C D Rosser Dental Practice Ltd

Green Park Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17th November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Green Park Dental Practice is located in the Green park area of Bath and provides private and NHS treatment to patients of all ages. The practice consists of two treatment rooms, one for the dentist and one for the hygienist. There are also two treatment rooms used by two other dental providers.The premises has toilet facilities for patients and staff, a reception/ waiting area and a staff room.

The practice treats both adults and children.The practice offers routine examinations and treatment. It is run by one dentist who is also the registered provider. A registered provider is a person who is registered with the Care Quality Commission and has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice's opening hours are

8.00am to 1.00pm and 2.00pm to 4.45pm on Monday to Thursday

8.00am to 1.00pm and 2.00pm to 4.00pm on Fridays.

A dentist is available in the evenings and at weekends in case of emergencies.

We carried out an announced, comprehensive inspection on 17th November 2015. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

Summary of findings

Before the inspection we looked at the NHS Choices website. In the previous year there had been one positive comment about the practice.

For this inspection 24 people provided feedback to us about the service. Patients were positive about the care they received from the practice. They were complimentary about the service offered which they said was good and excellent. They told us that staff were kind, professional, caring, condiderate, efficient and friendly. Patients told us that the practice was clean and hygienic. We received no negative comments.

Our key findings were:

• Safe systems and processes were in place, including a lead for safeguarding and infection control.

• Staff recruitment policies were appropriate and relevant checks were completed. Staff received relevant training.

• The practice had ensured that risk assessments were in place and that they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.

• The practice maintained appropriate dental care records and patients' clinical details were updated suitably.

• Patients were provided with health promotion advice to promote good oral care.

• Patients gave consent to dental treatment and were involved in decisions about their treatment.

• Staff were aware of the process to follow when a person lacked capacity to give consent to treatment.

• All feedback that we received from patients was positive; they reported that it was a caring and effective service.

• There were governance systems such as audits of infection control, medical histories and X-rays.

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

- Review the decontamination process and introduce the changing of heavy duty rubber gloves before examination of instruments to prevent recontamination of instruments after washing.
- Consider the use of disposable protective barriers on surfaces in the surgeries, that are frequently touched by the dentist to provide an additional level of protection for patients from the risk of infection.
- Obtain information about local translation services in case someone needs an independent translator.

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.

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely.

Appropriate checks were being made to make sure staff were suitable to work with vulnerable people. The necessary medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgery was fresh and clean. At the last inspection we issued a warning notice because the practice was not following guidance a bout the decontamination of instruments. The dentist had made improvements. The cleaning of instruments between patients took place in the surgery. This had been laid out according to the guidance about decontamination of instruments. The process carried out manual cleaning in line with the essential quality requirements identified in the guidance.

Are services effective?

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

They made the appropriate checks and took X-rays at appropriate intervals. All new patients completed a medical history questionnaire and this was updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentist discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentist. Staff received appropriate professional development and training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for written consent to treatment. Staff were aware of the Mental Capacity Act (MCA) and they had received training so that they would know what to if an adult lacked the capacity to make particular decisions for themselves.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were kind, professional, caring, considerate, efficient and friendly. People were given treatment plans by the dentist, which they had signed to show their consent and agreement to them.

Are services responsive to people's needs?

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

Summary of findings

The practice had a system to schedule enough time to assess and meet patients' needs. People also said that they could get an appointment easily. Emergencies were usually fitted in on the day they contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary.

There was an equality and diversity policy and staff had received training about equality and diversity. Most of the patients spoke English or brought their own translator so translators had not been needed. We saw no information about local translation services. There was level access for wheelchair users to the downstairs surgery and the practice manager was looking into a ramp so that they could access the building. They were also looking into a portable loop system for deaf people. People with assistance dogs were made welcome.

Are services well-led?

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

The practice had systems for clinical governance such as audits of the emergency drugs, infection control and spot checks of the decontamination processes. The dentist checked to make sure medical histories were updated and there was an audit of radiographs in September 2015.

