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Kingsthorpegrove Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 August 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

Kingsthorpegrove dental surgery is a dental surgery situated in the Kingsthorpe area of Northampton. It provides mainly general dental treatment to adults and children funded by the national health service. Treatment can be funded privately and dental implants can be arranged with a visiting implantologist. Dental implants are a metal post that is surgically placed into the jaw bone and used to support a tooth or multiple teeth.

The practice has wheelchair access to both treatment rooms, although the toilet facilities are not suitable for a wheelchair user.

The practice staff consisted of a dentist, dental hygienist, dental nurse and receptionist. An implantologist (a dentist with training in placing implants) occasionally visited the practice with a dental nurse.

A new patient appointment can normally be secured within a week or two. The practice endeavours to see any

Summary of findings

registered patients that contact them in pain on the day they contact the practice. Outside working hours the answerphone directs patients to contact the NHS 111 service for advice or treatment.

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.

26 patients provided feedback about the service by way of comment cards that were available at the premises for two weeks preceding our visit. The comments were overwhelmingly positive with patients commenting on the kindness and professionalism of the staff. Particular reference was made to how well nervous patients and children were put at ease by the practice team.

Our key findings were:

- The practice was visibly clean and free from clutter.
- Patients commented that staff were friendly and we witnessed staff greeting patients in a polite and professional manner.
- Infection control standards met those outlined in the Health and Technical Memorandum 01-05 published by the Department of Health.
- The practice carried medicines and equipment for use in a medical emergency in line with national guidance.
- Clinical discussions indicated that national guidance was being following in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the current staffing arrangements to ensure all dental staff, including hygienists are suitably supported by a trained member of the dental team when treating patients in a dental setting.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the understanding of Gillick competency and how it would apply in the practice setting.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had emergency medicines and equipment in line with national guidance. These were checked regularly to ensure they were available and in date in the event of a medical emergency.

Infection control standards met those outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health.

The practice completed appropriate pre-employment checks on all new staff, ensuring that they were employing fit and proper persons

No action

Are services effective?

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

The dentist made accurate, detailed and contemporaneous notes in patient dental records. They used national guidance in the care and treatment of patients.

Staff were appropriately registered in their roles, and had access to ongoing training and support.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and it's relevance in obtaining consent for patients who may lack capacity to consent for themselves.

No action

Are services caring?

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

Staff described how patients' confidential information was kept private. This included paper records being locked away and computers being password protected.

Comments received from patients were overwhelmingly positive and spoke of the friendly and caring attitude of the staff.

No action

Are services responsive to people's needs?

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

The practice made every effort to see emergency patients on the day they contacted the practice.

The practice afforded wheelchair access, and staff described various ways in which the individual needs of patients were met by the practice.

New patients to the practice could expect to secure an appointment within a week or two.

No action

Summary of findings

Are services well-led?

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

The practice had policies and protocols in place to assist in the smooth running of the service.

The practice sought feedback from patients by way of patient satisfaction surveys and the NHS friends and family test. Children were encouraged to give feedback on forms designed with pictures.

A maintenance schedule ensured that equipment was serviced in line with manufacturer's guidance.

No action

Kingsthorpegrove Dental Surgery

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.

We carried out an announced, comprehensive inspection on 22 August 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with three members of staff during the 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

Reporting, learning and improvement from incidents

The practice had a system in place for reporting and learning from significant incidents although the practice had not recorded an incident within the year preceding our inspection.

A policy on reporting and managing untoward incidents was available for staff to reference and had been reviewed this year. It indicated the need for thorough investigation of all incidents as well as reporting and learning from incidents, in this way it indicated the practice's expectation of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the principal dentist shared relevant alerts with the staff.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE), although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice had a policy in place which detailed the information regarding reporting to the HSE and the CQC.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection. This had been reviewed in May 2016 along with a safeguarding checklist to ensure that the practice had done all possible to prepare themselves for dealing with an incident of suspected abuse.

Contact numbers of agencies and individuals that a concern could be raised with were available with the policy document, but were not displayed on the wall. A poster was displayed indicating how abuse and neglect may be recognised. Following our visit the practice displayed the contact details for the local safeguarding hub.

Clinical staff had all received training in safeguarding appropriate to their role and staff were able to describe actions they would take should they be concerned.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that although a rubber dam kit was available, it was not used routinely.

The practice had a protocol in place for the safe use of sharps and re-sheathing devices were available for use by the dentist to reduce the risk of injury when re-sheathing a needle in line with the requirements of Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

A protocol was in the event of a sharps injury which detailed the actions necessary as well as the contact details for occupational health, and a requirement to attend accident and emergency if advice could not be sought elsewhere.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Are services safe?

The practice had six monthly resuscitation drills which were evaluated to ascertain where improvements could be made. Clinical staff had undergone training in basic life support.

Staff recruitment

The practice had a recruitment policy which had been reviewed in 2016, this indicated the pre-employment checks required prior to a new staff member starting work.

