Care Quality Commission

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Kingston Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 July 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 not providing well-led care in accordance with the relevant regulations.

Background

Kingston Dental Clinic is located in Kingston town centre. The premises consist of one treatment room, a dedicated decontamination room, waiting room, reception area and toilet. It is on the first floor only accessible by a staircase.

The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including general and cosmetic dentistry.

There was one dentist, a part time dental nurse and a part time trainee dental nurse. The dentist and the trainee dental nurse were available on the day of inspection.

The practice is open Monday and Wednesday from 9.00am to 6.00pm and on Saturday from 11.00am to 4.00pm by appointment.

This practice was first registered with the Care Quality Commission (CQC) in April 2013. It has not previously been inspected.

Nine people provided feedback about the service. Patients we spoke with on the day of inspection, and those who completed CQC comment cards, were positive about the care and treatment they received from the practice.

Our key findings were:

- Patients' needs were assessed and care was planned in line with national guidance such as from the National Institute for Health and Care Excellence.

Summary of findings

- Equipment, including the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Staff had received safeguarding and whistle blowing training and knew the procedures to follow to raise any concerns.
- Patients indicated that they were given information and time to decide on treatment options and felt listened to.
- The practice ensured staff attended relevant training to maintain the necessary skills and competence to meet patients needs.
- The practice had developed a clear complaints process that was accessible to patients at the practice and in the patient information leaflet.
- The dentist had a clear vision for the practice which staff understood.
- Patients were treated with dignity and respect and confidentiality was maintained.
- Risks to patients and staff had not been always been suitably assessed and mitigated.

We identified regulations that were not being met and the provider must**:**

- Review governance arrangements including the effective use of risk assessments, and audits, such as those for infection control and X-rays.
- Establish an effective system to assess, monitor and mitigate the risks including and not limited to those associated with cleaning of used dental instruments.

You can see full details of the regulations not being met at the end of this report.

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

- Review its protocols regarding receipt of Medicines and Healthcare products Regulatory Agency (MHRA) alerts to ensure they are received and acted upon in a timely way.
- Undertake regular checks to ensure emergency medicines, oxygen cylinder and equipment are within their expiry date.
- Revise the practice's recruitment arrangements so they are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- 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.
- Review the practice’s protocols for recording in the patients’ dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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.

While the dentist carried out checks before new staff started work, they had not sought references for one member of staff, gaps in employment were not always checked and records were not maintained of interviews.

The practice had systems and protocols to minimise the risks associated with providing dental services, however they were not fully utilised. The dentist was the infection control lead and staff had received training in infection prevention and control; however staff were not following the recommended procedures while cleaning of used dental instruments. This was brought to the attention of the principal dentist who assured us they would ensure increased supervision.

There was a safeguarding lead and staff understood their responsibilities for identifying and reporting any potential abuse. There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was maintained and checked for effectiveness.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the National Institute for Health and Care Excellence.

The practice monitored patients' oral health and gave appropriate health promotion advice. Patients were referred to other services in a timely manner if needed. Staff explained treatment options to ensure that patients could make informed decisions about any treatment.

The practice worked with other providers when required and followed up on the outcomes of referrals made to other providers. Staff were registered with the General Dental Council and were engaged in continuous professional development to meet the training requirements of their registration. Staff were supported through training, appraisals and opportunities for development.

Are services caring?

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

We received positive feedback from patients through discussions on the day of inspection and comment cards completed before the inspection. Patients felt that staff were friendly, kind, helpful and respectful. We found that patient records were stored securely and patient confidentiality was understood and maintained by staff.

Are services responsive to people's needs?

Patients had access to appointments, including emergency appointments, which could be available on the same day. Patients were invited to provide feedback through the practice website and social media.

There was a complaints policy which was displayed in the reception area and included in the practice information leaflet. Patients would speak with the dentist if they had any concerns. There had not been any complaints received by the practice in the last 12 months.

Summary of findings

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

There were regular staff meetings. Staff described an open and transparent culture and felt able to raise and discuss concerns and make suggestions to the dentist. While surveys were not used, feedback was sought from patients through the practice website and social media pages, although this had not identified any areas for improvement to date.

We found measures to improve quality of service such as audits of X-rays had not been carried out and an infection control audit due in February 2015 had not been completed. Arrangements were in place to identify and manage risks. However we found that staff were not following relevant protocols in the cleaning of instruments.

Kingston Dental Clinic

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 16 July 2015. The inspection took place over one day. The inspection was led by a CQC inspector who was accompanied by a dental specialist advisor.

We reviewed information received from the provider prior to the inspection which included their statement of purpose and details of staff members.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with the provider and the trainee dental nurse. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the trainee dental nurse carrying out decontamination procedures of dental instruments and observed staff interacting with patients in the reception area.

