

Greenwich & Bexley Emergency Dental Service Ltd Charlton Village Dental Practice

Inspection Report

20 The Village
Charlton
SE7 8UD
Tel: 020 8856 0660
Website: www.charltonvillagedental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 26 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Charlton Village Dental Practice is located in the London Borough of Greenwich and provides predominantly NHS dental services. The demographics of the practice were mixed, serving patients from a range of social and ethnic backgrounds.

The practice staffing consists of five dentists, three dental nurses, a practice manager and a receptionist.

The practice is open from 8.00am to 5.00pm on Monday, Thursday and Fridays; 8.00am to 7.00pm on Tuesdays; 8.00am to 1.30pm on Wednesdays and 9.30am to 12.15pm on Saturday and Sundays. The practice is set on the ground floor and facilities include two consultation rooms, a reception and waiting area, decontamination room, staff room/administration office. The premises were wheelchair accessible and toilets were also wheelchair accessible.

One of the owners of the practice is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. 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.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We received 23 completed Care Quality Commission comment cards and spoke with three patients on the day of the inspection. All the feedback we received from patients was very positive. Patients feedback indicated that staff were professional, caring and gave good explanations. They described the premises as being clean and tidy.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines and equipment in line with current guidelines for management of medical emergencies in dental practice.
- Dental instruments were decontaminated suitably.
- Appropriate pre-employment checks were carried out before staff commenced work in the practice.
- Patients' needs were assessed and care and treatment was delivered in line with published guidance, such as from the National Institute for Health and Care Excellence.
- All clinical staff were up to date with their continuing professional development (CPD).
- Appropriate systems were in place to safeguard patients from abuse.
- Patients were involved in their care and treatment planning so they could make informed decisions.
- Governance arrangements were in place for the smooth running of the practice; the practice did not have a structured plan in place to audit quality and the completed audits were not detailed or comprehensive.

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

- Review the process for updating and reviewing practice policies ensuring that policies are fit for purpose
- Review its audit protocols to document, where appropriate, the learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 provider had systems and processes in place to ensure care and treatment was carried out safely. There were systems to receive safety alerts from external organisations and share them appropriately with staff. Systems were in place to ensure patients were safeguarded from abuse. Most staff were trained to the appropriate level for child protection (or were booked to complete the training soon) and most had completed adult safeguarding training. The safeguarding policy was up to date and staff we spoke with were aware of their responsibilities and demonstrated sufficient knowledge of safeguarding.

Processes were in place for staff to learn from incidents and lessons learnt were discussed amongst staff. The practice undertook risk assessments and there were processes to ensure equipment and materials were maintained and safe to use. Dental instruments were decontaminated suitably. Medicines and equipment were available in the event of an emergency. Appropriate pre-employment checks were carried out before staff commenced work in the practice.

Are services effective?

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

There were suitable systems in place to ensure patients' needs were assessed and care and treatment was delivered in line with published guidance, such as from the National Institute for Health and Care Excellence. Patients were given relevant information to assist them in making informed decisions about their treatment and consent was obtained appropriately.

The practice maintained appropriate dental care records and patient details were updated regularly. Information was available to patients relating to health promotion including smoking cessation and maintaining good oral health.

All clinical members of the dental team were meeting or were on course to meet their requirements for continuing professional development. Opportunities existed for staff to undertake training and professional development. Most staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005; however some were uncertain about how the Act related to their role.

Are services caring?

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

Feedback from patients was positive and indicated that staff were friendly, professional, caring and treated patients with dignity. We received feedback from 23 patients via completed Care Quality Commission comment cards and spoke with three patients during the inspection. Patients described their interactions with patients and gave examples of where staff had displayed compassion, dignity and respect.

Are services responsive to people's needs?

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

Patients had access to the service which included information available via the practice leaflet and website. Urgent on the day appointments were available during opening hours. In the event of a dental emergency outside of opening hours patients were directed to the '111' out of hours' service. The building was wheelchair accessible. The provider gave positive example of how they responded to patient's needs.

Summary of findings

There were systems in place for patients to make a complaint about the service if required. Information about how to make a complaint was readily available to patients.

Are services well-led?

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

Governance arrangements were in place for the management of the practice; however some areas of improvements were identified. Staff meetings were held frequently and minutes were taken and shared with staff. Opportunities existed for staff to maintain their professional development. Audits were being conducted however improvements were required to ensure they were being used as a tool for continuous improvement. Policies and procedures were in place though some needed to be updated and in some instances to be more comprehensive. Improvements were also needed to ensure staff training needs were identified and staff, as a result some staff were not up to date in some areas.