There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had adopted policies provided by a company and these were reviewed to make sure they always reflect current practice.

The dentist was the lead for the practice supported by the practice manager. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice manager held six monthly team meetings where staff discussed developments in the practice such as the decontamination process and capacity and consent. Staff were responsible for their own continuing professional development and kept this up to date.

The practice sought feedback from patients through patient satisfaction feedback forms and these were analysed about once a quarter. The practice manager had made changes in the practice in response to this feedback.

Green Park Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 17th November 2015.

The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch and NHS England we did not receive any information from them.

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

Twenty four patients provided feedback about the service. Patients who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system for reporting and learning from incidents. Incidents were recorded and analysed. We saw a significant event analysis procedure and there had been one incident about a breach of data protection. We saw an analysis of the event and an action plan to prevent further occurrence. The practice manager said that following this they had discussed confdentilaity with staff in the staff meeting. There had been no other incidents. There was an accident book and a procedure for reporting accidents. Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any accidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. The practice manager was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding adults and children training in July 2015 and said that they felt confident that they would recognise potential signs of abuse. They would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the practice manager.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an automated external defibrillator (AED). (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). There were defibrillator pads for both adults and children. The oxygen cylinder was in date but the resuscitation mask was dated July 2014 and was out of date. The practice manager told us that they were ordering a new one. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We reviewed the contents of the emergency medicines kit. We saw records of monthly audits of the medicines and equipment and all the emergency medicines were in date.

Recruitment

The practice staffing consisted of a principal dentist, a hygienist, a dental nurse, a part time nurse, a receptionist and a practice manager. There was a recruitment procedure and appropriate checks were carried out to ensure new staff were suitable and competent for their role. This included an interview, a review of employment and medical history, checking of qualifications, identification, references and a check of the right to work in the UK. We looked at the records of recruitment checks. Each member of staff had completed an application form. They each had a disclosure and barring service (DBS) check and had a copy of their passport as proof of identity. There was information to show that they had the right to work in the UK. There was a record of their immunisation status and copies of written references in the file. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for all the qualified staff. There were certifcates of qualifications.

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. The practice had a fire risk assessment and there were certificates showing that the fire alarm system and emergency lighting had been serviced. The dentist was responsible for fire drills but these were overdue and had not been taking place at regular intervals. There were risk assessments for the general risks in the practice. These included the action to be taken to manage risk and were reviewed annually.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH)

Are services safe?

Regulations. There were COSHH assessments for hazardous substances and these were reviewed annually.

The practice followed national guidelines on patient safety. For example, the practice used a rubber dam for root canal treatments. 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.

The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems to reduce the risk and spread of infection. A dental nurse was the infection control lead for the practice. There was an infection control policy which included sharps injuries, hand hygiene, and prevention of blood bourne viruses. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilet. The dentist, nurse and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

At the last inspection we found that the practice was not following relevant guidance about the decontamination of instruments. Since then the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up their decontamination arrangements in the dentist's and hygienists treatment rooms. There was not a separate decontamination room.

We examined the facilities for cleaning and decontaminating dental instruments in the dentist's surgery. There was a clear flow from 'dirty' to 'clean.' Two sinks had been installed, one for washing and one for rinsing. There was a thermometer in the washing sink so that the nurse could check the temperature of the water, in line with the guidance, before washing the instruments. The nurse showed us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They washed the instruments in the washing bowl after testing the temperature of the water, scrubbed them with a long handled brush and rinsed them in the rinsing bowl. They inspected them for debris under an illuminated magnifying glass, placed them on trays and put them into the autoclave to sterilise. The nurse said that they would not remove the domestic style rubber gloves until they put the instruments in the autoclave. They told us that after the sterilisation cycle was complete they took the instruments out of the sterilser to the clean area of the surgery, bagged them up and put them away.

