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Bluedental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

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

The practice staffing consists of one dentist, one trainee dental nurse, a dental hygienist, practice manager (who is also a qualified dental professional) and a receptionist.

The practice is open from 9.00am to 5.00pm on Monday to Fridays. The practice is set on the ground floor and facilities include two consultation rooms, a reception and waiting area, decontamination room and staff room/ administration office. The premises were wheelchair accessible however there were toilet facilities were not wheelchair accessible.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

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

We received 35 completed Care Quality Commission comment cards. All the feedback we received from

Summary of findings

patients was very positive. Patients feedback indicated that staff were professional, caring and gave good explanations. They described the premises as being clean and tidy.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines and equipment in line with current guidelines for management of medical emergencies in dental practice.
- Dental instruments were decontaminated suitably.
- Appropriate pre-employment checks were carried out before staff commenced work in the practice.
- Patients' needs were assessed and care and treatment was delivered in line with published guidance, such as from the National Institute for Health and Care Excellence.
- All clinical staff were up to date with their continuing professional development (CPD).
- Appropriate systems were in place to safeguard patients from abuse.
- Patients' 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.
- Governance arrangements were in place for the smooth running of the practice; the practice had a structured plan in place to audit quality and safety which included the mandatory audits for infection control and radiography.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The provider had systems and processes in place to ensure care and treatment was carried out safely, which included systems to receive safety alerts from external organisations and share them appropriately with staff. Systems were in place to ensure patients were safeguarded from abuse. 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 we spoke with were aware of their responsibilities.

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

Are services effective?

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

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

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

All clinical members of the dental team were meeting their requirements for continuing professional development. Opportunities existed for staff to undertake training and professional development. Staff 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 positive and indicated that staff were friendly, professional, caring and treated patients with dignity. We received feedback from 35 patients via completed Care Quality Commission comment cards. Staff described their interactions with patients and gave examples of displaying compassion, dignity and respect.

Are services responsive to people's needs?

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

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

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.

Summary of findings

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, however, improvements could be made to better document the discussions and action points. Opportunities existed for staff to develop. Audits were being conducted and demonstrated they were being used as a tool for continuous improvements. Staff we spoke with were confident in their work and felt well-supported.

Bluedental

Detailed findings

Background to this inspection

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

The inspection took place on the 13 January 2016 and was undertaken by a CQC inspector and a dental specialist adviser. Prior to the inspection we reviewed information submitted by the provider and information available on the provider's website.

The methods used to carry out this inspection included speaking with the dentist, a trainee dental nurse, receptionist and the practice manager on the day of the inspection, reviewing documents, completed patient feedback forms and observations. We received feedback from 35 patients via completed Care Quality Commission comment cards.

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 and ensure they were shared with staff working in the practice. All safety alerts were received by the practice manager and they were responsible for ensuring relevant staff were aware of them. This included forwarding them to relevant staff and also printing them and leaving them in a central location for all staff to refer to. This included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England updates. Staff we spoke with confirmed they were made aware of relevant safety alerts.

All accidents were reported in the accident books. We discussed accident and incident reporting with the practice manager and their explanations of how they would handle them were in line with the practice policy.

All staff we spoke with were aware of reporting procedures including who and how to report an incident to. We spoke with the practice manager about the handling of incidents and the duty of candour. The explanation was in line with the duty of candour expectations. The example given showed that the person affected was updated, received an apology and informed of the action taken and lessons learnt by the practice. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

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

Reliable safety systems and processes (including safeguarding)

The dentist was the safeguarding lead. The practice had policies and procedures in place for safeguarding adults and children protection. We reviewed staff training records and saw that all staff had completed appropriate safeguarding training to the required level. Details of the local authority safeguarding teams were readily available to staff on the practice computer system. The relevant safeguarding escalation flowcharts and diagrams for recording incidents were also available to staff in the staff room and also at reception. Staff we spoke with demonstrated an understanding of safeguarding issues including how to respond to suspected and actual safeguarding incidents.

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

The system for managing medical histories was comprehensive. All patients were requested to complete medical history forms including existing medical conditions, social history and medication they were taking. Medical histories were reviewed at each subsequent visit and updated if required. During the course of our inspection we checked dental care records to confirm the findings and saw that medical histories had been updated appropriately.

Medical emergencies

There were emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Medical emergencies drugs were stored securely and those requiring refrigeration were stored appropriately. Staff checked the medicines on a weekly basis and monitored expiry of medication. Staff also had access to emergency equipment on the premises including medical oxygen and an automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. Staff told us they carried out checks to ensure equipment was in working order in the event of needing to use them.

Are services safe?

