Balsall Common Dental Practice Limited

Balsall Common Dental Practice

Inspection Report

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Overall summary

Balsall Common Dental Practice is a private practice that provides services to people of all ages. The services provided include prevention based, family dental care as well as a full range of procedures including whitening, veneers, crowns, white fillings, orthodontics, implants, bridges, dentures, root fillings, periodontal gum treatment and dental hygienist services.

Before our inspection we provided comment cards and asked patients to share their views and experiences of the service. We reviewed 44 completed comment cards and we also spoke with two of these patients by telephone after our inspection. The feedback received in comment cards was very complimentary of the practice and the care provided by staff. Patient comments included that the service and staff were caring and professional, the environment was clean, they could access the service in an emergency and they felt fully informed about their care and treatment.

Overall we found that the practice had arrangements to ensure patients received appropriate care in a safe and well led environment. Staff working at the practice had the appropriate skills and knowledge to support patients. We observed staff treating patients with care and understanding.

There were policies and procedures at the practice for staff recruitment and for safeguarding children and vulnerable adults. The practice had the equipment and medicines they would need in the event of a medical emergency. Staff had received training and demonstrated to us they knew how to respond. The practice had appropriate arrangements in place to ensure patients received care and treatment that met their needs. Staff working at the practice had the appropriate skills and knowledge for their roles.

However, there were some areas for improvement. In particular, the provider should:

- Develop an incident reporting policy and document all incidents to implement learning

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 overall the practice had systems in place to manage the risks associated with medical emergencies, taking x-rays and for reducing the risk of infection. Patients who completed comments cards told us they felt the environment was clean and hygienic. Staff we spoke with demonstrated an awareness of the principles of infection control.

The practice had arrangements to ensure equipment used within the practice was serviced regularly which included equipment used for the sterilisation of instruments. The practice had no formal policies and procedures for the management of adverse incidents. However, staff we spoke with were clear and consistent about what would happen should this occur.

Staff received training in child protection and safeguarding vulnerable adults and understood their responsibilities in terms of responding to any potential abuse.

Appropriate checks were carried out before the appointment of new staff and there were effective arrangements to ensure newly appointed staff were supported during the induction and probationary period.

Are services effective?

Patients' care and treatment was planned and delivered in a way that ensured patients' safety and welfare. Patients' medical history was obtained prior to the commencement of dental treatment**.** Patients' personal records including medical records were accurate and fit for purpose. Patients told us that they felt fully informed about their dental care and were subsequently able to make informed decisions about their proposed treatment.

Staff working at the practice were clear about their individual roles and responsibilities and had undertaken appropriate training to support them in their roles and enable them to meet the needs of patients.

Are services caring?

We found staff were very sensitive to the needs of their patients and aware of the need to ensure patient confidentiality. All of the patients who completed comment cards spoke very highly of the care they received at the practice and told us they were treated with professionalism and respect.

Are services responsive to people's needs?

We saw the practice had a book and a box available inviting patients to make comments and suggestions. Patients could also leave comments on the practice website. We saw that the practice responded to feedback received.

There was a complaints policy and we saw that the practice responded to complaints appropriately in accordance with the policy. We found the practice tried to meet the needs of different people such as those who may have high levels of anxiety or specialist needs. Patients we spoke with told us that they were able to get appointments when they needed to and that they could get appointments in an emergency.

The practice had a consultation room on the ground floor and one consultation room on the first floor. The provider had made changes to improve access for patients with disability such as a ramped access. However, the practice knew some of its limitations related to the structure of the building.

Summary of findings

Are services well-led?

There were systems in place ensure staff were aware of their roles and responsibilities. Regular staff and dental nurse meetings were held as well as daily short discussions to help communicate any issues on the day. Staff were aware of the leadership team and knew who to approach for specific issues.

Staff felt supported and were encouraged to extend their learning. We saw the practice had systems to capture feedback from patients who attended for care and treatment. This information was used to improve the service provided.

Balsall Common Dental Practice

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We carried out this inspection on 14 January 2015. During the inspection we looked at the premises, spoke with the principal dentist about their methods of working and reviewed documents. We also spoke individually with the practice manager, the clinical manager, the business manager and a dental nurse.

Before our inspection we provided comment cards and asked patients to share their views and experiences of the service. We reviewed 44 completed comment cards and we also spoke with two of these patients by telephone after our inspection.

