Purley Dental Care

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 November 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

Purley Dental Care is a mixed dental practice providing mainly NHS treatment. The practice is situated in a converted residential property. The practice had four dental treatment rooms two separate decontamination rooms for cleaning, sterilising and packing dental instruments, two patient waiting rooms, a staff room and administration office.

The practice is open 8.30am – 8.30pm Monday and Thursday; 8.30am to 5.30pm Tuesday, Wednesday and Fridays. The practice has four dentists working over the course of a week who are supported by three dental nurses, two dental hygienists and three receptionists.

The principal dentist 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 15 patients. These provided a completely positive view of the services the practice provides. Patients commented on the high quality of care, the caring nature of all staff, the cleanliness of the practice and the overall high quality of customer care.

Summary of findings

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Strong and effective leadership was provided by the practice owner.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- The practice had a system in place for reporting incidents which the practice used for shared learning.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff recruitment files were organised and complete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owners and practice manager.
- Staff we spoke with felt well supported by the practice owner and practice manager and were committed to providing a quality service to their patients.
- Information from completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained, although servicing of X-ray equipment was overdue. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. Effective infection control procedures were in place however staff needed updating on the 2013 Sharps regulations.

No action ✓

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action ✓

Are services caring?

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

We received 15 completed Care Quality Commission patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed. Patients also said they were treated with dignity and respect.

We observed that patients were treated with dignity and respect by reception staff, surgery doors were closed during consultations and conversations could not be overheard.

No action ✓

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to staff who could speak a variety of languages.

No action ✓

Summary of findings

The practice had a ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs. Information relating to making a complaint was available to patients and complaints were handled in line with the organisations procedure.

Are services well-led?

No action

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

Strong and effective leadership was provided by the principal dentist. The principal dentist who was also the practice owner had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place.

Staff told us that they felt well supported and could raise any concerns with the practice owner. All the staff we met said that they were happy in their work and the practice was a good place to work. Feedback was obtained from patients and the practice was developed based on their feedback.

Purley Dental Care

Detailed findings

Background to this inspection

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

The inspection was carried out on 22 November 2016 by a CQC inspector who was supported by a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During the inspection, we spoke with two dentists, dental nurses and receptionist staff and reviewed policies, procedures and other documents. We also obtained the views of three patients on the day of our visit. We reviewed 15 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

The principal dentist demonstrated an awareness of RIDDOR (The Reporting Of Injuries Diseases and Dangerous Occurrences Regulations, 2013). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were no serious incidents that required formal reporting over the past 12 months.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The practice manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every month. For example a recent alert relating to glucagon pens from their supplier had been shared with all staff via email and then discussed at the next team meetings. The practice held a central file of all alerts for staff to refer to.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that the safeguarding lead had received appropriate safeguarding training for both vulnerable adults and children. Records showed that all other staff had received recent training in child and adult safeguarding. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

We spoke to staff about the prevention of needle stick injuries. Dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes however could be improved to ensure they were more in line with the current EU directive on the use of safer sharps. We discussed this with the principal dentist and they assured us they would ensure all staff were familiar with the new regulations.

The principal dentist explained that instruments used during root canal were single patient use only which was in line with recommended guidelines. They explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

Medical histories were reviewed at each subsequent visit and updated if required. During the course of our inspection we checked dental care records to confirm the findings and saw that medical histories had been updated appropriately.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED) [a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm]. Staff had received training in how to use this equipment.

The practice also had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice staff had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

Are services safe?

There was a full complement of the staffing team. The team consists of four dentists, three dental nurses, two dental hygienists and three receptionists.

All relevant staff had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). [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].

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had in place a Control of Substances Hazardous to Health (COSHH,2002) Regulations file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

An external company monitored health and safety and carried out general risk assessment of the premises annually. The risk assessments included display screen, manual handling and premises. We reviewed the most recent one that was carried out on the 19 August 2016. Areas of improvement had bene identified and actioned.

There was a fire safety policy that covered maintenance of fire extinguishers, smoke alarms, electrical testing and fire drills. A fire risk assessment had been completed on the 7 September 2016 and was planned to be repeated annually. Fire equipment was tested regularly and appropriate fire safety signage was displayed around the practice. There were three appointed fire marshals. Fire drills were completed every six months (or when a new employee commenced work).

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. One of the nurses was the appointed lead for infection control.

We noted that the practice staff were following infection prevention and control guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

There were two decontamination rooms. One was for dirty instruments and the other was for clean.

There were three sinks in the dirty zone and one in the clean. One of the dental nurses gave a demonstration of the process for decontaminating of used dental instruments. Staff wore the correct personal protective equipment, such as apron and gloves during the process. The decontamination process included manually cleaning; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required) and placing in the autoclave.

