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Lindfield Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 11 January 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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
Lindfield Dental Surgery is in Amersham and provides NHS and private treatment to patients of all ages.

Summary of findings

There is level access for people who use wheelchairs, those with pushchairs at the front of the practice. Car parking spaces, including space for blue badge holders are available in the practice car parking area.

The dental team includes three dentists, two dental nurses, two trainee dental nurses, one dental hygienists and a practice manager. The nursing staff also cover reception. The practice has two treatment rooms.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of our inspection we collected 46 CQC comment cards filled in by patients and obtained the views of 13 other patients.

During the inspection we spoke with two dentists, two dental nurses, one trainee dental nurse, one dental hygienist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open 8.30am to 5.30pm Monday, Thursday and Friday, 8.30am to 8pm Tuesday and Wednesday and 8.30am to 1.00pm on Saturday.

Our key findings were:

- The practice appeared clean and well maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. The practice had systems to help them manage risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- Improvements were required to several areas of the practice all of which have been addressed since our visit.

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?

No action

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

The practice had systems and processes to provide safe care and treatment. Staff knew how to recognise the signs of abuse and how to report concerns.

Premises and equipment were clean and properly maintained. The practice followed national guidance for sterilising and storing dental instruments. Cleaning instruments did not follow best practice guidance. We have since received evidence to confirm this shortfall has been addressed.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as efficient, thorough and caring. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

Improvements were needed to the management of staff training and effectiveness of clinical audits. We have since received evidence to confirm this shortfall has been addressed.

Are services caring?

No action

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

We received feedback about the practice from 59 people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind, friendly and professional and were given kind and understanding treatment, and said their dentist listened to them.

Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice did not have access to language interpreting services. We have since received evidence to confirm this shortfall has been addressed.

Summary of findings

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Improvements were needed to the provision of equipment to assist patients with hearing loss.

Are services well-led?

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

The staff felt supported and appreciated. The practice team kept complete patient dental care records which were, clearly typed and stored securely.

The lack of effective management and clinical leadership at the practice resulted in shortfalls in the management the service. Improvements were required to the management of staff training, clinical audits and emergency medical equipment. We have since received evidence to confirm all these shortfalls have been addressed.

No action 

Are services safe?

Our findings

Safety systems and processes including staff recruitment, Equipment & premises and Radiography (X-rays)

The practice had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse.

Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

Evidence seen confirmed that ten of twelve staff received safeguarding training.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice also had a system to identify adults that were in other vulnerable situations e.g. those who were known to have experienced female genital mutilation.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment

The practice had a business continuity plan describing how the practice would deal with events that could disrupt the normal running of the practice.

The practice had a staff recruitment policy and procedure to help them employ suitable staff which reflected the relevant legislation. Improvements were required to ensure only fit and proper persons were employed. We looked at three clinical staff's recruitment records. Proof of identity and eligibility to work in the UK, a health assessment and references were not available for two staff. We have since received evidence to confirm this shortfall has been addressed.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The person responsible for fire safety management at the practice had not received training for this role. The practice was unable to provide evidence that the smoke detectors were tested. Emergency lights were not available. We have since received evidence to confirm this shortfall has been addressed.

The practice's five yearly electrical wiring installation test was not available. We have since received evidence to confirm this shortfall has been addressed.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. We saw evidence that the practice carried out radiography audits following current guidance and legislation. Clear records of the results of these audits and the resulting action plans and improvements were not available. We have since received evidence to confirm this shortfall has been addressed.

Dentists completed continuing professional development (CPD) in respect of dental radiography. We noted nursing staff had not completed radiography for nursing staff training.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken.

Are services safe?

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. We noted that the effectiveness of the vaccination was not checked for all staff.

Staff knew how to respond to a medical emergency. We saw evidence that confirmed all staff had completed training in emergency resuscitation and basic life support (BLS) every year.

Emergency equipment and medicines were mostly available as described in recognised guidance. Staff did not keep records of their checks to make sure these were available, within their expiry date, and in working order. We noted an AED, size 0 and 1 facemask, a Volumatic spacer and razor were not available. We have since received evidence to confirm these shortfalls have been addressed.

A body fluid kit and eye wash kit was available.

A dental nurse worked with the dentists and the dental hygienists when they treated patients in line with GDC Standards for the Dental Team. We noted a risk assessment was in place at times when a nurse was unavailable.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. We observed the storage of clinician's uniforms was not isolated from outdoor clothing. We have since received photographic evidence to confirm this shortfall has been addressed.

Records examined confirmed eight of 11 clinical staff completed infection prevention and control training. We have since received evidence to confirm this shortfall has been addressed.