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

Learning and improvement from incidents

From our discussion with staff members it was evident that the practice learned from and responded to incidents appropriately but did not always document this. We spoke with the principal dentist who described an incident where the telephone service they had purchased to divert out of hours calls to an appropriate person had failed over a holiday weekend. The practice had discussed this and had put mechanisms in place to ensure regular checks were made by a staff member. The dentist told us that this was not something that they thought of recording. Another staff member we spoke with told us another example of an incident which resulted in changes to the way stock was checked, ordered and managed but this was also not documented. The practice manager told us they had not considered these events as incidents but agreed that recording incidents would help the practice to recognise themes and trends.

The practice had an accident book which was used to record accidents such as needle stick injuries. We saw two accidents were recorded in the accident book and actions were taken where appropriate.

Reliable safety systems and processes including safeguarding

The practice had safeguarding children and vulnerable adults policy which contained relevant local authority contact information should staff require further advice. All the policies including the safeguarding policy were available on the practice shared drive on the computer system. We saw the policy named a lead person responsible for safeguarding issues in the practice. Staff we spoke with were aware who the lead was. We spoke with the safeguarding lead who told us that they had attended training appropriate for their role. We saw minutes of a staff meeting which demonstrated that learning was shared with practice staff to so they could recognise signs of abuse and know what actions to take if they were unsure.

We saw the care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. We reviewed eight patient paper records as well as other electronic records on the computer system. We saw that a medical history was obtained prior to the commencement of dental treatment and updated on a regular basis. Any risk factors were highlighted for example; we saw alerts on the computer system where a patient was allergic to penicillin.

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. They protect patients from inhaling or swallowing debris or small instruments used during root canal work, as well as isolating the tooth being treated. The dentist was using rubber dams as it was considered best practice.

Infection control

The practice had an infection control policy with the principal dentist as the overall lead and the clinical manager as a deputy responsible for day to day management of infection control issues.

We found the essential requirements for infection control as set out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05; National guidance from the Department of Health for infection prevention control in dental practices) were being met.

There were procedures in place to test all decontamination equipment was working optimally. Daily checks and protocols were in place to ensure infection prevention guidelines were being followed and to ensure equipment was working correctly. There were contracts in place to ensure regular maintenance by service engineers so that equipment was well maintained and safe to use.

A separate decontamination room was used to clean and reprocess instruments. The clinical manager talked us through the decontamination process that was followed. Dirty instruments were taken in sealed boxes where heavily soiled instruments were immersed in water (with detergent) to remove some of the blood and other visible soil before cleaning in an ultrasonic bath in the ‘dirty’ area. They were then examined under an illuminated magnifier to ensure they were clean, functional and in good condition before decontaminated in an autoclave. These measures ensured only hygienically cleaned instruments were being used. The staff member was aware of current infection control guidance and told us that the principal dentist always communicated any changes to them. The practice was part of the BDA (British Dental Association) good practice scheme and had the highest membership with

them. The principal dentist told us this enabled them to seek advice from the BDA who kept them updated about any changes to guidance. We found the practice had sought advice from the BDA regarding regular testing and use of the autoclave. An autoclave is a device for sterilising dental and medical instruments.

We saw contracts were in place for handling and disposal of clinical waste and hazardous waste. We saw documents showing they were collected by a registered waste contractor for disposal in line with current legislation.

Equipment and medicines

We saw pressure vessels such as the autoclave and the compressor had been serviced by an engineer and records demonstrated the equipment had been passed as fit for purpose.

We also saw records that demonstrated emergency medical equipment's such as face masks and the practice supply of oxygen was regularly checked to ensure they were fit for purpose and ready for use. The nurse carried out checks for cleanliness and effectiveness on the ultrasonic cleaner in accordance with the manufacturers guidance.

There were arrangements in place to deal with medical emergencies. The practice had an emergency drugs kit, first aid kit and oxygen available for use in an emergency. Staff we spoke with knew where the emergency medicines kit was stored and were able tell us their roles if an emergency occurred. We saw records to show emergency equipment and medicines were checked to ensure they were in working order and that all medicines were in date.

A recording system was in place for the prescribing and recording of the medicines and products used in clinical practice. The records we viewed were complete, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as prescribed. The batch numbers and expiry dates were always recorded.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and we saw records from staff meetings where the policy had been reviewed by staff so they were aware of any changes. The practice manager told us that the meetings were used for in-house educational purposes and were organised as part of a process of continuing professional development.

There was a fire awareness procedure in place which was displayed around the practice to make staff and patients aware. Fire safety had been discussed at a staff meeting which had identified the need to carry out a fire drill. We saw records that fire extinguishers and equipment were maintained. Contracts and certificates available for electrical equipment showed they were Portable Appliance tested (PAT). PAT ensures electrical appliances and equipment are safe to use.