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

We reviewed the staff recruitment files for five members of staff and found that DBS checks had been sought for all staff, and appropriate pre-employment checks had been carried out.

An induction checklist was used when a new member of staff joined the practice to ensure that they understood the policies and procedures of the practice. This included the fire procedure and other health and safety protocols.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy (which had been reviewed in June 2016) was available for staff to reference. This included details on electrical safety, accidents and training.

A general practice risk assessment had been completed on July 2016 as well as a health and safety self-assessment audit in June 2016.

A fire risk assessment had been reviewed and amended this year and did not highlight any immediate areas of concern. The practice carried out a full evacuation monthly and evaluated their performance. Staff we spoke with were able to describe their actions in the event of a fire including the external muster points.

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

Infection control

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

The practice had an infection control policy which was reviewed annually, most recently this year. This included hand hygiene, blood spillage procedures and personal protective equipment.

The practice had a dedicated decontamination facility with use of a washer disinfector to clean the instruments. A washer disinfector is a piece of equipment not dissimilar to a dishwasher that is designed specifically to clean dental instruments. Instruments were inspected after cleaning and sterilised in one of two autoclaves.

We observed the decontamination procedure in the practice and found that it met current national guidance, and checks performed on the process were in line with the requirements of HTM 01-05.

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

Environmental cleaning was carried out by practice staff. Cleaning equipment and materials conformed to the national guidelines for colour coding cleaning equipment in a healthcare setting, and a comprehensive cleaning log was kept for each area of the practice.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were

Are services safe?

seen to confirm this. Clinical waste was stored in a locked bin prior to removal, however the bin was not secured to prevent it being wheeled away. Following our inspection the bin was secured.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company in March 2015. The practice had taken action to address a high risk action raised in the report, however they were not regularly checking water temperature to confirm the hot and cold water temperature were within range as recommended in the report. Following our inspection the practice immediately commenced this checking.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in November 2014, the compressor and autoclaves had been serviced and tested within the previous 12 months. In addition the washer disinfector had been serviced and validated in April 2016. Fire equipment and the fire alarm had also been serviced within the previous year.

Glucagon is an emergency medicine used to treat diabetics. It is temperature sensitive, and although it can be stored at room temperature its shelf life would be reduced. We found that the practice was storing the glucagon appropriately at room temperature they had not amended the expiry date to reflect the fact that it was not refrigerated. This was immediately amended following the inspection.

Prescription pads were kept securely on the premises. Antibiotics could be dispensed, and stocks were seen to be stored appropriately and logs kept of their use. This was underpinned by the practice's prescribing and dispensing medicines policy.

Radiography (X-rays)

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

The practice had two intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time.

Local rules were available for each X-ray unit. These are a safety requirement to have a record of those persons responsible for the X-ray machines. In addition they are required to list those persons that are trained to operate the equipment, details of the controlled zone for each machine, and contingency plans in the event of the machine malfunctioning.

The machines had been tested and serviced in accordance with regulation.

The practice had acted on advice from their appointed radiation protection advisor to implement a faster speed film and rectangular collimation to further reduce the dose of radiation to patients.

Justification for taking an X-ray was documented in the patients dental care record, as well as a report of the findings of the radiograph.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

The practice had a robust system in place to ensure clinicians were kept informed of any changes to the patients' medical history. Patients were required to fill out and sign a medical history form annually. At all other visits the medical history was checked verbally with the clinician who documented this in the dental care record.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment, or possible referral to a specialist.

Clinicians demonstrated a clear understanding of guidance available in the care and treatment of patients including the National Institute for Health and Care Excellence guidelines.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology. Comprehensive and detailed notes were kept in the dental care records.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive.

Health promotion & prevention

We found a good understanding of the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' were being applied when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Clinicians described the appropriate use of fluoride varnish for children and prescribing high fluoride toothpaste for adults with a high caries risk.

The waiting area displayed a poster giving information on the sugar content of drinks, and colouring for children had a positive dental message regarding how to brush teeth. Children could also take a tooth brushing chart to help engage them in their oral hygiene.

Staffing

The practice was staffed by the principal dentist, dental hygienist, a dental nurse and receptionist. In addition an implantologist visited occasionally with their dental nurse.

Prior to our visit we checked the registration of the clinical staff with the General Dental Council (GDC) and found that they were all appropriately registered with no conditions on their practice. The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians orthodontic therapists and dental technicians.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Clinical staff was up to date with their recommended CPD as detailed by the GDC including medical emergencies and radiography.

We were told the dental hygienist normally worked without chairside support but support was available when requested. We drew to the attention of the provider the advice given in the General Dental Council's Standard (6.2.2) for the Dental Team about dental staff being supported by an appropriately trained member of the dental team when treating patients in a dental setting.

Working with other services

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

Referral guidelines were available to indicate when and to whom referrals could be made in different specialities such as gum disease or conscious sedation. Referral forms were used for ease and timeliness of referrals. Referrals made were tracked and chased up every three weeks to ensure that patients would be seen in a timely manner.