Nine people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice saying the place was always clean, the dentist explained things to them and they would recommend the service to their family and friends.

We informed NHS England area team that we were inspecting the practice; however we did not receive any information or concerns from them.

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 system to report and learn from incidents. Staff were clear about their responsibility to report accidents and incidents to the dentist. An accident book was in place, although this had not been needed. There was a needlestick policy that was displayed in the treatment and decontamination room.

The dentist told us that they had a duty under their registration with the General Dental Council to tell the patient if something had gone wrong with their treatment, although this situation had not occurred.

The dentist was clear about their responsibility on incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). There had been no recorded RIDDOR incidents in the last year. dental practices. However, the practice was not routinely receiving MHRA alerts electronically. The practice could not assure us that they were aware of any recent alerts.

Reliable safety systems and processes (including safeguarding)

The practice had safeguarding children and vulnerable adult policies and procedures in place. These provided staff with basic information about identifying and reporting suspected abuse and included the contact details for the local authority child protection and adult safeguarding teams. The dentist was the safeguarding lead and had completed child protection training to Level 2 and safeguarding vulnerable adults in December 2013. The dental nurse had attended child protection training in 2014. Staff told us they were confident about raising concerns with the dentist.

The practice had systems in place to help ensure the safety of patients and staff. These included clear guidelines about responding to sharps injuries. There were adequate supplies of personal protective equipment such as gloves and aprons.

The dentist described how they used a rubber dam during root canal treatment which was in line with guidance from the British Endodontic Society. (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).

Patient medical histories were taken when they first joined the practice. This included details of current medication, any existing conditions and known allergies. The dentist told us that medical histories were updated regularly. We were shown copies of patients' medical histories and saw they were updated appropriately. Patients confirmed they were asked to update the dentist on their medical history when they attended for an appointment or treatment.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. Staff were knowledgeable about what to do in a medical emergency and had received their annual training in basic life support in September 2014 and February 2015. The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely though there were no records to show that regular checks were made of the expiry dates of emergency medicines. The oxygen cylinder had expired in February 2015; the dentist ordered a replacement during the course of the inspection. The practice did not have a portable suction and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Staff recruitment

The practice staffing consisted of one dentist, one part time trainee dental nurse and a part time dental nurse.

There was a recruitment policy in place which noted the process candidates went through and checks completed before staff started work at the surgery which included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

We reviewed the recruitment files for two staff members. We saw that most of the required checks to ensure that the person being recruited was suitable and competent for the role had been carried out. No new member of staff had been recruited since the practice was registered with the CQC.

Are services safe?

We noted that practice policy was to carry out Disclosure and Barring Service checks for all members of staff and details related to these checks were kept. However, there were no references recorded for one member of staff; the dentist told us they had worked with this person for six years. Also, evidence was not in place to show gaps in employment history were checked and though we were told that interviews were held at the time of recruitment, records were not kept of the interview process.

Monitoring health & safety and responding to risks

Arrangements to deal with foreseeable emergencies were in place. We saw there was a health and safety policy in place. This document needed updating to reflect details of the practice. The provider had completed a fire risk assessment in April 2013 which stated it was due for review in 2014, however this had not been carried out. The dentist assured us they would ensure one was undertaken at the earliest. Risks to staff had been identified and actions they should take to minimise risk for example when dealing with blood and saliva.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file which contained product data sheets including actions staff need to take in the event of spillage or ingestion. COSHH products were stored securely.

Infection control

The dentist was the infection control lead. The dental nurse explained to us the cleaning of the treatment room environment following the treatment of a patient. They demonstrated a good system for decontaminating the working surfaces, dental unit and dental chair.

The practice had a separate decontamination room for cleaning instruments. This room was well organised, however some areas were not clean. Protocols were displayed on the wall to remind staff about the correct processes to follow at each stage of the decontamination process. Staff demonstrated the process to us- from taking the dirty instruments from the treatment room through to them being clean and ready for use again. We noted that the gloves were not changed from the treatment room to the decontamination room and a disposable apron was not worn.

The decontamination room had two sinks for cleaning and rinsing of used dental instruments and a dedicated sink for hand washing in line with best practice guidance. We however noted that the staff member used the hand wash sink for cleaning of instruments. Instruments were cleaned with a long handled brush but not below the water line to prevent splashes. The illuminated magnification device was available, though the staff member did not use it to inspect the instruments after cleaning to ensure suitability of the cleaning process. This was brought to the attention of the dentist who assured us they would ensure increased supervision.

When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines.

The autoclave had a data logger which records the temperature, pressure and time parameters. However, there was no empty test cycle completed on the autoclave on the day of the inspection and the last recorded weekly check was in February 2015.

The last infection control audit had been completed in August 2014 that had not identified any concerns. A further audit was due in February 2015 and this had not been carried out.