We saw that the practice had a folder containing information on Control Of Substances Hazardous to Health (COSHH). This included information on chemical products that help users of those chemicals to make a risk assessment. The clinical manager told us they reviewed COSHH sheets regularly to ensure any new chemicals or those that were no longer used were added or removed from the folder as appropriate. COSHH legislation 2002 was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.

A Legionella risk assessment had been carried out by an external company. A legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place. Actions identified were being followed by staff. We saw evidence of monthly checks of water temperatures by staff in the practice. Legionella is a bacterium that can grow in contaminated water and can be fatal.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. There was a range of suitable equipment including an automated external defibrillator (AED), emergency medicines and oxygen available for dealing with medical emergencies. This was in line with the Resuscitation Council (UK) guidelines. The emergency oxygen and medicines were all in date and securely kept. All staff we spoke with were aware of where it was kept. The expiry dates of medicines and equipment was monitored using a daily check sheet which enabled the staff to replace out of date drugs and equipment in a timely manner.

We saw staff had received the required training to use emergency medical equipment and carry out

cardiopulmonary resuscitation (CPR). This training was delivered by an external agency to all staff at the practice. This ensured that in the event of a medical emergency staff would be able to respond appropriately with the latest training and guidance. We spoke with a dental nurse who described the process they would follow in the event of a medical emergency. The staff member showed us a flow diagram displayed in both treatment rooms that also reminded staff of the actions to take. Records we reviewed showed a patient suffering a medical emergency had been managed appropriately.

The practice had in their emergency drugs kit a device for monitoring a patient's blood pressure in the event of a medical emergency (should it occur). However there was no evidence that it was being maintained and calibrated in accordance with the manufacturer's instructions.

Staff recruitment

There was a recruitment policy in place outlining appropriate recruitment procedures to follow when the practice employed new staff. The dentist employed all nurses and management staff. There was another dentist and four hygienists who worked at the practice but were not directly employed by the practice.

We looked at the recruitment record of a trainee dental nurse that had recently been employed. We saw evidence an appropriate and robust recruitment process was carried out. This included application and interview records as well as checking appropriate skills and qualifications. This ensured that staff had the current knowledge and skills to meet patients' needs.

We saw that a Disclosure and Barring Service (DBS) checks had been completed. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people including children. We saw the trainee dental nurse had provided details of two referees and the practice manager told us that they had sought telephone references which were not documented. The practice manager agreed to ensure future references sought by telephone were recorded as evidence of appropriate recruitment.

We reviewed employment records for the dental hygienist and a dentist working at the practice. Appropriate checks had been done to ensure they were registered with their appropriate professional bodies.

Radiography

We saw the practice had appointed an external organisation as their radiation protection adviser (RPA). We also saw that an individual was named as the radiation protection supervisor (RPS) for the practice.

The practice had a radiation protection file which contained all the necessary documentation pertaining to the maintenance of the X-ray equipment. The maintenance contract with the radiation protection adviser (RPA) had been in place and was up to date with details displayed in the x-ray room.

We spoke with a staff member who took X-rays and found they had attended appropriate training. We saw many radiography audits had been conducted. An audit from 2014 showed a 100% diagnosis and no retakes were required. If an X-ray is of good quality first time then, diagnosis can proceed and patients are not exposed to unnecessary radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice had a consent statement on every treatment plan. The dentist told us they would discuss treatment options with patients for consent and developing their treatment plan.

The dentist explained that as a private practice most of the work was bespoke and patients had an initial consultation to discuss their treatment needs and options. This was documented and sent to patients where appropriate so that they had a written copy of their discussion and any options that were considered. If the patient decided to go ahead with treatment, a plan would then be developed with the patient based on the initial discussion.

We saw an example of this where the dentist had initially recorded their discussion with the patient of their needs and options available to them. This was a four page document that was sent to the patient and if they had decided to go ahead with the treatment a formal plan was developed with the patient signing the treatment plan to consent to the commencement of the treatment.

We looked at eight records of treatment plans and they were all signed by patients. Where children were treated, parents or legal guardians signed on their behalf. However, this was not made clear on the treatment plan and the practice manager told us that they would amend the form to make it more clear who had signed.

There was no formal training on the Mental Capacity Act 2005 (MCA). MCA creates a framework to provide protection for people who cannot make decisions for themselves. The practice manager told us that they had covered mental capacity as part of the safeguarding training they had attended. We spoke with the dentist who displayed knowledge of capacity and consent. They gave us a recent example where they had consulted with another healthcare professional because they had suspected the patient was not able to consent to care and treatment.

