Dr. Mehrdad Seifouri

Craigweil Dental Practice

Inspection Report

Grand Avenue, Lancing, West Sussex BN15 9PS
Tel: 01903 762584
Website:

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Overall summary

We carried out an announced comprehensive inspection on 12th May 2015.

Regulations were being met.

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

Our key findings were:

The practice was situated in a residential area, close to public transport access. The practice offered general, preventative and cosmetic dentistry. It did not offer sedation services or domiciliary visits.

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

- Change the existing emergency medicine Diazepam to Midazolam as per BNF recommendations

Develop a short protocol about the safe management of sharps

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive to people's needs?

We found that the practice was responsive in accordance with the relevant regulations. Complaints were managed in a timely and satisfactory manner. There were systems in place to respond to patients' needs, such as a patient presenting in pain. The practice was accessible to patients with mobility problems and undertook regular risk assessments to ensure compliance with the law.

Are services well-led?

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

Craigweil Dental Practice

Detailed findings

Background to this inspection

The inspection was undertaken on 12th May 2015 and was conducted by a CQC inspector and a Specialist Dental Advisor

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

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

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

During the inspection we spoke with the dentist, dental nurse and receptionist. We also spoke with two patients. We reviewed policies, protocols, procedures and other relevant documentation.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

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

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

The practice recorded incidents and accidents formally. These were discussed at team meetings and an action plan devised.

Reliable safety systems and processes (including safeguarding)

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

Staff explained how they would prevent an event such as the accidental extraction of a healthy tooth. The decision to extract a particular tooth would be discussed with the patient at the initial assessment. On the day of the treatment the dentist would ask the patient to point to the tooth in question then this would be confirmed or otherwise with the dental charting on the practice IT system. Only when both parties were sure would the extraction take place.

We asked how the practice treated the use of instruments which are used during root canal treatment. Staff explained these instruments were single use only. They also 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. The practice followed appropriate guidelines set out by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

There was a range of suitable equipment which included an automated external defibrillator (AED), oxygen, oxygen masks, a range of airways and other pieces of equipment available for dealing with medical emergencies. This was in line with the Resuscitation UK Council guidelines. There was also a range of emergency medicines available for dealing with medical emergencies which were generally in line with British National Formulary (BNF) guidelines. The exception was the emergency medicine used in the treatment of an epileptic seizure. Although the practice had Diazepam in place for the treatment of this type of emergency, BNF guidelines suggest that Midazolam is the drug of choice.

The emergency medicines were all in date and stored securely, with emergency oxygen in a central location known to all staff. The AED was stored in the adjacent dental practice within the same building which is accessible to all in the event of a medical emergency. A check list monitoring the expiry dates of the emergency medicines was present in the storage cabinet. This ensured that the risk to patients' during dental procedures was reduced and patients were treated in a safe and appropriate manner.

Infection control

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

We noted that both dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet, hand washing protocols were also displayed in each of these areas. We spoke with the staff member responsible

Are services safe?

for the day to day infection control systems and processes within the practice. They shared the environment cleaning with an external contractor whose duties were detailed in a dedicated cleaning manual.

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

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

Due to the lack of space, decontamination of dental instruments was carried out within the dental treatment room. We were told plans were in place to convert the existing kitchen area into a separate decontamination area in the near future.

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

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

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

We observed that sharps containers were properly maintained and was in accordance with current guidelines. The practice sharps injury protocol was clearly understood when talking with staff. We asked if staff were aware of the management of safer sharps requirements under the 2013 EU Directive. Although the staff member was unsure of the directive, they explained they did not re-sheath needles using hands following the administration of a local anaesthetic. The staff member explained it was the dentist's responsibility to dispose of used needles who confirmed this. We explained that current guidance provided by the Health and Safety Executive requires a risk assessment with appropriate measures put in place to prevent needle stick injuries to satisfy the current EU Directive on the management of sharps. Staff told us they would develop a suitable protocol immediately. The last sharps injury was in 2013 involving a clean instrument. No contaminated injuries have been reported in the last five years.