If a serious pathology was suspected the referral would be sent by secure fax so that the practice could be assured that the hospital had received it.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The clinician described the process of gaining full, educated and valid consent to treat. This involved detailed discussions with the patients of the options available and the positives and negatives of each option. We saw that details of these discussions were documented in the patient care records.

Patients commented that they always received detailed explanations of the treatment offered to them. Patients signed the treatment plan document to indicate consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent, a family member having a legal power or attorney, and the principles involved in a 'best interests' decision.

Although staff had an understanding of the principles of Gillick competence (the situation when a child under the age of 16 demonstrates appropriate understanding and competence to consent for themselves) they seemed less sure of how to apply the knowledge in practise.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients indicated that they were very happy with the level of care they received from the practice. With some commenting that they would recommend the service to others.

Patients considered the staff to be very friendly and professional and several commented on how well they were able to alleviate the fears of nervous patients and children.

Staff we spoke with explained how they ensured information about patients using the service was kept confidential. The computer was password protected and positioned below the level of the counter so that it could not be overlooked by a patients stood at the counter. The waiting area was situated a short distance from the desk which helped to protect the privacy of a patient at the desk, in addition the receptionist indicated that if a conversation was of a sensitive nature they would suggest moving to a private room.

These measures were underpinned by a policy on confidentiality and data protecting which had been reviewed in July 2016.

Involvement in decisions about care and treatment

Following examination and discussion with the clinician patients were all given a copy of a treatment plan to consider, which they signed to indicate consent.

Patients commented that all options were fully explained to them.

The NHS charges were displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

At the time of our inspection a new patient appointment cold be secured at the practice within a week or two. Patient comments indicated that an appointment could usually be secured quickly and the dentist rarely ran late.

The practice was very busy at the time of our visit which was attributed to an increased number of children's appointment during the school holidays. Tooth brushing charts were available for the children to take home and colouring was available for children to do in the waiting room. This carried a positive dental message and these measures were designed to engage the children in their oral health.

Tackling inequity and promoting equality

The practice had an equality and diversity policy which indicated the practice's intention to welcome patients of all cultures and backgrounds. This was dated July 2016. The promotion of equality, diversity and human rights was a point of standing business at every staff meeting.

The practice afforded wheelchair access via a ramp to the front of the building. Internally the practice was laid out solely on the ground floor and both treatment rooms could be accessed. Although a patient toilet was available this was not large enough to allow access for a wheelchair user. A disability access survey was completed on 16 August 2016.

Staff commented that they would assist patients with limited mobility. They explained how patient's individual needs were assessed and they adjustments made to accommodate their needs. This included patients with autism spectrum disorders and nervous patients.

The practice leaflet was available in large print to assist the visually impaired.

Access to the service

The practice was open from 9 am to 5.30 pm Monday to Friday.

Outside normal working hours patients are directed to the NHS 111 service for advice or treatment.

During working hours patients of the practice with an emergency would normally be fitted in for an emergency appointment the same day.

Concerns & complaints

The practice had a complaints handling policy which had been reviewed in July 2016. This indicated the methods by which a patient could raise a complaint and listed external agencies to whom they could raise the complaint, although at the time of the inspection this was not displayed. Following the inspection this was amended.

In addition the practice had a leaflet available from the patient advice and liaison service indicated how to complain about NHS services.

Complaints that had been made to the practice had been investigated and fed back, and apologies given to patients where appropriate. Complaints were discussed with staff at staff meetings or at lunchtimes when this close knit team spoke most days.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice. In addition other staff members had been assigned lead roles in areas of the practice. We noted clear lines of responsibility and accountability across the practice team.

The staff had monthly staff meetings in which a recurring point of business was infection prevention and control. These also afforded an opportunity to discuss any business or training.

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

A yearly service plan was in place which indicated when certain equipment needed to be serviced or tested. In this way the practice could be sure of all equipment being serviced and maintained in line with manufacturer's guidance.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

An underperformance and whistleblowing policy was available. This was dated 6 June 2016 and detailed the practice's expectation of candour to raise any concern regarding a colleague's actions or behaviours. The policy detailed external agencies where a concern could be raised.

The policy was underpinned by a policy on being open and the professional duty of candour which explained the requirement of openness and candour.

Learning and improvement

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

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out at six monthly intervals and did not raise any areas of concern. An audit of the quality of X-rays taken by the dentist had been completed in the last year.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC. We also saw that the clinical team at the practice would regularly attend training together.

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

The practice sought feedback for patients and staff through various sources. They invited comment through the NHS friends and family test, and from their own patient satisfaction surveys. Children were encouraged to give feedback by indicating a picture that matched their feelings about their appointment.

We noted that the feedback received through the friends and family test had indicated an upward trend of late.

Staff were encouraged to give feedback, this was mostly informally across this small and close-knit team.