

Dr Achal Prashad, Dr Meeraj Patel

The Beckenham Dental Clinic

Inspection Report

233-235 High Street
Beckenham, Surrey
BR3 1BN

Tel:

Website: www.beckenhamdentalclinic.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 7 October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Beckenham Dental Clinic is located in the London Borough of Bromley and provides both NHS dental

services and services to private patients. The demographics of the practice is diverse, serving patients from a range of social and ethnic backgrounds. The practice is open 9.00am to 5.30pm Monday to Fridays, except on Thursdays when they open until 7.30pm. They also offer appointments on two Saturdays per month. The practice facilities include three consultation rooms, reception and waiting area, decontamination room, staff room/ administration office. The premises are wheelchair accessible and have facilities for wheelchair users, including an accessible toilet.

We received 24 completed Care Quality Commission comment cards from patients. They were positive about the service and gave good feedback. They told us that staff were friendly and polite and always treated them with respect. Information was given to them in formats easy for them to understand and if they did not understand anything staff always explained things well.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance.
- Patients were involved in their care and treatment planning so they could make informed decisions.
- There were effective processes in place to reduce and minimise the risk and spread of infection.
- There were appropriate equipment and access to emergency drugs to enable the practice to respond to medical emergencies. Staff knew where equipment was stored.

Summary of findings

- All clinical staff were up to date with their continuing professional development.
- There was appropriate equipment for staff to undertake their duties, and equipment was maintained appropriately.
- Appropriate governance arrangements were in place to facilitate the smooth running of the service, including a programme of audits for continuous improvements.

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 in place to ensure people were safeguarded from abuse. Staff were trained to the appropriate level for child protection and had completed adult safeguarding training. The safeguarding policy was up to date and staff were aware of their responsibilities. Systems were in place for the provider to receive safety alerts from external organisations. 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 well maintained and safe to use. Dental instruments were decontaminated suitably. Medicines and equipment were available in the event of an emergency and stored safely. X-rays were taken in accordance with relevant regulations.

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 and The Department of Health. 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 their requirements for continuing professional development. All staff we spoke with were aware of their responsibilities under the Mental Capacity Act (MCA) 2005.

Are services caring?

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

Feedback from patients was very positive. Patients indicated that staff were professional and caring and treated patients with dignity. We received feedback from 24 patients via Care Quality Commission comment cards. Patients were complimentary about staff, describing them as warm, accommodating and caring. They indicated that they were involved with their treatment planning and were able to make informed decisions about their treatment. Patients told us that staff acted in a professional manner and were helpful.

Patients commented that they found the practice clean and tidy and they did not have problems accessing the service.

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 website. There was a practice leaflet with relevant information for patients. Urgent on the day appointments were available during opening hours. In the event of a dental emergency outside of opening hours details of the '111' out of hours service were available for patients' reference.

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 effective management of the practice. Staff meetings were held frequently and minutes taken of the meetings. Leadership structures were clear and management lead by example. Opportunities existed for staff for their professional development. Audits were being used to improve the practice and staff we spoke with had received the required training, and were confident in their work and felt well-supported.

The Beckenham Dental Clinic

Detailed findings

Background to this inspection

The inspection took place on the 7 October 2015 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. We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we spoke with members of staff which included the dentist, dental nurses, trainee dental nurse and receptionist. We reviewed policy documents, staff records and CQC comment cards completed by 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 systems in place to receive safety alerts by email. All alerts were forwarded to staff via email and also printed off and kept in a central file. The alerts received included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England updates.

The practice had an incidents and accident reporting procedure. All incidents and accidents were reported in the incident and accident books. There was one reported accident in the past 12 months. We reviewed it and saw that the practice manager had taken the appropriate action to make staff aware of what had happened and had put procedures in place to reduce the risk of it occurring again. All staff we spoke with were aware of reporting procedures including who and how to report an incident to. We saw that the handling of the incident that related to a patient was in line with the duty of candour expectations. The person affected received an apology and was informed of the action taken. [Duty of candour is a requirement 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]. Staff meeting minutes we reviewed demonstrated that incidents were discussed appropriately with staff.

The practice had carried out a COSHH Regulations (Control of Substances Hazardous to Health, 2002) assessment and also had relevant documentation for reporting RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) incidents. They had not had any RIDDOR incidents within the past 12 months. The dentists demonstrated a good understanding of RIDDOR regulations.