The practice had suitable arrangements for transporting, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We noted the practice carried out manual scrubbing of instruments. We have since received evidence to confirm ultrasonic baths have been introduced to the decontamination process and told manual scrubbing alone has stopped

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. A legionella risk assessment was carried out by the principal dentist in December 2018. The dentist could not evidence their competency for this task. We have since received evidence to confirm this shortfall is being addressed.

The practice was clean when we inspected and patients confirmed that this was usual.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted a standard black household bin to the side of the premises and was told clinical waste was stored there but this was not a regular occurrence because the bins in surgery did not generally fill in the four-week period between collection. We advised the practice to consider a lockable bin outside and to empty the bins in surgery daily to reduce the risk of infection. We have since received evidence to confirm this shortfall has been addressed.

The practice carried out infection prevention and control audits once a year when this should be every six months. Clear records of the results of these audits and the resulting action plans and improvements were not available. An annual infection control statement was not available. We have since received evidence to confirm these shortfalls have been addressed.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and

Are services safe?

managed in a way that kept patients safe. Dental care records we saw were accurate, complete, and legible and were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. We noted referrals were not monitored to ensure they had been received in a timely manner. We have since received evidence to confirm this shortfall has been addressed.

Safe and appropriate use of medicines

The dentists were aware of current guidance with regards to prescribing medicines.

Improvement was needed for the management of prescriptions held at the practice. Antimicrobial prescribing logs were not kept and audits were not carried out. We have since received evidence to confirm these shortfalls have been addressed.

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues. In the previous 12 months there had been no safety incidents.

Lessons learned and improvements

The staff were aware of the Serious Incident Framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework.

There were adequate systems for reviewing and investigating when things went wrong.

The practice did not have an effective system for receiving, storing and acting on safety alerts relating to dentistry and orthodontics. We have since received evidence to confirm this shortfall has been addressed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

We spoke with the dentists who described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept very detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw evidence of a dental care record audits for the whole practice. Clear records of the results of these audits and the resulting action plans and improvements were not available. We have since received evidence to confirm this shortfall has been addressed.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a period of induction based on a structured induction programme. We confirmed that generally clinical staff completed the continuing professional development required for their registration with the General Dental Council. We noted the system for monitoring staff training required improvement to ensure staff could evidence of competency in core CPD recommended subjects which include safeguarding, fire safety, basic life support and infection control. We have since received evidence to confirm this shortfall is being addressed.

Staff told us they discussed training needs at appraisals.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

Are services effective?

(for example, treatment is effective)

The practice also had systems and processes for referring patients with suspected oral cancer under the national two-week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were welcoming and friendly. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the requirements under the Equality Act the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

Interpretation services were not available for patients who did not have English as a first language. We have since received evidence to confirm this shortfall has been addressed.

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information booklet and website provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, models, videos, X-ray images and print outs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Are services responsive to people's needs?

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had made reasonable adjustments for patients with disabilities. This included step free access to the practice, a ground floor treatment rooms.

The practice did not have a hearing loop available for patients who wore hearing aids. We have since received evidence to confirm this shortfall has been addressed.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in their practice information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The dentists took part in an emergency on-call arrangement with each other.

The practice website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice manager was responsible for dealing with their own patient complaints but this would change when the practice manager was fully in post. Staff told us they would tell the dentist about any formal or informal comments or concerns straight away so patients received a quick response.

Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received. Information for patients showed that a complaint would be acknowledged within wo days and investigated within ten days.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The dentists were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Improvements were needed to ensure the practice management had the capacity and skills to deliver high-quality, sustainable dental care and treatment. All of the shortfalls we identified have since been addressed.

We wish to note that the practice's management of its processes require constant attention to prevent shortfalls happening again in the future.

Vision and strategy

There was a clear vision and set of values. The practice had a realistic strategy to achieve priorities.

The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

The provider had a system of governance in place which included policies, protocols and procedures that were accessible to all members of staff.

There was a system of clear responsibilities, roles and systems of accountability.

The management arrangement indicated that the practice fell short of effective clinical and managerial leadership. This became apparent when we noted shortfalls in the management of emergency equipment, staff recruitment, fire safety, staff training and clinical audit analysis. We have since received evidence to confirm all of these shortfalls have been addressed.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used patient surveys, comment cards, verbal comments to obtain patients' views about the service. As a result of patient feedback, the practice emailed patients with any changes to practice opening hours when national holidays occurred.

We noted the results of surveys were not made available to patients.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. As a result of staff feedback, the practice introduced flexible time staggered lunches.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Clear records of the results of these audits and the resulting action plans and improvements were not available for these audits. We have since received evidence to confirm this shortfall has been addressed.

Are services well-led?

The provider showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The whole team had appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

We noted the system for monitoring staff training required improvement to ensure staff could evidence of competency in core CPD recommended subjects. We have since received evidence to confirm this shortfall has being addressed.

The General Dental Council also requires clinical staff to complete continuing professional development.