Eurodental

Eurodental Oxford

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 12 April 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

Euro Dental Oxford is a dental practice providing NHS and private treatment for both adults and children.

The practice is situated in Headington a suburb of Oxford. The practice has one dental treatment room and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The practice is based on the first floor above a retail fast food business.

The practice employs one dentist, two dental nurses of whom one is a trainee. This member of staff also covers reception duties and a practice manager who manages two practices belonging to the provider.The practice's opening hours are 8.00am to 5.30pm Monday to Thursday and Friday 8.00am to 1.00pm and Saturdays by special arrangement.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service. The practice has opted out of providing out-of-hours services to their own patients and refers them to South Central Ambulance Service via the NHS 111 service.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

During our inspection we reviewed 11 CQC comment cards completed by patients and obtained the view of five patients on the day of our inspection.

The inspection was carried out by a CQC specialist dental inspector.

Our key findings were:

- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and maintained.
- Infection control procedures followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff recruitment files contained essential information in relation to Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015.
- Staff received training appropriate to their roles and were supported in their continuing professional development by the practice manager.
- Staff we spoke to felt supported by the practice manager and were committed to providing a quality service to their patients
- Information from 16 patients gave us a positive picture of a friendly and professional service.
- The practice manager provided effective leadership for staff working at the practice.
- The practice reviewed and dealt with complaints according to their practice policy.

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

- Review the practices' appraisal process to include a formal pre-appraisal document to capture the employee's progress and aspirations since the previous appraisal.
- Review the audit process for the quality of radiographs to include an analysis of the various grades of quality of X-rays over each audit cycle.
- Review standards in relation to clinical record keeping in accordance with the guidance as set out by the Faculty of General Dental Practice.
- Consider using other appropriate safety measures to prevent inhalation or swallowing of root canal instruments during root canal treatment when a rubber dam is not used.
- Consider obtaining a hearing loop for patients with hearing impairments.

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 arrangements in place for infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). Equipment used in the dental practice was properly maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. Staff received professional training and development appropriate to their roles and learning needs. Staff where appropriate were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 11 completed Care Quality Commission patient comment cards and obtained the views of a further five patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in a language they could understand and had access to telephone interpreter services when required. Although the practice was situated on the first floor of the building, patients with mobility problems were sign-posted to nearby dental services with ground floor access.

Are services well-led?

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

The practice manager and the staff team had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had essential clinical governance and risk management structures in place. Staff told us that they felt supported and could raise any concerns with the practice manager. Staff we met said that they were happy in their work and the practice was a good place to work.

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Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 12 April 2016. The inspection was carried out by a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with four members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We reviewed CQC comment cards completed by patients and obtained the views of patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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 manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email from a dental supply company the practice uses. Alerts when relevant were discussed during regular staff meetings which facilitated shared learning. The practice told us there were no significant events or incidents in the previous year.

Reliable safety systems and processes (including safeguarding)

We spoke to staff about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) Directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentist was responsible for ensuring safe recapping using a metal block specifically designed for the purpose. Staff were also able to explain the practice protocol should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked how the practice treated the use of instruments used during root canal treatment. They explained that these instruments were single use only. They also explained that root canal treatment was carried out only occasionally using a rubber dam. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. On other occasions when root canal therapy was used, no specific safety measures were used to prevent the swallowing or inhalation of root canal files.

The practice manager acted as the safeguarding lead. They acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed staff received appropriate safeguarding training for both vulnerable adults and children. Information was displayed in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities in recent times.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. There was an automated external defibrillator, which is a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. Equipment included two oxygen cylinders along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. Emergency medicines and oxygen were all in date and stored in a central location known to all staff. The expiry dates of medicines and equipment was monitored using a monthly check sheet that enabled staff to replace out of date medicines and equipment promptly. We noted that the local primary care commissioning organisation provided the practice with a new emergency medicines kit on an annual basis. They also provided a new kit should the kit be used in the intervening period. All of the staff demonstrated to us they knew how to respond if a person suddenly became unwell.

Staff recruitment

The dentist and dental nurses had current registrations with the General Dental Council. The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

Are services safe?

We looked at four staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy. Staff recruitment records were ordered and stored securely.

Monitoring health & safety and responding to risks

The practice had a health and safety risk management process in place, which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice.

There were arrangements in place to deal with foreseeable emergencies. We found the practice had a fire risk assessment carried out by an appropriate external company in March 2015; this was valid until April 2017. Fire safety signs were clearly displayed, fire extinguishers had been serviced regularly and staff demonstrated to us how to respond in the event of a fire. Other assessments included health and safety dated March 2015 and Legionella dated April 2015.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found this to be comprehensive where risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them. The file was regularly updated when new materials or chemicals were introduced to the practice.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. Direct observation of the cleaning process and a review of practice protocols that showed HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We observed that audits of infection control processes carried out in December 2015 confirmed compliance with HTM 01 05 guidelines.

