Mr. Giles Kidner

Beaconsfield Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 June 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.

The provider delivers an Orthodontic Surgery service from Beaconsfield Dental Practice. The service is available for three half day sessions every month.

Referrals to the service are predominantly from the two general dental providers who own the practice from which the Orthodontic service is delivered. The provider delivers orthodontic care and treatment on a private basis.

Mr Kidner is registered as an individual with legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We met with the provider on the day of inspection. Staff who worked with the provider were employed by the two dentists registered at the practice and we spoke with them. We also reviewed management systems and records relevant to the management of the practice.

We did not speak with any patients who had received Orthodontic treatment because none were present on the day of inspection. None of the comment cards we reviewed referred to Orthodontic treatment. The provider showed us a satisfaction survey they had conducted within the last year. The survey included a sample group of patients and this showed very positive feedback on both outcomes of treatment and the way patients were treated.

Summary of findings

The three providers working from the practice shared staff, the premises and the processes and procedures in place to govern the practice. We inspected all three providers on the same day and our findings were relevant to all three.

Our key findings were:

- Staff were supported in receiving training appropriate to their role and to keep up to date with developments and best practice in dental care.
- The facilities were in good order and suitable for the treatments undertaken.
- There were systems in place to keep patients safe and sufficient staff were available.
- Appointments for orthodontic treatment were planned in advance and there were arrangements in place to deal with emergencies.
- The provider was aware of and was following best practice guidelines.

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 systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. Patients were given information they understood to make decisions about their care and treatment. Advice, and appropriate treatment, was given to support patients maintaining their oral health. Detailed clinical records were maintained for all patients and patients were given detailed treatment plans. Staff received training relevant to their roles and responsibilities. The provider was subject to appraisal and revalidation which enabled them to maintain their professional registration.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Patients' privacy and dignity was maintained. The results of a patient satisfaction survey conducted by the provider showed patients were positive about the care and treatment they received.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. The practice was accessible to patients with mobility difficulties. Appointments were planned with the patient to coincide with the need to adjust treatment. There were arrangements in place to deal with emergencies if an orthodontic appliance broke or required urgent adjustment. There was a procedure in place for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations. Staff who worked with the provider received induction training and were given opportunities to maintain their professional development. The provider conducted patient satisfaction surveys. Staff told us they were well supported to undertake their responsibilities. Management records, including those relating to health and safety, were maintained in an up to date manner and were available to staff if they needed to access them.

Beaconsfield Dental Practice

Detailed findings

Background to this inspection

The inspection of Beaconsfield Dental Practice, Mr Giles Kidner, took place on 18 June 2015 and was a comprehensive inspection. The inspection was led by a CQC inspector who was accompanied by a specialist Dental Nurse Advisor.

We contacted NHS England area team and Healthwatch Buckinghamshire regarding our inspection of the practice. We did not receive any information of concern from them.

During our inspection we looked at the practice premises to see whether they were accessible to patients and kept clean and tidy. We reviewed documents relating to the management of the practice. We were unable to speak with any patients who had used the specialist orthodontic service provided by Mr Kidner. Orthodontic clinics were not taking place on the day of inspection. None of the comment cards we reviewed referred to patients receiving orthodontic treatment. We also spoke with the provider and members of the dental nursing team who worked with the provider during their Saturday clinics.

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 provider employed the host dental practice system for reporting incidents and accidents that resulted in harm or injury. These would be entered in the accident book. There had been no reported incidents arising from orthodontic practice. However, there was no formal procedure for recording incidents that had not resulted in an injury. We were told that no such incidents had occurred in the last three years. The practice should introduce a protocol for reporting and recording incidents that did not result in injury.

Reliable safety systems and processes (including safeguarding)

The provider was able to demonstrate they had been trained to appropriate levels to identify and report abuse in both children and vulnerable adults. They had completed this training as during the course of their duties as a consultant at the local hospital. The practice had up to date Child Protection and Vulnerable Adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The provider worked with practice staff employed by the two dental providers at the same location. We spoke with four staff who were able to describe the types of abuse they might witness during the course of their duties. The policies were available to staff and staff knew where to locate them. Staff had access to contact details for the local authority's child protection and adult safeguarding teams. We saw records that staff had received training on safeguarding via eLearning. One of the dentists was the lead for safeguarding and we saw that they had received additional training to enable them to carry out this role.