Monitoring and improving outcomes for people

The practice was part of the BDA good practice scheme. By becoming members, practices demonstrate a visible commitment to providing quality dental care to nationally recognised standards. The practice also took out the 'Extra' membership which offers an enhanced range of benefit.

The dentist told us that if there were any changes to practice, guidance or regulation the practice received immediate updates via email so they could implement the changes.

The dentist told us they were part of two peer group reviews in Solihull. The dentist told us they discussed anonymised cases with other dental professionals so that learning could be identified. These discussions were not documented however, we saw records which showed the peer review meeting schedule.

The dentist also told us that through the peer review group they were able to improve outcomes for patients. They told us of a recent example where a manufacturer of tooth straightening products had changed their policy. Previously dentists could ask the manufacturer to make small amendments to the product if the patient was not happy with the way it fitted. Now, if a patient did not like the way the product fitted then the dentist was unable to do anything about it. The dentist told us that through the peer review group they wrote to the manufacturer which helped to get the policy changed.

Working with other services

The dentist was part of two peer review groups which also composed of specialist dentists. They told us that they would only refer complex cases to specialist they knew and were confident in. The peer review group allowed them to meet with various specialists which also made the referral process smoother. The dentist was also aware of various experts at the Birmingham Dental Hospital they could refer patients to depending on their need. They would review their patients after referral and if they felt that the outcome was poor for the patients they would seek alternative specialists.

We saw an example of a referral letter that had been sent to the appropriate specialist at the Birmingham Dental Hospital and a corresponding letter to the patient detailing the process. We saw that the letters received from the consultant were saved on the electronic patient record system.

Health promotion & prevention

Patient records showed that patients were given appropriate advice and demonstration of brushing

Are services effective?

(for example, treatment is effective)

technique using the appropriate brush. The practice sold high fluoride toothpaste and informed appropriate patients that they could purchase this at the surgery or elsewhere depending on the concentration.

Children were automatically offered fluoride varnish as part of their treatment. Fluoride varnish is a temporarily adhesive form of fluoride applied to the tooth surface as a prevention therapy for tooth decay.

Four dental hygienists worked at the practice and focused mainly on preventive dental health and treating gum disease. There were information leaflets in the waiting room on preventative advice and services available.

Staffing

All the qualified dental nurses were trained to work in reception. We looked at the appraisal document of a trainee dental nurse where a development target had been to train in the reception area after they had qualified. The practice manager told us that this allowed appropriate skill mix of staff who were able to cover each other during absence. We saw staff were supported to maintain their training and continuous professional development. Records we looked at and staff we spoke with confirmed they were supported and core and mandatory training was up to date. A staff member we spoke with told us that the practice had supported them to attend training and they were being supported to develop in their current management role.

The receptionist was a qualified dental nurse who covered for the absence of a dental nurse as required. They had maintained their training for continuous professional development. We saw certificates for training on infection control, safeguarding and safety in radiation. Annual performance appraisals included personal objectives.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff treating patients with respect, friendliness and professionalism. Patients told us on the comments cards treated with dignity and respect. Doors to treatment rooms were closed during appointments.

The waiting room was comfortable and there were three iPads that children could use when waiting. There were pencils and colouring paper available as well for children.

Staff told us that a private area or the X-ray room was used if a patient wanted to talk in private away from the reception area. Staff members we spoke with told us that they kept voice messages left for patients generic and did not reveal any personal information. The telephone lines were transferrable to another part of the surgery for private discussions which enabled the practice to maintain privacy as much as practicable.

Patients we spoke with and the comments cards we received stated that privacy was respected and doors to the consultation rooms were always closed when treatment was taking place.

We were told that the practice had a daily team 'huddle' in the mornings which allowed any issues to be communicated and discussed. We saw records of these discussions which were recorded on a prepopulated pro-forma with topics such as number of new patients and any patients that required extra help. We saw examples where these were noted so the practice could respond to the patients appropriately.

Involvement in decisions about care and treatment

There was information about fees displayed in the reception area and on the practice website. Leaflets available in the reception area detailed dental plans available for children and adults including the fees.

Records reviewed showed patients were given choices and options with respect to their dental treatment. We saw a consultation record which was posted to the patients' home address for the patient to consider before any treatment options were developed. The dentist said and records showed that they discussed treatment options with patients to gain their consent and agreement in developing their treatment plan.