Reliable safety systems and processes (including safeguarding)

The two principal dentists were the safeguarding leads. The practice had policies and procedures in place for safeguarding adults and children protection. Details of the practice safeguarding leads, local authority safeguarding teams and other useful telephone numbers were also in the policies.

Dentists had completed child protection training up to the appropriate level as had the nurses and administration staff. All staff had also completed adult safeguarding training.

All staff were required to update themselves with relevant policies and protocols such as the safeguarding policy and whistleblowing policy. All staff we spoke with demonstrated an understanding of safeguarding issues including how to respond to suspected and actual safeguarding incidents.

The practice 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].

Patients were requested to complete medical history forms including existing medical conditions, social history and any medication they were taking. Medical histories were updated at each subsequent visit. 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 provider had appropriate arrangements to deal with medical emergencies. There were emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Staff also had access to emergency equipment on the premises including an automated external defibrillator (AED) in line with Resuscitation Council Guidance 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]. We saw records of the daily checks that were carried out to ensure the medicines were not past their expiry date. We also saw records of the checks to the AED and medical oxygen.

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

Staff recruitment

Are services safe?

There was a full complement of the staffing team. The team consisted of four dentists, four nurses and two trainee dental nurses. The nurses also performed reception duties. We saw confirmation of all clinical staff's registration with the General Dental Council (GDC).

The practice had a recruitment policy and procedure that outlined how staff were recruited and the pre-employment checks that were carried out before someone could commence work in the practice. This included confirming professional registration details, proof of address, proof of identification and qualifications, references, indemnity, Disclosure and Barring Services (DBS) check, curriculum vitae and immunisation proof. We saw that all of these checks had been carried out when staff commenced work in the practice.

Monitoring health & safety and responding to risks

There were appropriate arrangements in place to respond to and deal with risks and foreseeable emergencies. This included having a business continuity plan in place and carrying out risk assessments. The business continuity plan covered events such as a flu pandemic, power failure and flooding in the premises. The policy was updated annually (last update was November 2014). There were details of relevant organisations to contact in the event of an emergency.

The provider had a health and safety folder with policies and procedures relating to maintaining health and safety. There were also a set of risk assessments that were carried out. This included a premises risk assessment conducted on 1 November 2014 and a fire risk assessment completed in November 2014. Risks were identified and where necessary actions were set out to ensure the health and safety of staff and visitors to the service.

The fire alarm was tested every month and there was a copy of the evacuation plan at reception so staff and visitors were aware of where to go in the event of a fire.

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 two sinks in the decontamination room; a hand washing

sink and a sink for cleaning of used dental instruments. Instruments were rinsed using a bowl in the washing sink which was in line with acceptable procedures for cleaning instruments.

One of 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; placing in a washer disinfectant; 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 reviewed records of the checks and tests that were carried out to the autoclaves and washer disinfectant and the records were in line with guidance.

All relevant staff had been immunised against blood borne viruses and we saw evidence of this. There was a contract in place for the safe disposal of clinical waste, which was collected every two weeks. The practice had blood spillage and mercury spillage kits.

The surgeries were visibly clean and tidy. There were appropriate stocks of personal protective equipment for both staff and patients such as gloves, safety glasses and disposable aprons. There were enough cleaning materials for the practice. Cleaning equipment was stored appropriately. Wall mounted paper hand towels and hand gel was available as were clinical waste bins. The dental nurses cleaned 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.

The last legionella risk assessment had been completed in January 2015. Actions were identified; for example, that the practice should carry out monthly water temperature checks. We saw the action that the practice had taken since the assessment was carried out. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. The dental lines were maintained with a purifying agent. Taps were flushed daily in line with recommendations.

Are services safe?

Infection control audits were being carried out and we reviewed the most recent one carried out in December 2014.

Equipment and medicines

There were appropriate service arrangements in place to ensure equipment was well maintained. There were service contracts in place for the maintenance of equipment such as the autoclave and washer disinfecter. The washer disinfecter was serviced in June 2014 and was due to be serviced in the coming months. The air compressor and pressure vessel had been inspected in August 2015 and certified as passed. The autoclave was serviced in February 2015. The practice had portable appliances and carried out PAT (portable appliance testing) annually. Appliances were last tested in January 2015.

Medication was stored appropriately in a secure location.

Radiography (X-rays)

One of the dentists was the radiation protection supervisor (RPS). All relevant staff had completed radiation training. The practice had an external radiation protection adviser (RPA). The practice had records in their radiation protection file which included a list of X-ray equipment present. The file also had the maintenance history of X-ray equipment along with the critical examination and acceptance test report. Local rules were displayed in the surgery and included in the radiation protection file.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were assessed and care and treatment was delivered in line with current guidance. This included following the National Institute for Health and Care Excellence (NICE) guidance and Delivering Better Oral Health toolkit. Copies of both were available in the practice.