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

Staff recruitment

There was a full complement of the staffing team. The team consisted of a dentist, a trainee dental nurse, a receptionist and a practice manager. The practice manager told us that the current staffing numbers were sufficient to meet the needs of their patients.

The provider had an appropriate policy in place for the selection and employment of staff. This included requiring applicants to provide proof of address, proof of identification, references, and proof of professional qualifications and registrations (where applicable). We reviewed staff files and saw that all employed staff had had pre-employment checks carried out. DBS checks had been completed for all staff. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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

Monitoring health & safety and responding to risks

The practice had a health and safety policy and appropriate plans in place to deal with foreseeable emergencies. The health and safety policy covered identifying hazards and matters relating to staff and people who accessed the practice. This included hazardous substances, manual handling and infection control. There was a business continuity plan that outlined the intended purpose to help staff overcome unexpected incidents and their responsibilities and duties. The plan outlined potential problems such as loss of computer system, loss of telephone and loss of electricity. Procedures were in place to enable them to respond to each situation. Where relevant, contact telephone numbers of organisations to contact were listed in the policy.

The practice completed practice risk assessments regularly, the last one being completed in January 2016. The risk assessment covered various areas including assessing health and safety risks in the premises and equipment. Where action was required this was marked with completion dates.

Fire drills were conducted twice a year and evacuation procedures were clearly displayed around the practice, and fire exits were clearly labelled. The practice were due to have an external fire risk assessment carried out in the days following the inspection.

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. The dentist was the infection control lead.

There was a separate decontamination room. There were two sinks in the decontamination room; one for hand washing and the other was used for cleaning dental instruments (instruments were rinsed in a separate bowl). 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 an washer disinfector; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); placing in the autoclave; pouching and then date stamping, so expiry date was clear. Staff wore the correct personal protective equipment, such as apron and gloves during the process.

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

Staff were immunised against blood borne viruses and we saw evidence of when they had received their vaccinations. The practice had blood spillage and mercury spillage kits. Clinical waste bins were assembled and labelled correctly in each surgery and were stored appropriately until collection by an eternal company, every week.

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

The surgeries were visibly clean and tidy. The dental nurse was responsible for cleaning all surfaces and the dental

chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings. External cleaning staff had been appointed for the domestic cleaning at the practice.

The practice did not have external legionella risk assessment but had carried out their own internal one. This included having systems in place to check water temperature. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. Purified water was used in dental lines and managed with a purifying solution. Taps were flushed daily in line with recommendations.

The practice carried out an infection control audit every six months in line with current guidance. We reviewed the last two conducted in January 2016 and July 2015. No additional activity was required from the most recent audit.

Equipment and medicines

There were appropriate arrangements in place to ensure equipment was maintained. Service contracts were in place for the maintenance of equipment including the autoclave and compressor. The autoclave had been serviced in November 2015. The compressor and washer disinfector had been tested and serviced the week before our inspection. We reviewed paperwork to confirm the history of previous testing and it was appropriate. The practice had portable appliances and carried out PAT (portable appliance testing). Appliances were last tested in March 2015 and were due for re-test in March 2016.

Radiography (X-rays)

The practice had a radiation protection file that was up to date and demonstrated appropriate maintenance of X-ray equipment. The equipment was serviced on the 12 January 2016 and the test pack and critical examination was completed on the 13 January 2016. The dentist was the radiation protection supervisor (RPS) and the practice had an external radiation protection adviser (RPA).

All relevant staff had completed radiation training. There was evidence of the practice having undertaken critical examination test and risk assessment. Individual audits were completed for each X-ray and audits were carried out twice a year.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists used current guidelines such as those from the National Institute for Health and Care Excellence (NICE) to assess each patient's risks. During the course of our inspection we checked a sample of dental care records from all the dentists 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 habits such as eating and activity and an extra- and intra-oral examination. The reason for visit was documented and a full clinical assessment was completed. An assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.

Health promotion & prevention

We saw evidence that the dentist was proactive with giving patients health promotion and prevention advice. The dentist told us that they gave health promotion and prevention advice to patients during consultations and dental records we reviewed confirmed this. This ranged from teeth brushing techniques, dietary advice, smoking cessation and advice on products to use.

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

Staffing

The dentist had current registration with their professional body, the General Dental Council and was up to date with their continuing professional development requirements, working through their five year cycle. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 every five years]. The dental nurse was a trainee and we saw evidence of the support they were given.

Working with other services

The practice had processes in place for effective working with other services. Information relating to patients' relevant personal details, reason for referral and medical history was contained in the referral. Copies of all referrals made were kept on the patients' dental care records. We reviewed two referrals that were made to the hospital and a periodontal specialist and saw that the process was appropriate with relevant information being taken; information about the referral being recorded and saved on the patients records and a system in place to monitor the outcome.