Charlton Village Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of

our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on the 26 January 2016 and was undertaken by a CQC inspector and a dental specialist adviser. Prior to the inspection we reviewed information submitted by the provider and information available on the provider's website.

The methods used to carry out this inspection included speaking with the dentists, a dental nurse, receptionist and the practice manager on the day of the inspection,

reviewing documents, completed patient feedback forms and observations. We received feedback from 23 patients via completed Care Quality Commission comment cards and spoke with three patients during the inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were systems in place to receive safety alerts by email and ensure they were shared with staff working in the practice. All safety alerts were received by the practice manager who was responsible for ensuring relevant staff were aware of them. This included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England updates.

We reviewed the documentation relating to the accidents and incidents that had occurred in the last 12 months and noted they had been handled in line with the practice policy. All the accidents had been fully investigated by the practice and a response sent to the patient involved. All the accidents were logged in the accident book. We discussed accident and incident reporting with the principal dentist and the practice manager. They were aware of how incidents should be reported and acted upon.

We discussed the requirements of the duty of candour with the principal dentist and they were fully aware of its requirements. Improvements could be made to ensure other staff were also aware of its requirements. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The practice manager demonstrated a good understanding of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) Regulations and had the appropriate documentation in place to record if they had an incident. There had not been any RIDDOR incidents, within the past 12 months.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead. The practice had policies and procedures in place for safeguarding adults and child protection. We reviewed staff training records and saw that clinical staff had completed appropriate safeguarding training to the required level. Some non-clinical staff had not completed safeguarding training; however they demonstrated a good knowledge of

safeguarding and knew who to go to in the practice if they had a query. Details of the local authority safeguarding teams were readily available to staff on the practice computer system. The relevant safeguarding escalation flowcharts and diagrams for recording incidents were also available to staff.

The dentist was following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured].

The practice protocols required that all patients were requested to complete medical history forms including existing medical conditions, social history and medication they were taking. Medical histories were reviewed at each subsequent visit or after two months, and updated if required.

Medical emergencies

There were emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Medical emergencies drugs were stored securely and those requiring refrigeration were stored appropriately. Staff checked the medicines on a monthly basis and there was a system in place to monitor the expiry of medication. Staff also had access to emergency equipment on the premises including medical oxygen and an automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. [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 told us they carried out checks to ensure equipment was in working order in the event of needing to use them.

Most clinical staff and all non-clinical staff had completed basic life support training in 2015 and the training was repeated annually. All staff were aware of where medical equipment was kept and knew how to use the AED and medical oxygen.

Are services safe?

Staff recruitment

There was a full complement of the staffing team. The team consisted of five dentists (working part-time hours), two dental nurses, a receptionist and a practice manager.

The provider had a policy in place for the selection and employment of staff. This included requiring applicants to provide proof of address, proof of identification, references, and proof of professional qualifications and registrations (where applicable). We reviewed staff files and saw that all employed staff had had pre-employment checks carried out. DBS checks had been completed for all staff. (The DBS checks 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).

We saw confirmation of all clinical staffs' registration with the General Dental Council (GDC).

Monitoring health & safety and responding to risks

The health and safety policy covered identifying hazards and matters relating to staff and people who accessed the practice. This included hazardous substances, manual handling and infection control. There was a business continuity plan that outlined the intended purpose to help staff overcome unexpected incidents and their responsibilities and duties. However, improvements could be made to ensure the plan had sufficient information for staff to know what to do or who to contact in the event of an emergency.

A practice-wide risk assessment had been completed in December 2015. The risk assessment covered various areas including assessing health and safety risks in the premises and equipment such as the autoclave and electrical appliances.

Fire drills were conducted every month and the fire evacuation procedure was displayed in the practice. The practice had an external fire risk assessment which was carried out in 2010 (just before the practice was opened) and had carried out their own assessment in October 2014 and October 2015. The practice manager and principal dentist told us that planned to carry out another external fire risk assessment soon.

Infection control

The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. One of the dental nurses was the infection control lead.

There was a separate decontamination room. There were three sinks in the decontamination room in line with current guidance; one for hand washing and the other two were used for cleaning dental instruments. The dental nurses gave a demonstration of the decontamination process which was in line with guidance issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. This included manually cleaning; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); placing in the autoclave; pouching and then date stamping, so expiry date was clear. Staff wore the correct personal protective equipment, such as apron and gloves during the process.