Another nurse demonstrated how they cleaned the hygienist's instruments manually. They wore personal protective equipment (PPE) including an apron, face mask and gloves. They used domestic style gloves for washing instruments, tested the temperature of the water and scrubbed the instruments under water in the washing sink with a long handled brush. The nurse rinsed the instruments in the rinsing sink and checked them under an illuminated magnifying glass in line with guidance. They lubricated the hand pieces and dried the instruments with a lint free cloth before placing them on a tray and placing them in the autoclave to sterilise them. The nurse washed the long handled brush and put it in the steriliser, washed the yellow gloves, removed them and left them to drain. They closed the steriliser and switched it on. The nurse cleaned down the work surfaces, the outside of the steriliser and the illumintated magnifier before removing their PPE. They washed their hands, put on new gloves and cleaned the goggles before removing their gloves and using hand gel.

On the whole the processes followed by the nurses were in line with the guidance, HTM0-1-05,for the essential quality requirements for manual cleaning of instruments. However, neither nurse removed their household gloves until after they had placed the instruments in the steriliser. This practice poses a risk of recontaminating the instruments once they have been washed.

The nurses also showed us how they cleaned down the surgeries between patients. They used disinfectant wipes to sanitise the surfaces. We noted that there were no disposable protective barriers on items that were frequently touched such as the light. These would provide extra protection from infection if used together with cleaning.

Are services safe?

At the last inspection we found that there was no monitoring of the decontamination process through spot checks. During this inspection we found that the infection control lead nurse conducted spot checks of the dental nurse's practice.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. We saw a certificate to show that it was serviced annually.

The practice had carried out infection control audits every six months. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and

segregated. This included clinical waste and safe disposal of sharps. A Legionella risk assessment was carried out by a water treatment company which also tested the water for bacteria levels. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). A new boiler had been fitted and the tanks had been removed so the company was going to conduct a new risk assessment the following month. The nurse told us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy. The practice had cleaning schedules that covered all areas of the premises. The nurses cleaned the surgeries. Three patients who commented said that the practice was always clean and hygienic. s

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. We saw an up-to-date electrical testing certificate for all electrical items..

Medicines were stored securely in a cupboard in the surgery. The defibrillator was kept in reception. There were two oxygen cylinders with up to date certificates.

Radiography (X-rays)

There was an X–ray unit for small X-rays in the surgery and a unit for larger X-rays in a designated room. There were suitable arrangements in place to ensure the safety of the equipment. The name of an external radiation protection adviser (RPA) was made available and the dentist was the radiation protection supervisor (RPS). X-rays were graded as they were taken. There was an audit of the radiographs in September 2015. A certificate was seen to show that the dentist had radiation training in 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found evidence that the dentist conducted audits of radiographs and medical histories. The dentist said that all new patients completed a medical history questionnaire. The information was entered in their records and reviewed at every visit. This kept the dentist reliably informed of any changes in people's physical health which might affect the type of care they received.

We reviewed fifteen dental care records with the dentist. The dentist took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.) Patients' BPE scores were recorded in their notes.

The practice kept up to date with current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients. The dentist was also aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

Health promotion & prevention

The practice promoted the maintenance of good oral health through information about effective tooth brushing. The dentist said that they discussed health promotion with individual patients according to their needs. This included discussions around smoking and sensible alcohol use.

The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there was some information about tooth brushing displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

There was a practice manager, a full time nurse, a part-time nurse and a dental hygienist. The Practice shared the building with two other dental providers with their own nurses so they could share nurses to cover sickness. However, they tried to make sure the dentist and nurse took holidays at the same time. There was an additional nurse who provided cover to all three providers.

The practice manager told us that all staff received professional development and training. The hygienist and the nurses were responsible for their own continuing professional development (CPD.) Staff did online training and attended conferences for verifiable CPD. They logged all their training hours online with the General Dental Council (GDC.) All the staff were registered for on-line training. We saw certificates of training and all staff had received training about medical emergencies, first aid, infection control, health and safety, equality and diversity and safeguarding adults and children. The dentist had received training about radiography.

Annual appraisals for the staff were completed by the practice manager and all had been completed for this year. We noted that the dentist was due to receive an appraisal in the near future.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery, orthodontics or endodontics. The practice completed referral forms or letters to ensure the specialist service had all of the required information about each patient, including their medical history and X-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. The dentist discussed treatment options, including risks and benefits, as well as costs, with each patient. They provided two copies of the treatment plan, one for the dentist and one for the patient and the patient signed these to show consent.