We observed that the dental treatment room, waiting area, reception and toilet were clean, tidy and clutter free. There was clear separation of clean and dirty areas in the treatment and decontamination room. A hand wash sink with liquid soap and paper towels was available in the treatment and decontamination room and toilets.

The drawers and cupboards in the treatment room were inspected and we noted that instruments were pouched and labelled with the date and it was clear which items were single use. Syringes and safety devices were being used and the dentist was responsible for disposing of sharps. The sharps injury policy was displayed, however the dental nurse was not aware of following appropriate protocols after a sharps injury. There was sufficient personal protective equipment including gloves, aprons and eye protection available for staff and patient use.

The dental water lines were flushed to prevent the growth and spread of Legionella bacteria. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method

Are services safe?

described by the dental nurse was in line with Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05):Decontamination in primary care dental practices' (HTM 01-05) and records were maintained of this task.

A Legionella risk assessment had not been carried out however we were shown a March 2015 certificate which stated water samples were analysed by an external contractor for microbial growth and no issues had been identified. The dentist was recording hot and cold water temperatures every two to three months.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and general waste were properly maintained and stored. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

There was evidence to show that the dentist had received appropriate immunisation against Hepatitis B. The dental nurse had started a course of immunisation for Hepatitis B.

Equipment and medicines

We found that the equipment used at the practice was serviced regularly. For example, we saw documents showing that the air compressor, pressure vessel, autoclave, fire equipment and X-ray equipment had all been inspected and serviced in 2014. Portable electrical appliance testing had been completed in accordance with good practice guidance in 2013.

The only medicines held at the practice were emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely though there were no records to show that regular checks were made of the expiry dates of emergency medicines.

Radiography (X-rays)

The dentist was the Radiation Protection Supervisor and the Health Protection Agency were named as the Radiation Protection Advisor in accordance with the Ionising Radiation Regulations (IRR)1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The practice had a radiation protection file, in line with these regulations. The file contained the critical examination and acceptance test report dated November 2012 and October 2013. The dentist had completed five hours of IR(ME)R 2000 training in December 2011.

We noted that no audits of X-rays had been undertaken and there was no evidence of quality assurance of X-rays taken at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines.

The dentist described how they carried out patient assessments using a typical patient journey scenario. They used a pathway approach to the assessment of the patient which began with the patient completing a medical history questionnaire, disclosing any health conditions, regular medicines being taken, any allergies and details of their dental and social history.

This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and screening for mouth cancer followed by a discussion with the patient about the treatment options. The dental care record was updated with the proposed treatment after options were discussed and agreed with the patient.

Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A review of a sample of dental care records showed that the findings of the assessment and details of the treatment carried out were generally recorded appropriately. The records were well-structured and contained sufficient detail about each patient's dental treatment. The medical history had been updated at subsequent visits in four out of five records seen. We saw note of details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE 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 at each dental health assessment. Details of the treatments carried out were documented and details of the local anaesthetic used was recorded although the batch number and expiry date were not recorded. We saw patients signed treatment plans.

However we found that the reason for taking the X-ray and quality of the X-ray was not always recorded in the patients care records or elsewhere as recommended in IR(ME)R 2000 guidance.

Also risk assessments for caries or periodontal disease were not completed and re-calls were not set.

Health promotion & prevention

The reception area and waiting room contained a range of leaflets that explained the services offered at the practice and information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of products that patients could purchase that were suitable for both adults and children.

Our discussions with the dentist and our review of the dental care records showed that, where relevant, preventative dental information was given in order to improve outcomes for patients. This included advice around smoking cessation, alcohol consumption and diet. The dentist carried checks to look for the signs of oral cancer. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to patients in ways they understood and through the use of models. Patients we spoke with confirmed they were given advice about general health and tooth brushing.

Staffing

There was one dentist, a part time dental nurse and part time trainee dental nurse employed at the practice. The dentist told us they kept up to date with training and we saw training certificates to confirm they were up to date with training on dealing with medical emergencies, decontamination, safeguarding and radiography. They had also attended updates on record keeping, reporting accidents, law and ethics and were booked to attend further updating training in September 2015.

There was an induction programme for new staff to ensure that they understood policies, procedures, protocols and systems in place at the practice.

The dentist held regular supervision and review meetings with staff which gave individuals opportunities to discuss their performance and career development. The trainee dental nurse was being supported by the dentist to carry out and complete the tasks required to evidence their training.

Working with other services

Are services effective?

(for example, treatment is effective)

The dentist worked with other professionals when required. For example, referrals were made to hospitals and other dental services. The dentist completed referral forms and detailed this in the individual dental records with any outcome of specialist advice. The dentist had prepared an information sheet to help patients understand urgent referrals.

