Care Quality Commission

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Oakland Dental Care

Inspection Report

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Ratings

Overall rating for this service	
Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

We carried out an announced comprehensive inspection on 8 October 2015 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

Summary of findings

Oakland dental clinic is situated on the first floor of premises in South Woodham Ferrers. The practice has limited access for patients with restricted mobility, such as those in a wheelchair. The practice provides regulated dental services to patients in South Woodham Ferrers and the surrounding area. The practice provides wholly private dental treatment. Services provided include general dentistry and dental hygiene.

The practice is open on Mondays from 9am - 5pm, Tuesdays from 2pm - 8pm and on Thursdays from 8am - 2pm. The practice is closed on Wednesdays and Fridays The practice is open on Saturdays by appointment only

Patients who require appointments for urgent treatment outside of opening hours can ring the practice telephone number and follow the answerphone message.

The practice has one dentist, one dental nurse and a dental technician. The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

We received positive feedback from five patients about the services provided. Patients said they were happy with all aspects of the practice. The dentist was approachable and there were no concerns over the treatment provided. Patients also said the dental nurse was friendly and approachable.

Our key findings were:

- Staff had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, good practice and current legislation.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to handle emergencies, and appropriate medicines and life-saving equipment were readily available.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.
- Some governance arrangements were in place; however the practice did not have a structured plan in place to audit quality and safety in some areas round the planning and delivery of care and treatment. They planned to establish a more detailed system for this.

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

- Review the procedures in place for assessing the risk of legionella.
- Carry out regular infection control audits to test the effectiveness of these procedures.
- Review the arrangements in respect of fire safety including fire safety risk assessments and evacuation plans.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'
- Review the practice's protocols for completion of dental records so that they contain relevant information in respect of patients care and treatment including details of assessments carried out such as soft tissue examinations, details of patients smoking status and a record of patients consent to care and treatment,
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by patients.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

Summary of findings

- Review the systems in place for assessing and monitoring the quality and safety of services provided and develop the practice auditing processes to identify and secure improvements where these are needed.
- Establish a system for obtaining and acting on feedback from patients on the services provided, for the purposes of continually evaluating and improving the services.

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 systems and processes to record any accidents and significant events. The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

Staff had been trained in safeguarding vulnerable adults and children. There were guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

Infection control procedures followed published guidance to ensure that patients were protected from potential risks. However regular audits were not carried out to test the effectiveness of the infection control procedures. Equipment used in the decontamination process was maintained by a specialist company and regular frequent checks were carried out to ensure equipment was working properly and safely. No formal Legionella risk assessment had been undertaken.

The practice carried out radiographs (X-rays). However, the practice did not have systems or processes in place for when storing X-rays in the event that they could not be saved due to IT issues.

Are services effective?

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

Patients were clinically assessed by a dental professional before any treatment began. However, this was not recorded accurately within the dental care records. Patients completed a health questionnaire or updated one if they were returning patients.

There were arrangements in place for working with other health professionals.

Patients consent to care and treatment was sought in line with legislation and guidance; however the practice did not always retain a copy of the consent in the patients file.

Are services caring?

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

Staff were aware of the need for confidentiality, and took steps to ensure patients' this was maintained. This was both in the practice with the patients, and with regard to record keeping.

Patients were treated with dignity and respect. Staff at the practice were welcoming to patients and made efforts to help patients relax.

Patients said they received very good dental treatment and they were involved in discussions about their dental care. Patients said they were able to express their views and opinions.

Are services responsive to people's needs?

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

The practice had an appointments system which patients said was accessible and met their needs. Patients who were in pain or in need of urgent treatment were usually seen the same day if the practice was open.

Summary of findings

There were systems for patients to make formal complaints, and these were displayed within the practice. The leaflet did not contain information about other agencies a patient could contact if the complaint was not resolved to the patients satisfaction.

Are services well-led?

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

There was a clear management structure at the practice, and staff were aware of their roles and responsibilities.

Governance arrangements were not always effective. Policies and procedures had been reviewed; however, there were limited systems in place to assess and monitor the quality and safety in relation to areas including Legionella, audits of radiological images, clinical notes, incidents and near misses and autoclave checks.

There was no formal system in place for patients to express their views and comments.

Care Quality Commission

Oakland Dental Care

Detailed findings

Background to this inspection

This announced inspection was carried out on 8 October 2015 by an inspector from the Care Quality Commission (CQC) 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 reviewed information we held about the provider. This included information from NHS England and notifications which we had received.

During the inspection we viewed the premises; spoke with the dentist and dental nurse, receptionists and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of any complaints received in the last 12 months.

We obtained the views of 17 patients who had completed CQC comment cards and we spoke with three patients who used the service on the day of our inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

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

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence.

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

Reliable safety systems and processes (including safeguarding)

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

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

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

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included face masks for both adults and children. Oxygen and medicines for use in an emergency were available. Records completed showed regular checks were done to ensure the equipment and emergency medicine was safe to use.