The dentist considered the need for a chaperone for patients with mental health issues or dementia patients before treatment started. This would usually be a family member of the patient or carer.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice population was such that most patients spoke English. An interpreting service was available but the dentist told us that they had never needed to use it. Occasionally a patient would attend the practice who did not speak English but the patient would usually bring a family member to translate for them.

The dentist told us that emergency slots were available every day. The number of slots would vary depending on the previous pattern of need. Some days there would be three slots available and another day only one. If all emergency slots had been taken then the patient would still be seen but would have to come into the practice and wait in for an available slot.

During our visit we looked at a record which showed the dentist had responded to an urgent need and provided treatment to a patient who arrived with a dental problem.

Tackling inequity and promoting equality

There was equality and diversity policy and staff had access to the policies on the shared computer drive. We were given an example of how the practice had acted to make reasonable adjustments to ensure that patients received care and treatment regardless of any other conditions.

The dentist also told us that they had patients who had difficulties with their hearing and they would always stand in front of them when communicating. This ensured that the patient understood their treatment. They had considered a hearing loop but felt that they did not need one.

A telephone translation service was available and the dentist told us documents could be translated into other languages if required.

Access to the service

There was ramped access to the surgery which would allow access to a patient using a wheelchair. There were two treatment rooms, one on the ground floor and one on the first floor. Staff told us that the ground floor treatment room would be used for patients that had difficulties with their mobility and this was communicated during the daily short meeting or 'huddle'. We saw evidence that patients' specific needs were a regular topic of discussion in the meeting pro-forma.

The practice was aware there were limitations for future service development with the current premises because there was a toilet on the first floor which would be difficult to access for patients with mobility difficulties.

Concerns & complaints

There was a clear complaints procedure displayed in the reception area. A complaints policy was available which also contained details of the BDA and the dental complaints service that patients could complain to if they were unhappy with the practice.

The practice manager told us that they did not receive many complaints. We saw there was a record of a complaint received in September 2011. We found the complaint was responded to according to the time frame in the practice complaints policy and was resolved.

Are services well-led?

Our findings

Leadership, openness and transparency

There was a clear leadership structure with a practice manager, a clinical manager and a business manager with the principal dentist as the overall lead. Staff we spoke with understood their roles and knew which management staff to approach if they had any issues. The practice had a clear vision to deliver a quality service and the daily 'huddle' meetings was one of the ways it ensured staff shared this vision to deliver a consistent service. We saw many positive comments in the comments cards we received as well as the comments left by patients in the comments book in the reception area.

Governance arrangements

The practice staff we spoke with were able to tell us the leadership structure which was clear. There was a practice manager who was responsible for day to day running of the business including recruitment and training. There was a clinical manager who supervised dental nurses and ensured staff followed appropriate guidelines such as infection control procedures. There was a business manager who was responsible for finance and marketing. Staff members we spoke with were aware of their roles and knew who they would need to speak with depending on the issues.

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

The practice had a suggestion box and a comments book in the reception area. The practice manager told us that they did not receive many comments in the box but we saw many positive comments were left in the book. Patients were also able to leave feedback using the practice website and we saw many positive comments left by patients.

We saw evidence the practice responded to feedback received from patients. The practice manager told us patients had commented the medical history form was too long and so they had shortened it to make it more convenient for patients. Further comments received from patients were that they did not like to fill in forms so the practice had purchased iPads allowing patients to update their medical records electronically which were then transferred on to their records.

Management lead through learning and improvement

One of the dental nurses was coming to the end of their training and we saw an external assessor attend the practice during our inspection. This helped them to promote and extend their knowledge.

We were shown examples of minuted regular staff meetings which demonstrated an effective medium for cascading training and information to practice staff. We saw the meetings were organised in a way to qualify for CPD points for appropriate staff which provided an incentive for staff to attend. CPD is a process of tracking and documenting the skills, knowledge and experience gained both formally and informally through work, beyond any initial training. It is a record of staff experience, learning and application.

The dentist we spoke with had attended various postgraduate courses and was also part of two peer review groups. This enabled them to learn from anonymised case studies with other specialist dentists.

Undertaking clinical audits encourages dental practitioners to self-examine different aspect of their clinical practice, to implement improvements where the need is identified and re-examine, from time to time, those areas, which have been audited to ensure that a high quality of service is being maintained or further improved. We saw regular audits were carried out to help improve practice. They included record keeping audits carried out for both dentists with strengths and weakness identified and further actions for improvement. Other examples included X-ray quality audits.