We saw that the dental treatment room, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in the treatment room. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of the treatment room were inspected and these were clean, ordered and free from clutter. The treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The lead dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. This included the working surfaces; dental unit and dental chair were decontaminated. They also explained how the dental water lines were maintained. The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out in April 2015 at the practice by a competent person. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The lead dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifier instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, they were pouched and stored until required. Pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. We observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste

Are services safe?

bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste. We also saw that general environmental cleaning was carried out by the dental nurses working at the practice and they carried out cleaning according to a cleaning plan developed by the practice. Cleaning materials were stored in a separate storage facility.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in January 2016 and the practice air compressor had been serviced regularly within current national regulations. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations with the next service due in 2017. Portable appliance testing had been carried out in March 2016. Medicines such as local anaesthetics were stored securely for the protection of patients. We found that the practice stored prescription pads securely to prevent loss due to theft. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We saw documentation that showed the practice managed dental radiography in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). We saw the names of the Radiation Protection Advisor and the Radiation Protection Supervisors and the necessary documentation pertaining to the maintenance of the X-ray equipment. Other documentation included three yearly maintenance logs and a copy of the local rules.

Dental care records we saw showed when dental X-rays were taken they were justified and , reported upon. A quality assurance process was in place to document the quality of each X-ray taken by the dentists. Apart from the lack of a current audit of the quality assurance records the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with demonstrated they carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of oral cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded albeit briefly. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The dentist was focussed on the prevention of dental disease and the maintenance of good oral health. They explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition or prescribed high concentration fluoride tooth paste. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay where applicable. They gave advice on tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Staffing

The practice had one dentist who was supported by two dental nurses, a receptionist and a practice manager.

We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the practice owners and the practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

We confirmed that the dental nurses received an annual appraisal. These appraisals were carried out by the practice manager along with supportive follow up meetings where necessary. We saw that the practice manager provided written feedback to each member of staff following the appraisal. However, formal pre-appraisal document was not completed which would capture the employee's progress and aspirations since the previous appraisal.

The practice manager showed us their system for recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover where applicable.

Working with other services

The dentist was able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with the dentist about how they implemented the principles of informed consent; they had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care

Are services effective?

(for example, treatment is effective)

and treatment to patients to help ensure they had an understanding of their treatment options. They went on to say that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options.

We also asked the dentist about how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

All of the patients we asked told us the dentist treated them with care and concern. Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment room which protected patient's privacy.

Patients' care records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in a lockable filing cabinet behind the reception desk. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. All the patients we asked told us the dentist was good at explaining treatment and involved them in decisions about their care and treatment.

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw that the practice waiting area displayed a variety of information including the practice patient information leaflet and a range of practices policies; these were displayed in a carousel display unit in the reception area. The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. On the day of our visit, we observed that the appointment diary although busy, was not unduly overbooked. This provided capacity each day for patients with dental pain to be seen by the dentist with patients invited to come and sit and wait. The dentist decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. They used this service rarely because the dentist spoke several European languages which catered for the needs of the local population. Although the practice was situated on the first floor of the building, patients with mobility difficulties were sign-posted to nearby dental services with ground floor access.

Access to the service

The practice's opening hours were 8am to 5.30pm Monday to Thursday and Friday 8am to 1pm and Saturdays by special arrangement. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms.

We asked five patients if they were satisfied with the practice opening hours. All said they were.

Concerns & complaints

There was a complaints policy which provided staff with information about handling complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided. We were told the practice had received no written complaints for several years. The low level of complaints reflected the caring and compassionate ethos of the whole practice.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. We asked five patients if they knew how to complain if they had an issue with the practice. All of the patients new how to make a complaint if they needed to.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location were overseen by the practice manager and a lead nurse who were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. We noted management policies and procedures were kept under review by the owner's management team. Staff were aware of where policies and procedures were held and we saw these were easily accessible.

Leadership, openness and transparency

It was apparent through our discussions with the dentist and staff the patient was at the heart of the practice with the dentist adopting a holistic approach to patient care. We found staff to be hard working, caring and committed to the work they did. Staff told us they enjoyed their work and were well supported by the practice owner and practice manager.

Staff described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the dentists, practice manager or owner of the practice. They felt they were listened to and responded to when they did raise a concern.

Learning and improvement

We found there were a number of audits taking place at the practice. These included infection control and clinical record keeping. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example infection control audits were undertaken every six months. Although the practice captured the quality of the X-rays taken, the practice did not collate and analyse these results in a formal audit process.

Staff were supported to maintain their continuing professional development as required by the General Dental Council. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through compliments, a patient satisfaction survey system and the family and friends test. We saw that the practice analysed feedback from patients which resulted in improvements, this included opening on Saturdays and extended opening times in the week.

Staff we spoke with said they felt listened to. Staff told us that the practice manager and principal dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every month; the minutes of these were made available if they could not attend. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements.