Duston Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 February 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

Duston dental practice is a general dental practice situated in the Duston area of Northampton. It is located in a converted Victorian townhouse and has five treatment rooms, an office and staff room, a small autoclave room, waiting room and reception room. In addition there is a decontamination room that was out of service at the time of our inspection.

The practice offers a full range of general dentistry, and a visiting dentist from a nearby practice undertakes placing dental implants when required. (these are metal posts that are placed surgically into the jaw bone and used to support a single tooth, bridge or denture).

The practice has two principal dentists and one of these 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.

Prior to the inspection we left comment cards and asked patients for feedback on the service. In addition we spoke to patients on the day of our visit. In total 26 people provided feedback about the service.

Summary of findings

The feedback we received was entirely positive with patients commenting on the friendliness and professionalism of the staff.

Our key findings were:

- Patients commented that the service was prompt and efficient, and staff were helpful and respectful.
- Essential standards in decontamination as outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health were being met.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice had monthly team meetings to discuss the running of the practice, any complaints and learning opportunities.
- Governance arrangements were in place for the smooth running for the practice, including the use of clinical audit to highlight areas that could be improved.
- Staff recruitment checks had been carried out in accordance with schedule three of the Health and Social Care Act 2008. Disclosure and barring service checks had been carried out on all staff to ensure the practice employed fit and proper persons.
- Staff demonstrated a good knowledge of how to raise a safeguarding concern, and the situation in which that might be required.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Consider the use of patient information leaflets to aid the process of consent and oral health promotion.
- Review the security of the clinical waste bin.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum01-05: 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

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 met the essential standards in infection control, however a review of the flow of decontaminated instruments from dirty to clean could improve the overall effectiveness of the process.

Staff demonstrated a thorough knowledge of the situations where they might raise a safeguarding concern for a child or vulnerable adult, and how they would achieve this.

The practice had medicines and equipment for managing medical emergencies in line with the current guidelines with the exception of a full range of sizes of oro-pharyngeal airways (these help hold the airway open in an unconscious or semi-conscious patient). Following our inspection these were immediately ordered.

Are services effective?

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

Clinicians used oral screening tools to identify dental disease, and kept accurate and detailed dental care records.

Staff had a good understanding of the Mental Capacity Act 2005, and it's relevance in obtaining full and valid consent for a patient who lacks the capacity to consent for themselves.

The practice had a robust system in place for ensuring that urgent referrals were received by the hospital in a timely manner.

Are services caring?

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

Patients commented that staff were friendly, helpful, polite and professional and always treated them with dignity and respect.

Staff understood their responsibilities towards the confidentiality of the patient and were able to explain the ways in which patients' personal information was kept private.

Are services responsive to people's needs?

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

The practice offered both early morning and late evening appointments to give flexibility to those patients who might have commitments during normal working hours.

The practice had reconsidered the way in which emergency appointments were scheduled in response to comments from patients. They now operated a successful 'sit and wait' clinic at the end of every morning which they have found has met their patients' needs.

Are services well-led?

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

The practice had polices in place to ensure the smooth running of the service, these were up to date and tailored to the service to ensure their effectiveness.

Summary of findings

Feedback was sought from patients via various pathways, and analysed to look for ways to improve the service.

Audits were employed to highlight clinical areas which could be improved.

Duston Dental Practice

Detailed findings

Background to this inspection

The inspection was carried out on 2 February 2016 by a CQC inspector and a dental specialist advisor.

We requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice principals, the practice manager, two further dentists, two dental nurses and a receptionist. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service, and spoke with patients.

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 practice had a robust system in place to reporting, investigating and learning from significant incidents. A policy was accessible in the office that detailed the process for reporting significant incidents, this involved filling in a template which demonstrated that appropriate investigation had been carried out and what could be done to prevent reoccurrence. Learning from these incidents was fed back through the practice meetings so that all staff would benefit.

The practice had a duty of candour policy. This detailed the practice's expectation that staff would deal with the patients in an open and honest way, and that apologies should be issued to patients in a timely way, if appropriate.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the practice manager would disseminate relevant alerts to the staff at the next practice meeting, if there was one soon, or by e-mail for more urgent communications.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager informed us of how they would make such a report, and this was outlined in the practice policy.

Reliable safety systems and processes (including safeguarding)

The practice had systems and policies in place regarding child protection and safeguarding vulnerable adults. Policies were readily available in the office with detailed the signs of abuse as well as steps to take should staff suspect abuse. A flow chart detailing how a concern could be raised was displayed on the staff noticeboard, as well as useful contact numbers.

Staff we spoke with had a good understanding of the situations that might lead them to raise a concern, and how they would go about this. All staff had undertakien safeguarding training appropriate to their role.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 30 June 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice routinely used rubber dams when carrying out root canal treatment. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment.

Medical emergencies

The practice carried medicines for use in a medical emergency in line with the recommendations of the British National Formulary. These were kept in a central and secure location and staff with spoke with were clear on how to access them, and what medication would be required for a range of specific medical emergencies.

The Resuscitation Council UK lists medical equipment that all practices should carry for use in the event of a medical emergency. This included an automated 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. The battery and pads were checked regularly to ensure that they would function correctly if required. Records were seen pertaining to these checks. However the practice only carried one set of pads, which, as they are single use, once used would take time to re-order. Following the inspection we received information that a spare set of pads had been ordered.

In addition the emergency kit did not have a full range of sizes of oro-pharyngeal airways (these are plastic tubes in different sizes that can be placed in the mouth of an unconscious or semi-conscious patient to help to keep their airway open). A range of sizes is necessary to effectively keep the airway open. In addition there were no syringes to administer certain of the medicines that would have to be drawn up from vials if needed. Following the inspection we received information that this had been ordered.

The practice staff underwent medical emergencies training including basic life support every six months.

Are services safe?

Staff recruitment

The practice had a staff recruitment policy in place which detailed the pre-employment checks that would be carried out prior to a staff member joining the service. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had a policy to carry out DBS checks on all staff members. DBS checks and all other pre-employment checks were in place for the four regular members of staff whose staff recruitment files we looked at.

However the practice did not hold any pre-employment checks for a dentist who visited the practice to carry out dental implants occasionally. Following the inspection we received information that pre-employment checks had been carried out.

Monitoring health & safety and responding to risks

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place which had been reviewed on 16 November 2015. This policy formed part of the initial staff induction training of the practice.

A fire risk assessment had been carried out on 23 November 2015. This was underpinned by a fire management policy and all staff had undertaken fire training.

We saw records that fire equipment had been serviced by an external contractor, and an assessment had been made on 6 January 2016 that a further two fire extinguishers were required to meet the requirements of the building. We saw evidence that these had been purchased and were in place.

Staff we spoke with had a good understanding of their role in an evacuation of the building and were able to point out the muster point.

There were adequate arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information about the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors

The practice carried out a sharps' risk assessment which had been reviewed in October 2015. This detailed the systems in place to reduce the risk of sharps' injury to staff. This involved the dentist being responsible for disposing of sharps at the point of use. Needle guards were available for dentists to mitigate the risk further. There had been a recent incident of sharps injury, in dealing with this the practice were able to demonstrate effective use of their policy in action.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which had been reviewed in November 2015. This outlined the decontamination process (Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again), hand hygiene, protocols regarding the dental unit water lines and disinfecting impressions.

Although the practice had a separate facility for the decontamination process, this had been decommissioned as it was found to be too small for use in a large practice. As a result of this, the practice was carrying out manual cleaning of the equipment in each individual surgery, before transporting it to a small autoclave room where the instruments were inspected and sterilised in the autoclave. After sterilisation they were removed back to the surgery to be placed into sealed pouches, and dated with the date upon which the sterilisation would become ineffective.

Are services safe?

Although the system in place met the essential standards as outlined in HTM 01-05, we discussed with the provider how improvements could be made to the flow of instruments. The provider told us that they would review their process in this regard.

We saw evidence that checks were being performed on the autoclaves to ensure they were working effectively. These checks were in line with HTM 01-05 guidance.

All clinical staff had documented immunity against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A risk assessment had been carried out by an external assessor on 11 January 2016. This had highlighted actions to reduce the risk of Legionella contamination. We observed that these actions had been implemented by the practice. In addition the practice carried out appropriate flushing and disinfecting of the dental unit water lines in line with the practice's policy on the same.

Environmental cleaning was carried out by an external contractor. There were schedules of cleaning in place for the practice, and audits were carried out by the contractor to ensure quality. However although the cleaners were making records of what had been cleaned for their company, the practice did not have oversight of this. We discussed this with the practice manager who made arrangements for the completed schedules to be copied to her.

We examined the practice's protocols for storing and disposing of clinical and contaminated waste. The clinical waste bin was situated in the garden of the practice, and although locked was not secured to the wall or other bins. We raised this with the practice manager who took steps to ensure the clinical bin could not easily be wheeled away.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out the full range of dental procedures that they offered.

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Pressure vessel testing had been carried out on the autoclaves and compressor within the last year to ensure they functioned safely.

Glucagon is an emergency medicine which is given to diabetics in the event of a hypoglycaemic attack (low blood sugar). It needs to be stored within two to eight degrees celsius in order to be valid until the expiry date. We found that the medicine was kept in a designated fridge the temperature of which was being recorded to ensure it would be effective if required.

Prescription pads were kept securely, and issued to dentists one at a time.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice used exclusively digital X-rays which meant that images were able to be viewed almost instantaneously, as well as providing a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which detailed the responsible people involved in taking X-rays as well as appropriate testing and servicing of each X-ray machine.

Dental care records demonstrated that clinicians were reporting the justification for taking an X-ray as well as logging the quality of the X-ray taken and what the image showed.

In this way the effective dose of radiation to the patient was kept as low as reasonably possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with four dentists and we saw patient care records to illustrate our discussions**.**

Medical history forms were given to the patient to fill in when they first attended the practice. The medical history was then checked verbally at every appointment, but a written form was not routinely given at each examination and signed for by the patient. There was a possibility therefore that patients would not volunteer a change in their medical history if they did not think it was relevant to their dental treatment.

We discussed this with the practice principal who immediately implemented a system whereby a new form is filled in at every check-up appointment. The practice would therefore be better informed of a change in the patients' medical history which may have affected their treatment.

Records showed assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums. Higher figures would trigger further investigation, referral to a dental hygienist, or to an external specialist.

Dentists demonstrated a thorough understanding of the national guidelines available to aid diagnosis and treatment. This included the National Institute of Health and Care Excellence (NICE) guidelines pertaining to wisdom teeth extractions, recall intervals and antibiotic prescribing for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it). Also the Faculty of General Dental Practitioners' guidance on when X-rays were required and necessary. We found that this guidance was being followed by the dentists.

Dental care records we reviewed showed that accurate and detailed notes of the discussions and treatment carried out were being recorded.

Health promotion & prevention

Medical history forms that patients were asked to fill in included information on alcohol and nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease. However the practice did not have oral health leaflets that would offer an opportunity for the patient to take the information home and revisit the advice given

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice demonstrated appropriate staffing levels, and skill mix to deliver the treatments offered to the patients.

The practice was a training practice for a foundation dentist. This is a dentist who has just qualified from dental school and is given support and further training in a practice setting for a year following their qualification. Both the principal dentists in the practice acted as trainer for the foundation dentist.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Referrals for suspected serious disease would be made to the hospital via a pre formatted template that could be e-mailed securely, and backed up by a phone call to the hospital to ensure the referral had arrived. In this way the practice could be assured of the timeliness of a referral if urgent.

Consent to care and treatment

Clinicians we spoke with made it clear that the process of obtaining patients' consent involved multiple stages of discussion and explanation that could not be assumed or

Are services effective?

(for example, treatment is effective)

rushed. Dental care records we were shown indicated that detailed discussions had taken place with patients, during which risks and benefits of all treatment options were pointed out. The practice did not however, have a range of treatment specific patient information leaflets, which would be helpful in the consent process.

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 themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent, understanding that capacity should be assumed even if the patient has a condition which might affect their mental capacity, and when it might be necessary to make decisions in a patient's best interests.

Staff we spoke with had a good understanding of the situation which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence and relies on the assessment of a child's understanding of the procedure and the consequences of having/not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed patients to the practice being treated in a friendly and kind manner. Feedback we received from patients commented how the staff were able to put at ease nervous patients, and were professional and respectful.

Staff we spoke with explained how patients' confidentiality was maintained in the practice. The reception area was in a separate room, although connected, to the waiting room. There was a radio playing in the waiting room, this ensured that a patient at the desk would not be overheard by patients in the waiting room.

In addition the computer screens were located below the level of the counter top, thereby obscuring them from the view of patients at the desk. Dental care records were computerised and password controlled, and the computers would shut down automatically if left idle.

Confidentiality was underpinned by a data protection and information governance policy which were available for staff to reference in hard copy.

Involvement in decisions about care and treatment

Patients that we spoke with felt fully involved in decisions about their treatment. Dental care records shown to us gave a detailed description of discussions held between the clinician and patients regarding the treatments options available to them, and their risks and benefits.

Costs were discussed with patients before treatment started, and NHS and private price lists were displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We examined the appointments book and found that adequate time had been allocated per patient for discussion and treatment.

We discussed the arrangements for patients with a dental emergency. In response to feedback from patients that had indicated a difficulty in getting a prompt appointment in the event of an emergency. The practice had implemented a triage traffic light system to prioritise patients in pain, and offered a 'sit and wait' appointment to those patients whose need was not so great.

The practice put aside an hour daily for emergency patients, and so all patients in pain could be seen on the day if they call in the morning.

The practice offered late evening opening (until 7 pm) twice a week, and early morning appointments (from 7.45 am) Monday to Friday. This offered flexibility for patients who might have commitments during normal working hours.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs. This was underpinned by an equality and diversity policy which was dated 12 November 2015.

We discussed with staff how they could assist patients for whom English was not their first language or had other communication difficulties. They explained how extra appointment time could be allocated, in order to allow the clinician time to explain things, draw diagrams and be sure that the patient understood.

Access to the service

The practice had a Disability Discrimination Act audit carried out on 1 November 2013. This highlighted that lack of disabled access through the front of the building (steps) however patients with limited mobility could access the practice through the rear which was step free. Staff explained how patients' individual needs were met, for example if a patient could not manage the stairs arrangements would be made for them to be seen in the downstairs treatment room.

Out of hours' arrangements had been put into place so that patients could access dental care at any time. There was a local practice that offered a service to 8pm every week night, which patients could access outside practice hours. After this time patients were directed to contact the NHS 111 service.

The practice was shut on a Friday afternoon, and at this time one of the dentists from this, or its sister practice would be available on the phone to speak to patients and arrange to see them if necessary.

Concerns & complaints

We looked at the practice's procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

We saw that apologies were issued to the patient in a timely manner if appropriate, and complaints were regularly discussed at the monthly team meetings.

Information for patients on how to make a complaint to the service was displayed in the waiting area. This document also indicated how to take a complaint further should they not receive a satisfactory response from the practice.

Are services well-led?

Our findings

Governance arrangements

The practice had in place two principal dentists and a practice manager and clear lines of responsibility and accountability lay between them. In addition the management team had delegated lead roles to other staff in the practice such as radiography lead, and cross infection lead. Staff we spoke with were able to identify these individuals.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance and whistleblowing. These had all been reviewed within the last year.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice including sharps, fire safety, and control of substances hazardous to health.

The practice had monthly team meetings where discussions were held on training, complaints and significant events. The minutes of these meetings were e-mailed to all staff following the meeting.

Leadership, openness and transparency

Staff reported an open and honest environment where the opinions of all staff were taken into account. This was underpinned by the practice's policy on candour which highlighted the practice's expectation of honesty from staff.

Staff we spoke with expressed that they felt comfortable approaching any member of the management team either formally or informally.

The practice had in place a whistleblowing policy that directed staff on how to take action about co-worker whose actions or behaviours were of concern. This was available for all staff to reference in the policy folder.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audits were used to identify areas that could improve and highlight how those improvements could be made. We saw recent audits in cross infection control and radiography. In addition there was a clinician specific record keeping audit, which had been carried out just over a year prior to our inspection. These audits had action plans to improve the overall quality.

In addition to this, the practice's treatment rooms would be subjected to regular spot checks to confirm that standards were being met. These were completed on a template and fed back to the clinicians involved.

Staff felt supported in their roles and commented on the availability of training to further their careers. The practice subscribed to online training systems on behalf of all of the staff. Staff underwent regular appraisals in order to identify their training needs and wishes, as a result of these a personal development plan was drawn up, which could be followed.

The practice had a foundation dentist who received a weekly tutorial as well as clinical support from their mentors and the opportunity to discuss individual cases.

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

The practice obtained feedback from patients from several pathways. They had the NHS friends and family test cards for patients to fill in. In addition the practice regularly checked for new feedback via the NHS choices website, and online search engine reviews. They had a link to a feedback questionnaire that was attached to all e-mails that the practice sent out. We saw evidence that feedback was analysed and shared with staff, and we were given examples of situations where patient feedback had elicited a change with in the practice.

Staff feedback was welcomed formally, through practice meetings, or informally across the practice's close knit team.