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

Equipment and medicines

We examined documentation related to the maintenance and servicing of equipment in use at the practice. These were in line with the manufacturers' guidelines. We examined the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations(2000), the most recent service being carried out in October 2014.The dental compressor was serviced regularly. It was last carried out in September 2014 which was in line with current regulations. X-ray machines were the subject of regular, recorded visible checks. A specialist contractor calibrated and reviewed all

Are services safe?

X-ray equipment to ensure they were operating safely. The most recent report, dated August 2014, was compliant with the Ionising Radiation Regulations (1999). A maintenance contract was in place for the replacement of the emergency oxygen ensuring that the contents and the metal oxygen cylinder did not deteriorate over time.

Radiography (X-rays)

We were shown a radiation protection file which was completed in line with the Ionising Radiation Regulations (1999) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation related to the maintenance of the x-ray equipment. These included critical examination packs for each x-ray set along with the three yearly maintenance logs and a copy of local protocols. Also present in the file was training records of the dentist in relation to IRMER requirements. We saw a copy of the most recent radiological audit This showed a very high percentage of radiographs were of Grade 1 standard. The clinical records we saw showed dental x-rays were justified, reported on and quality assured on each occasion. This showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Staff recruitment

Appropriate checks were undertaken before staff began work. We examined staff files containing recruitment information for three staff members. We noted staff had undergone procedures required by the provider, including Disclosure and Barring Service (DBS) checks before being allowed to work with patients. There were also copies of blood borne virus risk assessments, staff references, staff contracts and job descriptions in staff files. The provider also had systems in place to ensure staff maintained registration with the appropriate professional bodies. We noted, on commencing employment, all staff underwent a formal induction period. The records showed this process was structured around allowing staff to familiarise themselves with the practice's policies, protocols and working practices. Staff 'shadowed' more experienced staff until such time as they were confident to work alone. One staff member told us, “I never felt out of my depth. I could always ask someone if I needed to”.

Monitoring health and safety and responding to risks

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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

Health promotion & prevention

Staff told us they adopted a collaborative approach when treating patients. This meant helping the patient to maintain a healthy, functional and comfortable mouth. Advice on smoking cessation and alcohol consumption reduction was included in this. Patients also had the option of using the dental hygienist on a private basis if they preferred.

Staff described how they used the computer screen to assist in getting across the preventative message to patients, for example when patients present with gum disease. Patients were shown anonymised photographs of patients suffering from gum disease. This was followed by photographs illustrating where gum disease has resolved to show how effective tooth brushing and interdental cleaning worked.

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

Staffing

We looked at the practice's policies, staff training records and associated documentation. We found contained relevant and up to date information. Patients we spoke with had confidence in the staff's ability to provide good care. One patient told us, "I wouldn't come back if the care was no good". There were regular staff meetings held. We looked at the minutes of these meetings and saw staff were given the opportunity to discuss professional issues. Staff were able to access training in subjects relevant to the needs of the patients they were treating. These included the detection of oral cancer, safeguarding vulnerable adults and children and record keeping. Staff we spoke with were satisfied with the training opportunities on offer.

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

Working with other services

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

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

We looked at the provider's consent to care and treatment and consent to outside referral policies. Patients told us the dentist always discussed treatment options with them after initial examination. Our observations confirmed this. One patient said, "II never leave not knowing what's happened". Another patient told us, "They (staff) always make clear what the options are and ask me which one I prefer".

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

We looked at a recently completed patient satisfaction survey. We noted that all of patients asked were satisfied or highly satisfied in areas of treatment discussion and involvement in decision making. We saw that patients' written consent had been sought and obtained in a variety of areas. Each patient received written information, outlining proposed treatment, which was signed as read and agreed by the patient. We asked about matters of consent in relation to children registered at the practice. We were told children were accompanied by a parent or guardian, from whom written consent was always sought. One staff member said, "We always get parental consent for children but we do involve older ones in the decision making process. They have to be on board or there's little point in the treatment". The staff we spoke with understood their responsibilities in relation to the care of people who did not have the capacity to consent to treatment. The documentation we looked at and the observations we made showed appropriate consent had been sought for treatment. This was done either face-to-face during a consultation or by letter sent from the practice. All of the patients we spoke with were satisfied they had been fully consulted.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

People told us all of the staff treated them with respect and were friendly and approachable. We observed reception staff welcoming people and checking their identity before booking them in for appointments. One person told us that "It's a small practice and very friendly ".