Records showed staff regularly completed training in emergency resuscitation and basic life support including the use of the automatic external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

The clinical staff had current registration with the General Dental Council, the dental professionals' regulatory body. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. The practice had a recruitment policy which described the process when employing new staff. This included obtaining proof of their identity, checking their skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service check was necessary. We saw that all staff members had a Disclosure and Baring Service (DBS) check in place. These are 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 may have contact with children or adults who may be vulnerable.

There were sufficient numbers of suitably qualified and skilled staff working at the practice.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The principal dentist carried out health and safety checks which involved inspecting the premises and equipment and ensuring maintenance and service documentation was up to date.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control and risks associated with Hepatitis B. There were robust processes in place to monitor and reduce these risks so that staff and patients were safe. However there was no fire risk assessment or a Personal Emergency Evacuation Plan (PEEP). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of any emergency.

Are services safe?

We viewed evidence in relation to health and safety including hazardous waste, electrical installation and portable appliance testing which showed that the practice maintained a safe environment for staff and patients. There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for products used within the practice.

The practice had a comprehensive business continuity plan in place for incidents such as power failure or building damage, however a copy of this was not kept off site to ensure it could be accessed in an emergency.

Infection control

We saw there were systems in place to reduce the risk and spread of infection. During our visit we spoke with the dental nurse, who had responsibility for infection prevention and control. They were able to demonstrate they were aware of the safe practices required to meet the essential standards published by the Department of Health -'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05).

The equipment used for sterilising dental instruments was maintained and serviced as set out by the manufacturer's guidelines. Daily and weekly tests were kept of sterilisation cycles and when we checked those records it was evident that the equipment was in good working order.

There were processes in place to ensure used instruments were cleaned and sterilised, these processes were compliant to relevant guidance. Decontamination of dental instruments was carried out in a separate decontamination room. A dental nurse demonstrated to us the process; from taking the dirty instruments out of the dental surgery through to clean and ready for use again. We observed that dirty instruments did not contaminate clean processed instruments. The process of cleaning, disinfection, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty to clean.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. (Legionella is a particular bacterium which can contaminate water systems in buildings.) Flushing of the water lines was carried out in accordance with current guidelines and supported by a practice protocol. However the practice did not have a building Legionella risk assessment. Therefore no regular water tests were being carried out to ensure that patients and staff were protected from the risk of infection due to growth of the Legionella bacteria in any of the water systems.

The segregation of dental waste was in line with current guidelines laid down by the Department of Health. The treatment of sharps and sharps waste was in accordance with the current European Union directive with respect to safe sharp guidelines; this mitigated the risk of staff against infection. We observed that sharps containers were correctly maintained and labelled. The practice used an appropriate contractor to remove dental clinical waste from the practice and waste consignment notices were available for us to view.

Equipment and medicines

The practice maintained a comprehensive record of all equipment including dates of when maintenance contracts required renewal. The practice manager told us this helped them check and record that all equipment was in working order. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner.

The practice had an effective system in place regarding the prescribing, recording, dispensing, use and stock control of the medicines and materials used in clinical practice. The dentists used the British National Formulary to keep up to date about medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored safely for the protection of patients.

Blank prescription forms were stored securely, logged and tracked through the practice in line with national guidance to prevent their misuse.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced.

A Radiation Protection Advisor and Radiation Protection Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were displayed in each treatment room. Those staff authorised

Are services safe?

to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training. On the day of the inspection the IT system was not allowing the operator to save X-rays, and these could only be viewed for a short time.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. Dental assessments were carried out in line with recognised guidance from the Faculty of General Dental Practice UK (FGDP) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. This was documented and also discussed with the patient.

We reviewed with the dentist the information recorded in patient care records regarding the oral health assessments, treatment and advice given to patients. Five clinical records were reviewed and these records were incomplete and did not include all of the relevant information in respect of patient's dental care. For example records did not include details of the condition of the patients' teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. Records showed the dentist did not on two occasion's record the patients smoking status. Patient's notes did not include a record of their consent to the treatment carried out. The dentist informed us that the patient retained the only copy, and from now on they would keep a copy in the patient's notes. However we noted that the dentist had not always recorded details of the condition of patients' gums using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an x-ray was recorded in the patient's care record; however there were no x-ray audits undertaken or planned this evidenced to us that results of monitoring were not being used effectively to improve quality.

Records showed a diagnosis was discussed with the patient and treatment options explained.

Patients were given a copy of their treatment plan, including any fees involved. Patients spoken with told us they always felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment. The comments received on CQC comment cards reflected that patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

Information about patients' care, treatment and their outcomes was collected and monitored. This included assessment, diagnosis and referrals to other services if appropriate. This information was used to improve care.

The dentist also provided patients with advice to improve and maintain good oral health. Patients told us that they were well informed about the use of fluoride paste and the effects of smoking on oral health. Staff spoken with were aware of the Department of Health publication -'Delivering Better Oral Health; a toolkit for prevention' which is an evidence based toolkit to support dental practices in improving their patient's oral and general health.

Staffing

Staff told us they had good access to on-going training to support their skill level. Staff were supported to maintain the continuous professional development (CPD) requirements made by the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all relevant staff and we saw evidence of on-going CPD, including mandatory requirements pertaining to medical emergencies and infection control.