During the course of our inspection we checked 10 dental care records (sample taken from each dentist) to confirm the findings. 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 eating habits and an extra and intra-oral examination. The reason for visit was documented and a full clinical assessment was completed. 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]. Dentists were also recording when oral health advice was given.

Appropriate information was given to patients for health promotion. There were a range of leaflets available in the patients' waiting room relating to health promotion including oral cancer and smoking cessation.

Staff we spoke with told us that they gave health promotion and oral health advice to patients during consultations. Notes we checked confirmed this; for example we saw that dietary advice, brushing techniques and smoking cessation advice was given to patients. We saw that dentists had discussions with patients about the advantages of a good diet and preventative measures for decay. On occasion diet analysis were carried out, mainly with children to assess the impact of diet on their oral health.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council and were all up to date with 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]. Both principal dentists monitored CPD and staff were required to bring in certificates of training attended and maintain a log of their CPD at the practice.

Infection control and basic life support was mandatory training that all staff in the practice had to attend. This was arranged and conducted for all staff to take part in together.

Opportunities existed for staff to pursue development opportunities. We reviewed staff training records and saw that staff had attended a range of courses and conferences for their development. Staff we spoke with confirmed that they had access to opportunities for developmental purposes.

The dental care records that we checked were comprehensive and demonstrated that dentists were following appropriate record keeping guidelines. We reviewed staff files and saw that staff had completed the appropriate training and had relevant qualifications to enable them to provide treatment and care to patients.

Working with other services

The provider had arrangements in place for working with other health professionals to ensure quality of care for their patients

The practice had procedures in place for referring patients. This included referring to the community dental services, local hospitals or for treatments that require sedation. Copies of referral letters were saved to patients' files and a copy was also given to patients. Patients were advised to contact the practice if they had not heard from the referral agency within six weeks. We reviewed patient referral records. All the details in the referral were correct for example the personal details, details of the issues, and copies of the referrals had been stored on patients records appropriately, and where necessary referrals had been followed up.

Consent to care and treatment

Staff confirmed that informed consent for treatment was obtained verbally, recorded in the patients' notes and patients were given a treatment plan. We checked dental care records and saw that consent was documented appropriately. The practice had separate consent forms for some procedures including extractions, root canal treatment and dentures.

Are services effective?

(for example, treatment is effective)

Staff whom we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005, including the best interest principle and Gillick competence and had received training. [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]. Staff gave us comprehensive examples of when the Act would apply and how it related to their roles.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 24 patients through completed CQC comment cards. Feedback was very positive. Staff were described as professional, and caring. Patients said staff ensured they maintained their privacy during consultations and when providing confidential information. Patients gave us examples of when staff had treated them with compassion and empathy. Patients described how the dentist would stop if they indicated they were in pain or distressed. Patient feedback indicated that staff were always respectful when speaking to patients.

We observed staff interaction with patients in the waiting room and saw that staff interacted with patients in a respectful and friendly manner. The dentist told us that consultations were in private and that staff never interrupted consultations unnecessarily and if they did, they would either send a message via email or knock and wait to be invited in. We observed that this happened with doors being closed so that the conversations could not be overheard whilst patients were being treated and staff knocking if they needed to interrupt a consultation. The environment of the surgeries was conducive to maintaining privacy. We saw that reception staff made every effort to ensure they spoke to patients in lowered voices to maintain privacy.

Patients' information was held securely electronically and we were told it was backed up off-site. All computers were password protected with individual login requirements.

Involvement in decisions about care and treatment

Patient feedback indicated that they felt involved and informed in decisions about their treatment and care. They stated that information was given in clear, plain language and anything they did not understand was always explained.

Staff we spoke with told us they always explained the diagnoses to patients and never carried out treatment if a patient was unsure. Dentists used visual aids such as models of crowns, dentures and flowcharts for gum disease to make their explanations clearer. We were given examples of how patients were involved in decisions about their care and treatment and the examples were in line with what would be expected. The dental care records we checked also demonstrated that people were involved in planning because it was documented in their clinical notes. For example we saw that the risks and benefits of treatment were explained and the options available to patients for treatment were also outlined.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was open from 9.00am to 5.30pm Monday to Fridays, except for one evening when they opened until 7.00pm and every other Saturday. Staff told us that the appointment times were reflective of patients' needs. Patients who provided feedback were satisfied with the opening times.