Consent to care and treatment

The dentist gave specific examples of how they would take mental capacity issues into account when providing dental treatment. They were aware of the Mental Capacity Act 2005 (this Act 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) and explained how they would manage a patient who lacked the capacity to consent to dental treatment. They told us if they had any doubt about a patient's ability to understand or consent to the treatment they would postpone treatment and involve the patient's family and others as required. They were therefore able to demonstrate a clear understanding of requirements of the Act.

The dentist explained how they obtained valid informed consent. They told us they explained their findings to patients and kept detailed clinical records showing that they had discussed the available options with them. The dentist told us that they would only see children under 16 with their parents to ensure consent was sought before treatment was undertaken.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from nine patients who provided a positive view of the service the practice provided. Patients commented that the staff were kind and caring. Patients were happy with the quality of treatment provided and stated that they would recommend the practice to friends and family members. During the inspection we observed staff in the reception area. They were polite, greeting patients in appropriate and helpful ways.

The staff we spoke with were clear about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity.

The practice received regular feedback from patients on a range of social media websites. We saw three positive testimonials from patients on the practice website and nine positive comments.

There were systems in place to ensure that patients' confidential information was protected. Paper dental care records were stored securely in a locked cabinet. Staff understood the importance of data protection and confidentiality and were clear about their responsibilities regarding information governance. The dentist told us they were able to have private conversations with patients in the treatment room.

Involvement in decisions about care and treatment

The practice displayed information in the reception area and in a folder in the waiting room which gave details of dental charges and treatment plan fees. There were a range of information leaflets in the reception and waiting room which described the different types of dental treatments available. Patients were given copies of their treatment plans which included details about the proposed treatments and costs. We reviewed a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

The dentist described how they told patients about treatment options and gave them time to consider which was best for them and did not undertake any treatment until the patient was ready.

The patient feedback we received from discussions and comments cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the information given by the dentist.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice leaflet and website explained the range of services available to patients. This included regular check-ups, fillings, extractions, root canal, dentures, bridges and crowns. The practice undertook private treatments and costs were clearly explained to patients. All new patients to the practice were required to complete a patient questionnaire so that the dentist could conduct an initial assessment and respond to their needs. This included a medical history form.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The dentist told us they had not needed to use translation services but would be able to if required. There was written information for people who were hard of hearing.

Access to the service

The practice was open Monday and Wednesday from 9.00am-6.00pm and Saturday from 11.00am to 4.00pm. The opening hours were displayed on the practice website and in the patient information leaflet.

The dentist described the appointment system which she said included time to assess and treat each patient. Routine appointments were booked in advance and the dentist aimed to provide urgent appointments although if this was not possible, they referred patients to other dental practices to ensure they were not kept waiting. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to enable assessment and treatment to take place.

The practice was on the first floor and did not have a lift or a ramp to enable access for patients who used a wheelchair. This was made clear to patients before they registered at the practice. The dentist told us they had spoken with the landlord and been told it was not possible to install a lift in the premises.

Concerns & complaints

There was a complaints policy which described how the practice handled complaints from patients. Information about how to make a complaint was displayed in the reception area and on the practice information leaflet.

There had not been any complaints in the last year. Patient feedback confirmed they had not made a complaint but would speak to the dentist if they had any concerns.

Are services well-led?

Our findings

Governance arrangements

There were clear governance arrangements and management structure. The dental nurse and trainee dental nurse reported to the dentist and meetings were held on a regular basis. Relevant policies and procedures were in place, were accessible to staff and most had been reviewed in the last year. Arrangements were in place to identify, record and manage risks. However we found that the staff were not following relevant protocols in the cleaning of instruments to minimise the risk of spread of infection.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff told us they were comfortable about raising concerns with the dentist and they felt they were listened to.

The dentist had a clear vision for the practice. The practice aims were to provide high quality dental care, to give advice to prevent dental disease and to create a friendly and relaxed atmosphere.

Learning and improvement

The dentist showed us their continued professional development was being maintained through regular attendance at courses. The trainee dental nurse was enrolled on a training course and the dental nurse was up to date with their training. We saw staff meetings were held regularly and the dentist worked with the dental nurse or trainee and spoke with them daily when the practice was open.

We found measures to improve quality of service such as audits of X-rays had not been carried out and an infection control audit due in February 2015 had not been completed.

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

The practice gathered feedback from patients through the Friends and Family Test and patients comments on their website and social media pages. These indicated patients were happy with the services provided and would recommend the dentist to others. Staff told us they felt able to raise ideas and concerns with the dentist.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** How the regulation was not being met: The provider did not have effective systems in place to : · Assess, monitor and improve the quality and safety of the services provided. · Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. · Ensure that their audit and governance systems were effective Regulation 17 (1) (2) (a) (b) (f)