We saw records of the daily and weekly checks and tests that were carried out on the autoclave to ensure it were working effectively.

Staff were immunised against blood borne viruses and we saw evidence of when they had received their vaccinations. The practice had blood spillage and mercury spillage kits. Clinical waste bins were assembled and labelled correctly in each surgery and were stored appropriately until collection by an external company, every three weeks. Staff displayed good knowledge relating to safe use of sharps and dealing with sharps injuries. Needle stick injury posters were displayed in the surgeries.

There were appropriate stocks of personal protective equipment such as gloves and disposable aprons for both staff and patients. There were enough cleaning materials for the practice. Wall mounted paper hand towels was available. Hand gel was also available.

The surgeries were visibly clean and tidy. External cleaning staff had been appointed for the domestic cleaning at the practice. Cleaning schedules were in place for the cleaning staff to follow. The dental nurse was responsible for cleaning all surfaces and the dental chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings.

A legionella risk assessment had been carried out by the practice manager in 2014. No issues had been identified.

Are services safe?

[Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. Purified water was used in dental lines and managed with a purifying solution. Taps were flushed daily in line with recommendations.

The practice told us that they carried out an infection control audit annually; the last one having been completed in January 2016. They were unable to produce paperwork of previous audits completed.

Equipment and medicines

There were appropriate arrangements in place to ensure equipment was maintained. Service contracts were in place for the maintenance of equipment including the autoclave and compressor. The autoclave and compressor had been serviced in April 2015. The practice had portable appliances and carried out PAT (portable appliance testing). Appliances were last tested in May 2015.

The practice did not stock any medication except for medical emergency medication.

Radiography (X-rays)

The practice had a radiation protection file that was up to date and demonstrated appropriate maintenance of X-ray equipment. The equipment was serviced in January 2016 and the critical examination was completed in October 2014. One of the dentists was the radiation protection supervisor (RPS) and the practice had an external radiation protection adviser (RPA).

All relevant staff had completed radiation training. Individual audits were completed for each X-ray and audits were carried out twice a year. The last audit was completed in September 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists used current guidelines such as those from the National Institute for Health and Care Excellence (NICE) to assess each patient's risks.

We saw evidence of comprehensive assessments to establish individual patient needs. The assessment included completing a medical history, outlining medical conditions and allergies (which was reviewed at each visit), a social history recording habits such as eating and activity and an extra and intra-oral examination. The reason for visit was documented and a full clinical assessment was completed. Records confirmed that treatment was explained with the benefits and consequences of treatment being outlined. An assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.

Health promotion & prevention

We saw evidence that the dentists were proactive with giving patients health promotion and prevention advice. Dental care records were reflective of advice being given. This ranged from teeth brushing techniques, dietary advice, smoking cessation and advice on products to use. The nurse was the lead for smoking cessation advice to patients and signposted them to other services. Patients we spoke with confirmed this advice was given as well as other oral health advice.

There was a range of printed information available to patients in the waiting room as well as posters on display.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council and were

working towards completing their five year cycle of their continuing professional development requirements. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 every five years]. Staff we spoke with told us that they had lots of opportunities for further development. We saw evidence that opportunities existed for additional training such as oral cancer and preventative treatments.

Working with other services

The practice had processes in place for effective working with other services. There was a referral policy in place for staff to refer in the event of a patient needing to be referred. Referrals for minor surgery were made via an on-line process. Information relating to patients' relevant personal details, reason for referral and medical history was contained in the referral. Copies of all referrals made were kept on the patients' dental care records.

Staff we spoke with were aware of the procedures for referring patients. Patients we spoke with had been referred to other services and confirmed the process was smooth and they were updated appropriately.

Consent to care and treatment

The practice had a consent policy for staff to refer to. The policy outlined how consent could be taken and how it should be documented. Consent was usually obtained verbally and recorded in patients' dental care records.

All staff whom we spoke with demonstrated understanding of capacity issues, Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005, although some were not totally confident about the requirements. [The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them]. We did not see evidence that staff had completed MCA training.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 23 patients via Care Quality Commission comment cards and spoke with three patients during the inspection. Feedback was very positive. Patients' feedback indicated that staff provided a friendly and professional service and were caring. Patients also stated in the comment cards that they were treated with dignity and respect.

Staff told us that they ensured they maintained patients' privacy during consultations by closing treatment room doors and asking if they were comfortable.

Patients' information was held securely electronically. All computers were password protected with individual login requirements.

Involvement in decisions about care and treatment

Patients told us they were involved in decisions about their care and treatment and that things were explained well and they were provided with treatment options. Comments indicated that they were happy with their level of involvement and trusted the advice they were given by staff.