We saw evidence that staff received appraisals, although not at regular intervals. Staff we spoke with explained that they were always supported in their training needs and felt they could engage with the principal dentist or practice manager informally at any time.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice, for example orthodontic treatment. The practice referred patients for secondary (hospital) care when necessary. For example for assessment or treatment by oral surgeons. Referral letters contained detailed information regarding the patient's medical and dental history.

The dentist explained the system and route they would follow for urgent referrals if they detected any serious concerns during the examination of a patient's soft tissues.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff we spoke with told us that all treatment options were discussed in detail, including the risks and benefits of a particular treatment option and costs involved before decisions were made. Written treatment plans were provided and patients were encouraged to take time to consider them before agreeing to start treatment.

Dental care records that we looked at confirmed good recording of these conversations and the options given to the patients. However a copy of patients signed consent forms were not consistently kept in their care records.

Patients we spoke with on the day also commented on how involved they felt with their care and how well the options for care were explained to them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patient's privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but we were told by reception staff/dental nurse that they considered conversations held at the reception area when other patients were present. They also confirmed that should a confidential matter arise, a private area or a free surgery was available for use. Staff members we spoke with told us that they never asked patients questions related to personal information at reception. Instead they showed them details such as their date of birth and address on record and asked them to confirm.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of, and the secure handling of patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely.

A patient we spoke with and those who completed comment cards said that they felt that practice staff were kind and caring and that they were treated with dignity and respect and were helpful. A patient commented how the dentist and staff spoke with them about 'normal things' during treatment to reduce nervousness and anxiety about their treatment. Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients with learning disabilities or severe anxiety.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. All staff had received training in the Mental Capacity Act (MCA) 2005.

Patients were also informed of the range of treatments available and their cost in information leaflets, on notices in the practice and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We reviewed the appointment process, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

New patients were asked to complete a confidential medical history form. This allowed the practice to gather important information about the patient's previous and current dental and medical history. Information requested included any medicines being taken, alcohol and smoking information and allergies and health conditions. For returning patients the medical history was updated so the dentists could respond to any changes in health status.

The treatment room was spacious and well equipped. We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Tackling inequity and promoting equality

The needs of the local population were not fully identified or taken into account when planning services. No risk assessment had been performed to ensure the practice met the requirements of the Equality Act 2010 and that they had considered the support needs of patients who visited the premises. The practice had not identified the need to provide extra support to patients to manage the steep stairs. Patients using wheelchairs or those with limited mobility would have to attend a different practice. We were told they had enquired if a stair lift could be installed but the building owner had a fire risk assessment done which identified the stairs were not wide enough to accommodate a stair lift without impeding the fire exit route.

The practice was unable to modify the premises to provide an accessible toilet and told us they advised patients of this when scheduling appointments.

There was no hearing loop at the practice. Staff told us that currently there were no patients who had severe hearing difficulties and who would require additional support or equipment.

Access to the service

We asked staff how patients were able to access care in an emergency or outside of normal opening hours. They told us an answer phone message detailed how to access out of hours emergency treatment. Each day the practice was open, emergency treatment slots were made available for people with urgent dental needs. Staff told us patients requiring emergency care during practice opening hours were always seen the same day. This was reflected in patients' feedback we reviewed.

Concerns & complaints

The practice had a complaints procedure for patients who wanted to make a complaint. The procedure explained the process to follow, however it did not make it clear which other agencies a patient could contact if the complaint was not resolved to the patients satisfaction.

Information about how to make a complaint was displayed in the practice waiting room.

From information received before the inspection we saw that there had been no formal complaints received in the past 12 months. The practice did not have a complaints file, so we were unable to review any complaints that might have been received over a longer period of time.

Are services well-led?

Our findings

Governance arrangements

Oakland dental care had a small staff team, and therefore the management structure at the practice was clear. The dental nurse said they could speak with the dentist if they had any concerns. We did not see any evidence that the practice held formal, minuted staff meetings. However, the dental nurse said that there was an open and on-going discussion with the provider.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. These included child protection, safeguarding vulnerable adults, medicines management and a confidentiality policy. All policies were found to be up to date.

Leadership, openness and transparency

The dentist was the leader in all aspects of the practice. They were responsible for leading the staff team in clinical and non-clinical activity. The dental nurse said they understood the management structure and deferred to the dentist on all matters within the practice.

Staff said they were confident they could raise issues or concerns at any time with the provider.

The practice had a whistleblowing policy which identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. Staff said they were aware of the policy, and knew the circumstances when it could or would be used.

Learning and improvement

There were limited systems and audit processes in relation to quality governance. We saw that some audits had taken place. For example: infection control had been audited during 2015. However, there were several clinical topics for which there was no evidence that audits had been completed. For example: there was no radiograph audit and no audit of record keeping. We brought this to the attention of the provider and were assured a structured audit plan to ensure completed audit cycles will be established.

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

There was limited approach to obtaining the views of people who used services and other

stakeholders. There were no systems in place to act upon suggestions received from patients. There were no suggestion boxes in the reception area and the practice had not completed any patient satisfaction surveys in the past two years.