We observed that the ground floor reception desk was in the main waiting area and as such offered limited privacy to people. However, there was a second room on the ground floor which could be used if privacy was required. The people we spoke with did not have any concerns about the location of the reception desk. We noted when reception was left unstaffed from time to time, confidential patient information was not left on display.

The staff we spoke with were clear about their responsibilities in relation to ensuring people's dignity and privacy were maintained. One staff member told us, "Confidentiality is obviously important to us. If someone wants to say something in confidence, we'll make sure they can".

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

Involvement in decisions about care and treatment

Staff were aware of the importance of involving patients in decisions about care and treatment. The dentist explained they would not normally provide treatment to patients on the first appointment unless they were in pain or their presenting condition dictated otherwise. The dentist felt patients should be given time to think about the treatment options presented to them. Our discussions and observations indicated patients could withdraw consent at any time. They had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

We spoke with staff and patients and examined documentation concerning the provider's response to patients' needs. One patient told us, "Well I never have any problem getting an appointment. They (staff) are always helpful". We examined the provider's emergency appointment policy and spoke with staff. We noted the provider operated a grading system from one to three depending on the urgency of the patient's situation. We were told those fitting the grade one criteria (those in severe pain) were always seen immediately. All others were seen either within 24 hours or as soon as practicable. We looked at the provider's appointment system and saw this in practice. We noted the appointment system was flexible enough to cope with emergency situations. There was no double booking of appointments. Our examination of returned patient satisfaction questionnaires showed a high degree of satisfaction in waiting times, both for routine and emergency appointments.

Tackling inequality and promoting equality

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

Access to the service

The practice was accessible for people with restricted mobility and for those who used a wheelchair. There was access to the ground floor where there were consulting rooms. The reception desk on the ground floor was easily accessible to people and there was a toilet suitable for people with restricted mobility. The practice was situated in a residential area and parking was available near to the practice.

Concerns and complaints

The practice took account of complaints and comments to improve the service and explained how complaints would be dealt with. The patients we spoke with felt they could make a complaint if they needed and would be listened to. We examined the complaints policy and procedures and found they included clear guidelines on how and by when issues should be resolved. They also contained the contact details of relevant external agencies, such as the local NHS commissioners. The policy was also displayed in the waiting area. There had been two recent complaint made. We looked at documentation related to these and found the complaints had been resolved in a timely and satisfactory manner. The management of complaints was reviewed regularly in team meetings and remedial action taken where necessary. Our conversations with patients and staff indicated a culture of openness in which people, their representatives and staff could raise issues of importance to them.

Are services well-led?

Our findings

Governance arrangements

We were told the day to day running of the practice was the responsibility of the dentist. There was no dedicated practice manager. There was a clear management structure however, with staff acting as dedicated leads in areas such as infection control and safeguarding children and vulnerable adults. There were clear and relevant risk assessments in place, in areas such as environmental cleaning, the safety and suitability of premises and infection control. The provider also had a dedicated COSHH file (care of substances hazardous to health). We examined the file and saw it was reviewed and updated regularly.

Leadership, openness and transparency

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

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

The practice regularly sought the views of patients who used the service via questionnaires. We examined 21 recently returned patient satisfaction surveys. We also looked at 12 returned NHS 'Friends and Family' Test cards and one comment card returned directly to the Care Quality Commission. All of those examined showed a high degree of satisfaction in all areas, including cleanliness, waiting times and staff attitudes. All of those returning Family and Friends cards were 'extremely likely' to recommend the service to others. The practice also captured the views of patients informally following their visit to the practice. The patients we spoke with were satisfied their views were taken into account.

Management through learning and improvement

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

We asked if all relevant staff were registered with the General Dental Council and adequately indemnified. We were shown documentation to confirm this. Our conversations with staff indicated a clear understanding of their professional responsibilities and accountability. The practice operated an informal appraisal system via team and one-to-one meetings. The staff we spoke with were satisfied with this arrangement.