Information relating to costs was displayed in the patient waiting area, including details about the different NHS band charges. The dentist told us that treatment options were discussed with the benefits and consequences pointed out. The dentists used visual aids and models to help patients understand the diagnoses and proposed treatment. Discussions with patients and efforts to involve them were clearly documented in dental care records.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an appropriate appointments system that responded to the needs of their patients. Patients we spoke with told us that they always go appointments at times to suit them.

Emergency and non-routine appointments were also available throughout the day. The dentist told us that appointment slots were kept free to accommodate this.

Information was available in other formats such as large print for patients who required it.

Tackling inequity and promoting equality

The practice manager told us that the local population was diverse with a mix of patients from various cultures and background. The staff team spoke different languages which included Urdu, Hindi and Nepalese. Staff also had access to NHS translation services if patients spoke another language that staff did not speak. The practice also had access to sign language interpreters for patients with hearing difficulties, which they used on occasion for patients.

The practice was located on the first floor and the building was wheelchair accessible including wheelchair accessible toilet facilities.

Access to the service

The practice opening times were displayed on the practice door, in the practice leaflet and on-line. Appointments were booked by calling the practice or in person by attending the practice.

The practice was the location for the local out of hours dental service. This included opening time which include Saturday and Sundays. The practice made their patients aware of this. The practice also had arrangements in place to notify patients of who to contact when they were closed. If a patient needed to see a dentist outside of opening times they were directed to contact the "111" hours services. They were informed of the service via the recorded message on the practice answer machine and a poster on the practice door. The dentist told us that sometimes if it was possible and depending on the complaint, they would open the practice and see patients.

Concerns & complaints

The practice manager explained their complaints policy and procedure. At the time of our inspection there had not been any complaints in the last 12 months. The practice manager explained how complaints were investigated and responded and the explanations were in line with their policy. This included the patient receiving an apology and explanation of the investigation.

Information relating to complaints was readily available to patients. A copy of the complaints procedure was displayed in the patient waiting room and details were also on-line. Details of external organisations where patient could make a complaint to were also made available to them.

Are services well-led?

Our findings

Governance arrangements

The practice had completed audits over the past 12 months which included audits on infection control, health and safety and patient involvement. We reviewed the audits and saw that improvements could be made to the audit process to clearly outline the aim of the audit and document learning outcomes. The practice did have a completed clinical audit on antimicrobial prescribing. This audit was comprehensive. The aim of the audit was well documented and learning outcome and action to be taken was well documented.

The practice had a range of policies and procedures for the smooth running of the service which were available electronically and in paper format. Staff we spoke with confirmed that they knew how to access the practice policies.

Dental care records we checked were complete, legible and stored securely.

Leadership, openness and transparency

Staff in the practice were clear about the lines of responsibilities and were confident in approaching the practice manager or the principal dentist to discuss issues if they needed to. Leadership was also clear with the dentist and practice manager had a clear presence.

We discussed the duty of candour requirement in place on providers with the principal dentist. The principal dentist demonstrated understanding of the requirement and gave good examples of when this is applied. They also gave us explanations of how they ensured they were open and transparent with patients and staff. The explanations were in line with the expectations under the duty of candour.

Learning and improvement

The practice manager told us they monitored training needs of staff to ensure staff stayed up to date. However some staff had not completed recent adult safeguarding, infection control and mental capacity training. The need for refresher training was evident when we spoke with some staff who had limited knowledge in these areas.

Appraisals were completed annually and reviewed periodically. We reviewed a sample of appraisals and saw they were completed appropriately. Staff confirmed that appraisals were used to identify their learning and development needs and assist in their improvement.

Staff meetings were held monthly and informal meetings were held frequently. Minutes were maintained of the monthly meetings. Staff confirmed that they found the meetings useful and they received appropriate updates and were notified about events. We reviewed the team meeting minutes and saw that they discussed patient feedback, training, staffing issues and general updates.

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

The practice participated in the NHS “Friends and Family Test” (FFT) and individual dentists completed their own satisfaction surveys on an ad-hoc basis. Results from the FFT were collected monthly and analysed to pick up any patient feedback. We reviewed the results of the satisfaction survey carried out by one of the dentists. The results of the survey were very positive. The practice was able to give us examples of where patient’s feedback had led to changes in the practice. For example patients’ feedback about problems with the answer phone message and this had led to changes.

Staff we spoke with confirmed their views about practice developments were sought through the staff meetings.