Consent to care and treatment

The practice had a consent policy for staff to refer to. The policy outlined how consent could be taken and how it should be documented. Consent was usually obtained verbally and recorded in patients' dental care records. There were consent forms for certain procedures such as implant surgery.

All staff whom we spoke with demonstrated understanding of Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005. [The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them]. All staff had completed recent mental capacity Act training.

Dental care records we checked demonstrated that consent was obtained and recorded appropriately.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 35 patients via Care Quality Commission comment cards. There were no patients available on the day of our inspection to speak with. Feedback was very positive. Patients' feedback indicated that staff provided a friendly and professional service and were caring. Patients also stated in the comment cards that they were treated with dignity and respect.

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

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

Involvement in decisions about care and treatment

Patients commented that things were explained well and they were provided with treatment options.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an appropriate appointments system that responded to the needs of their patients. The practice is open from 9.00am to 5.00pm Monday to Fridays. The dentist explained that they responded to patients needs in various ways which included keeping slots for children outside of school times, keeping protected slots available from 12.00pm to 1.00pm for emergencies (as a result of patient feedback). Emergency and non-routine appointments were also available during the rest of the day.

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

Tackling inequity and promoting equality

The practice manager told us that the local population was diverse with a mix of patients from various cultures and background. The staff team staff spoke different languages which included French, Urdu, German and Hindi. Staff also had access to NHS translation services if patients spoke another language that staff did not speak.

The practice was located on the first floor and the building was wheelchair accessible, although the patient toilet was not wheelchair accessible. The practice was planning refurbishment of the premises and adding a wheelchair accessible toilet was part of their improvements.

Access to the service

Appointments were booked by calling the practice or in person by attending the practice. If a patient needed to see a dentist outside of normal opening times they were directed to contact the "111" hours services. They were informed of the service via the recorded message on the practice answer machine and a poster on the practice door. The dentist told us that sometimes if it was possible and depending on the complaint, they would open the practice and see patients.

Concerns & complaints

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

Staff we spoke with demonstrated knowledge of their complaints procedure, including knowing timescales for responding, and what to do in the event of a patient needing to make a complaint.

Information relating to complaints was readily available to patients. A copy of the complaints procedure was displayed in the patient waiting room and details were also on-line.

Are services well-led?

Our findings

Governance arrangements

The practice had completed audits over the past 12 months which included audits on infection control, medical histories, clinical records and radiography. 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 medical history form was to ensure they were updated appropriately. The practice reviewed 30 records and found that they had updated 100% accurately. The action set was to ensure they continued to complete the forms accurately.

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

The practice carried out an annual clinical governance review. The report included an analysis of audits carried out, risk assessments, patient reports and staff development. The report highlighted the actions that were required and also planned for the year ahead (2016). We saw that the review assisted in evaluating the quality of the service and future service planning.

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

Leadership, openness and transparency

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

We discussed the duty of candour requirement in place on providers with the dentist and the practice manager. They both demonstrated understanding of the requirement. They gave us explanations of how they ensured they were open and transparent with patients and staff. The explanations were in line with the expectations under the duty of candour.

Learning and improvement

The practice had processes in place to ensure staff were supported to develop and continuously improve. There was a training matrix that outlined all completed and pending training. The practice manager monitored training needs of staff to ensure staff stayed up to date.

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

Staff meetings were held monthly and informal meetings everyday between 2.00pm and 2.30pm. Minutes were maintained of the monthly meetings. Staff confirmed that they found the meetings useful and they received appropriate updates and were notified about events where lessons could be learnt. We reviewed the team meeting minutes and noted that improvements could be made to better document the discussions held during meetings such as incidents or learning form events. The practice manager explained that this was because they were usually discussed at the daily meetings and records were not maintained of these meetings. The practice manager agreed that they would ensure important incidents and lessons learnt would be a standard agenda item for the monthly meetings to ensure appropriate records were maintained.

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

The practice participated in the NHS “Friends and Family Test” (FFT) and also completed their own satisfaction surveys on an annual basis. Results from the FFT were collected monthly and analysed to pick up any patient feedback. The results of the practice survey were also very positive. We reviewed the results of the last annual survey conducted in February 2015. They received 34 completed forms and scored between good and excellent on most questions including explaining procedures well; friendly reception staff and cleanliness of the practice. Suggestions made by patients included adopting earlier opening times and improving information for new patients. We saw that they had implemented the improved information for new patients and were working on the other actions.

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

Are services well-led?

They also said that the practice manager and principal dentists were approachable and they could discuss with them if they had suggestions for improvement to the service.