Patients experiencing pain and in need of an urgent appointment were always offered an appointment on the same day. If a patient had an emergency they were asked to come in, and would be seen as soon as possible. Pregnant women and children with urgent needs were always seen on the same day without delay.

Tackling inequity and promoting equality

Staff told us that the patient population was quite diverse although the majority of patients were British. Whilst language barriers was not a common issue for patients accessing the service, the practice still had access to interpreting services via NHS. There was also a multi lingual team of staff who spoke languages including Polish, Nepalese, Hindi and Gujarati. Information was available in other formats including large print and other languages if requested by patients.

The practice was set out over two levels. There was step free access into the ground floor of the building which was suitable for wheelchairs and pushchairs to be manoeuvred around.

Access to the service

The practice had a website with information about their services, treatments, opening times and contact details. Opening times were displayed on the website as well as on the practice door. There was a patient leaflet with detailed information for patients outlining treatment costs, emergency out of hours' details and services.

If patients required an appointment outside of normal opening times they were directed to the local out of hours' dental service or the "111" service. The service tried to ensure that patients had access to the details of the out of hours' service by advertising the contact details on the practice door and website and they were also given on the practice answer machine message when the practice was closed.

Feedback received from patients indicated that they were happy with the access arrangements. Patients said that it was easy to make appointments and opening times suited their needs.

Concerns & complaints

The provider had a complaints policy and procedure in place. The policy included receiving, handling and resolving complaints. Details about how to make a complaint and complaints handling, and how to escalate the complaint to external bodies were also in the policy. At the time of our visit there had been two complaints in the past 12 months. One of the dentists went through the complaint with us and their explanations were very thorough and in line with their policy. We also reviewed the paperwork for both complaints and saw that appropriate action had been taken.

Are services well-led?

Our findings

Governance arrangements

Staff we spoke with told us they were well supported and were clear about their roles and responsibilities. There were appointed leads for certain areas such as infection control and safeguarding and staff we spoke with were aware of the leads and who to go to. There were a range of policies and procedures in place for the smooth running of the practice. This included policies for staff recruitment and human resources, infection control, training and health and safety. Policies were available in hard copy or via the computer and staff we spoke with were aware of this.

Dental care records we checked were complete, legible and accurate and stored securely on computers that were password protected.

The practice had a programme of audits in place. Various audits had been completed over the past 12 months and included audits on antimicrobial prescribing, patient satisfaction, record keeping and infection control.

We reviewed the audits and saw that the aim of the audit was clearly outlined along with learning outcomes. For example the aim of the antimicrobial prescribing audit conducted from April to May 2015 was to determine if antibiotics were being over prescribed and whether the right dose and frequency was being prescribed. The learning outcome showed that prescribing was correct on each occasion; however improvements could have been made with the frequency given. Actions had been put in place to improve this.

Leadership, openness and transparency

Leadership in the practice was clear. The principal dentists told us they led by example and this was confirmed in conversations we had with staff. Staff were very proud to work in the service and spoke respectfully about the leadership and support they received from the principals as well as other colleagues. Staff we spoke with were confident in approaching the principal dentists if they had concerns and displayed appreciation for the leadership.

We discussed the duty of candour requirement in place on providers. The dentist and practice manager gave us relevant examples of how they had displayed duty of candour through their incidents handling. The explanations of how they ensured they were open and transparent with patients and staff was in line with the expectations under the duty of candour. [Duty of candour is a requirement 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].

Learning and improvement

Team meetings were the main method to support communication about the quality of the service. Staff told us that regular topics included discussing the outcomes of audits, complaints and incidents. We reviewed team meeting minutes and saw that other areas discussed included updating on fire procedures, confidentiality, medical emergencies and staffing matters.

The staff received formal supervision and told us they felt confident to approach the practice manager at any time. We reviewed staff files and saw notes of staff supervision. Notes demonstrated that staff had access to development opportunities and support needs were discussed.

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

The practice carried out on-going patient satisfaction surveys and also sent out a sample of questionnaires every six months to patients who had visited in the last month. One of the principal dentists told us that they analysed the results by looking for themes and trends. We saw that improvements were identified and acted on. For example, patients had commented on the condition of the external building and the provider had taken this on board and made improvements. The practice also collected the NHS Friends and Family test survey. The results were collated every month and sent off to NHS as well as analysed by the practice. The results from this survey also fed into patient feedback.