radiographs and infection control. The record keeping audit had highlighted a number of areas for improvement that the dentist was aware of and working towards implementing.

Health promotion & prevention

Patients were asked about their smoking and alcohol intake as part of their medical history and dental care records we reviewed demonstrated the dentist had given a lot of preventative oral health advice to patients and made referrals to other dental health professionals when necessary. One patient told us the dentist reminded them about correct tooth brushing techniques at every visit.

The practice did not sell any dental products to help patients manage their oral hygiene but we noted an excellent range of information leaflets available to patients at the reception desk, providing them guidance on a range of dental issues.

Staffing

The practice team was small and consisted of one dentist, his wife (who worked as a receptionist) and a dental nurse. Staff told us they were enough of them for the smooth running of the service and a dental nurse always worked with the dentist. Both staff and patients told us they did not feel rushed during appointments.

Files we viewed demonstrated that staff were appropriately qualified and had current professional validation and professional indemnity insurance. The practice had appropriate Employer's Liability insurance in place.

The dentist conducted an annual performance appraisal for the nurse, which she described as useful.

Working with other services

The dentist made referrals to other dental professionals when he was unable to provide the necessary treatment himself and there were clear referral pathways in place. However, a log of the referrals made was not kept so they could be could be tracked and monitored, and patients were not given a copy of their referral for their information.

Consent to care and treatment

Patients told us that they were provided with good information during their consultation and they had the opportunity to ask questions before agreeing to a particular treatment. Dental records we reviewed demonstrated that treatment options had been explained to them. Patients were provided with plans that outlined their treatment and its cost, and signed to show they agreed with it.

The practice had appropriate policies in place in relation to patient consent and the Mental Capacity Act 2005 (MCA). Staff had received specific training in the MCA in May 2015 and understood the relevant consent and decision-making requirements of legislation and guidance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received many positive comments about the caring, empathetic and friendly nature of staff. In particular, patients spoke highly of the dentist's concern for their welfare and those of their family members. One patient told us that the dentist had visited her husband at home when he returned from hospital, and another that the dentist had been supportive when their partner had died. A patient told us the dentist had very good rapport with children and we noted a number of children's drawings on display in the treatment room. The nurse told us of additional support measures she had implemented to support one patient with autism.

Staff were aware of the importance of maintaining patients' confidentiality. All consultations were carried out in the privacy of the treatment room and blinds had been put on windows to prevent outsiders looking in. The practice's waiting room was completely separate from the reception area allowing for good privacy. The reception computer screen was not overlooked and was password protected. Patients' paper records were stored in a separate cupboard but we noted this could not be looked to ensure their security.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and that advice was given clearly and treatments explained well by the dentist. The dentist told us he regularly used an intra-oral camera, dental models, X-rays and pictures to help patients better understand their oral health and treatment. Patients also had access to a wide range of leaflets explaining treatments such as apicectomy, tooth extraction and implants

A plan outlining the proposed treatment was given to each patient so they were fully aware of what it entailed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In addition to general dentistry, the practice offered a number of cosmetic treatments, including tooth whitening, veneers and implants. The practice also had an intra-oral camera that was used to help patients understand their dental care.

Patients told us they were satisfied with the appointments system and that getting through on the phone to the practice was easy. Although the practice was only open three days a week, both the dentist and nurse told us that any patient experiencing dental pain would be seen that day, and the dentist had on occasion driven up from London in order to attend to a patient when the practice was closed.

Tackling inequity and promoting equality

The practice had taken some measures to meet the needs of patients with disabilities. A ramp was available to help wheelchair users and the treatment room was on the ground floor, although there was no disabled toilet. There was no portable hearing loop available despite a number of patients with hearing aids, or easy riser chairs in the waiting area to accommodate patients with mobility needs. The practice did not have any information in other formats such as large print, audio or braille.

Concerns & complaints

There was a large poster in the waiting room outlining the practice's complaints procedure to patients. This included timescales within which complaints would be dealt with and external organisations that patients could contact if unhappy with their treatment. There were also details in the patient information leaflet about how to raise concerns.

It was clear that the practice used complaints to improve the service. For example, as a result of one patient's concerns the practice introduced a policy that it would now ring patients' dental insurers themselves and inform them if a patient had left the practice.

Are services well-led?

Our findings

Governance arrangements

The dentist had responsibility for the day-to-day running of the practice, supported by a receptionist. The practice had a set of policies and procedures to support its work and we viewed those in relation to patient consent, infection control and complaints handling. Although some were a little basic, there was good evidence that they had regularly been reviewed by the dentist to ensure they were still relevant to the practice

Communication across the practice was structured around a monthly staff meeting, minutes of which we viewed. These showed a range of essential topics was regularly discussed such as data protection, patient consent, complaints and confidentiality. However, the recording of minutes from these meetings was not detailed .The minutes did not contain any summary of what was discussed, the outcome of those discussions, or any agreed action.

Staff received an annual appraisal which covered their objectives, job satisfaction, training and development.

Regular audits were undertaken to assess standards in radiography, infection control and the quality of clinical notes. However, results were not always used to make improvements. For example, the infection control and sharps' audits had identified a number of minor shortfalls but no action had yet been taken to address them.

Leadership, openness and transparency

The practice only employed one dental nurse. She told us she felt she was 'part of a family' and described very good relations between herself and the dentist. She told us that the dentist was very approachable and she felt she could give her views about how things were done at the practice.

A policy for following the Duty of Candour was available and staff were able to describe clearly the principles of being open and honest with patients when things went wrong.

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

Patients were encouraged to complete a satisfaction questionnaire, which asked them to comment on the friendliness of the reception staff, the ease of making an appointment and the skill of the dentist. Result we viewed show high satisfaction rates amongst the respondents. It was clear that the practiced responded to patients' suggestions. For example, a radiator had been purchased for the waiting room following feedback that it was cold sometimes. The dentist had reduced the number of patients he saw each day so that waiting times could be shortened for those having arrived at for their appointment.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with the dentist. We were given examples where staff's suggestions had been listened to. such as redecorating the practice and renovating the exterior window.