There were two autoclaves. We saw records of all the daily and weekly checks and tests that were carried out on the autoclave to ensure it was 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. We noted that single use items such as rose head burs and matrix bands were being re-used.

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.

Are services safe?

The drawers of a treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in December 2015.The risk assessment was repeated every two years. .

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Infection control audits were completed every six months.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in June 2016 and there was a contract in place for this to be repeated twice a year. The Pressure Vessel Certificate had been issued and was due to be reviewed in January 2018. Electrical testing had been carried out in March 2016 and was repeated annually.

Radiography (X-rays)

We were shown a radiation protection file that contained documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The principal dentist was the Radiation Protection Advisor and the practice had appointed an external Radiation Protection Supervisor.

The file had the necessary documentation pertaining to the maintenance of the X-ray equipment. The equipment had not been serviced in just over three years. The principal dentist said this was an oversight and would arrange for it to be completed as soon as possible.

Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations. Regular X-ray audits were being completed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and 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. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE 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).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

We saw evidence that where required clinicians in the practice gave patients health promotion and prevention advice. Dental care records documented discussions about advice given to maintain oral health and fluoride application. The dentists also told us that they gave health promotion and prevention advice to patients during consultations.

Health promotion leaflets were available to patients. This included such as on smoking cessation and improving dietary habits.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council. We saw example of staff working towards their continuing professional development requirements, working through their five year cycle. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 hours every five years]. We saw examples of opportunities that existed for staff for further training and courses that were outside the core and mandatory requirements.

Working with other services

Staff explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used standard referral forms to refer patients to different services such as the hospital and orthodontist. Referrals were sent by post or faxed if appropriate. Patients were asked to contact the dentist if they had not heard from the referral agency after three months. Copies of referrals were kept on patients individual dental records.

Consent to care and treatment

The dentists had a very clear understanding of their responsibilities as far as obtaining and documenting patient consent for treatment and examination was concerned.

They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. To underpin the consent process the practice had developed bespoke consent forms for more complex treatment including root canal treatment, surgical removal of teeth and the provision of crowns and bridges.

The principal dentist explained how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there

Are services effective?

(for example, treatment is effective)

was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They told us they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. [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 capacity to make particular decisions for them]. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and paper records stored in lockable records storage cabinets in the reception area. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 15 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients also commented that treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Information was available in the waiting area about the costs of both NHS and private treatment. Staff explained that they paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including a patient information leaflet which detailed the services the practice offered including the cost of treatments.

The practice reserved slots every day to accommodate emergency and non-emergency appointments. If a patient had a dental emergency they were asked to attend the surgery and would be seen as soon as possible.

The practice had good knowledge of their patient population and planned services to respond to their needs. For example they developed a system of putting a yellow alert on the system for patients who they knew had difficulty with reading or writing for various reasons relating to literacy, vision or any other reason. The alert would flash up and staff knew that these patients would need assistance with reading and filling in forms.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. The practice had access to staff who could speak a variety of languages including Polish, French, Arabic and Russian.

To improve access the practice had level access and a treatment room on the ground floor for those patients with a range of disabilities and infirmity as well as parents and carers using prams and pushchairs.

Access to the service

The practice is open 8.30am to 8.30pm Monday and Thursday and 8.30am to 5.30pm Tuesday, Wednesday and Fridays. This provided good access to the service for all patient groups including the working population who required evening appointments.

Patients were able to access urgent or emergency care when the practice was closed. This information was publicised in the practice leaflet and also on the practice answering machine when the practice was closed.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and on the practice website. The practice had received five complaints in the past 12 months. We looked at the practice procedures and found that the complaints had been managed according to the practices' policy.

Information was available to patients informing them how to make a complaint and how to escalate to external organisations if they were not satisfied.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The practice owner was responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice manager on a regular basis.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, water line, medical history, clinical records and X-ray quality. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Leadership, openness and transparency

Strong and effective leadership was provided by the practice owner. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the practice owners. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did. Staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and reception staff received an annual appraisal; these appraisals were carried out by the principal dentist.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development. Most training was self-identified, but the practice was supportive in encouraging staff to develop.

Team meetings were held every month with all staff. Staff told us they found the meetings useful and were important for continual learning and development.

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

The practice participated in the NHS Friends and Family Test (FFT). Results from the FFT were collected monthly and analysed to pick up any patient feedback.

The practice gave us examples of where they had acted on feedback from patients to improve the service. One example was related to referrals. Some patients had commented that they were not receiving details about their referral and appointments; this was because some referrals were not being processed. To ensure that all referrals were received the practice put a system in place where they faxed referrals to ensure that the referral agency received them