There was a policy about consent which stated that all patients must be assumed to have capacity to consent to treatment. It referred to the Mental Capacity Act (2005) (MCA) and capacity to consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care

Are services effective?

(for example, treatment is effective)

professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist showed awareness of how to treat a patient if they lacked capacity to give consent. We noted that staff had attended recent MCA training.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice used an electronic record system. We noted that the computer screens in reception were shielded so that they could not be seen by patients.

Patients were afforded appropriate privacy as the dentist and hygienist treatment room doors were closed during consultations. Conversations could not be heard from the other side of the door. The waiting room was away from the consulting rooms. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they treated with respect.

Patients who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were kind, professional, caring, condiderate, efficient and friendly. They said that they provided a very good service. One patient said that they were very nervous about visiting the dentist. They commented that the dentist and dental nurse were fantastic at easing their nerves and making them feel comfortable. Another patient said that the dentist was skilled in engaging with their child on their first appointment with a dentist.

Involvement in decisions about care and treatment

The practice provided treatment plans for private patients which gave options for treatment and indicative costs. There were also clear NHS treatment plans. Written consent was obtained for the dentist's treatment plans showing that people were involved in decisions about their care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. Patients commented that the staff provided a good service. One patient said that they received the right treatment at the right time. Others described the service as prompt and swift. The practice actively sought feedback from patients on the care being delivered. We saw evidence that the practice responded to feedback that they received directly. Following analysis of some feedback forms they had improved information for patients about different treatments available and costs of treatment.

Tackling inequity and promoting equality

There was an equality and diversity policy which stated that the practice recognised that people had diverse needs, they aimed to accommodate needs in relation to disability and they respected the rights and dignity of patients. Work was taking place to put this into practice. They told us that they were considering a ramp for wheelchair users who could be seen in the downstairs surgery. They were looking into a portable loop system for deaf people. The manager said that they could accommodate assistance dogs and one patient brought their guide dog. The practice manager said that if people needed a translator they usually brought a translator with them. However, we saw no information about local translation services in case someone needed an independent translator.

Access to the service

The opening hours were displayed on the front door and the website. Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day they contacted the practice.

Concerns & complaints

There was a procedure about how to make a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was posted on the practice website. There had been one complaint about charges for treatment. This had been investigated and responded to appropriately by the dentist.

Are services well-led?

Our findings

Governance arrangements

The practice had systems for clinical governance. The practice manager conducted six monthly audits of infection control and the decontamination lead nurse conducted spot checks of the decontamination processes and the dentist spot checked their decontamination practice. There was an audit of emergency medicines, the dentist audited to make sure medical histories were updated and there was an audit of radiographs in September 2015.

There were checks of equipment. We saw evidence that the autoclave and compressor were serviced. The nurse told us that they conducted daily checks of the autoclave and we saw records of these tests in a log book.

We saw that there were policies which the practice had adopted. These were provided by a company and they were reviewed annually to make sure that they always reflect current practice.

Leadership, openness and transparency

The dentist was the lead for the practice supported by the practice manager. We saw information for staff in the policy folder about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The practice manager told us that there were six monthly team meetings. We saw the minutes of the meetings on 5th February and 15th October 2015 which showed that staff discussed developments in the practice such as the decontamination process. The nurse and the hygienist told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw certificates to show that relevant training had taken place, for example for safeguarding and health and safety.

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

There were patient satisfaction feedback forms and these were analysed about once a quarter. We saw the analysis of five of the most recent forms. Patients had fed back that they could not tell when their appointments were due because there was no clock in reception. They said that treatments and costs were not explained fully and there was no information about staff names. An action plan was produced and a clock was purchased for reception. More explanation was given to patients about different treatments and the cost and literature was provided about oral health. Staff photographs with their names were on a board in reception and the practice manager was looking into name badges for staff.