Computer records were password protected to protect personal data.

Medical emergencies

The practice had arrangements in place to deal with most medical emergencies. All staff had attended training for cardiopulmonary resuscitation (CPR). We checked the medical emergency drugs kit and found all contents were in date and in accordance with national guidelines. We saw evidence to show all emergency drugs were regularly checked and kept up to date. Medical emergency oxygen was available and we saw that the cylinder was regularly checked. There was a protocol in place to ensure correct maintenance of this piece of equipment. The practice had an Automated External Defibrillator (AED) An AED is a portable electronic device that diagnoses life threatening irregularities of the heart and is able to deliver a shock to attempt to correct the irregularity. The AED was working and we saw that it was regularly checked and the results of the check recorded.

Staff recruitment

Staff employed by the two dental providers at the practice were allocated to work with the provider. The practice had a recruitment policy that included the requirement to obtain references, check qualifications and experience, and be registered with an appropriate professional body and to obtain proof of identity. Checks were also made with the Disclosure and Barring Service to ensure staff were safe to work with children and vulnerable adults. We looked at six staff files and found they contained the relevant documentation for all staff recruited since the practice became subject to regulation. We were able to confirm that all staff had undertaken criminal records checks and that the provider and the dental nurses who worked at the practice were all registered correctly with their professional body and had the necessary qualifications, skills and experience to work there.

The certificates we saw in staff files evidenced the qualifications of the dental nurses who assisted the provider and we checked that the provider was appropriately qualified and registered with the correct professional body prior to the inspection.

Monitoring health & safety and responding to risks

A health and safety policy with supporting risk assessments was in place at the practice and this was used by the provider. Staff employed at the practice knew where to locate the policy if they needed it. The policy described risks and the actions identified to mitigate risk. We saw that when the practice identified a risk to the local community from drivers exiting the practice car park they had taken action to reduce the risk by requesting drivers to take extra care and drive slowly when leaving the car park.

There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control, a legionella disease risk assessment, fire evacuation procedures and risks associated with hepatitis B. Processes were in place to

Are services safe?

monitor and reduce these risks so that staff and patients were safe. For example we saw records confirming that all staff, including the provider, had received their course of immunisations for hepatitis B.

Staff induction included briefing on health and safety procedures including what to do if there was a fire in the practice. New staff were required to familiarise themselves with the practice health and safety guidance.

Infection control

The practice had an infection control policy that applied to the activities undertaken by the provider. We reviewed the cleaning standards in all the consulting rooms and general areas and found the practice clean and tidy. Practice staff undertook the cleaning and there was a checklist for them to follow.

Clinical waste leaving the practice was in colour coded bags or in the appropriate containers required by legislation. The clinical waste was held securely in a locked container awaiting collection. There was a contract in place for the disposal of all clinical waste. Records of collection of clinical waste by the approved contractor were signed and retained appropriately.

We observed a member of staff cleaning the work area in a consulting room between dental treatments. The process was also used during orthodontic clinics and followed current guidance for the cleaning and decontamination of dental practices and appropriate personal protective equipment (PPE) was worn throughout the procedure. Dental lines that carry water to the dental chair units were flushed through in accordance with best practice and a chemical application to reduce the risk of bacteria growing in the lines was appropriately applied.

Dental instruments were cleaned and decontaminated in a dedicated decontamination room. This was laid out appropriately with clear separation of the dirty instruments entering the room and the clean sterile instruments coming out of the autoclave (an autoclave is a piece of equipment that treats instruments at high temperature to ensure any bacteria are killed). A member of staff demonstrated the process for cleaning and sterilising instruments and the process followed current guidance and appropriate PPE was worn throughout the procedure. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers.

Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was clear that the equipment was in working order and being effectively maintained.

Hand washing guidance was displayed above the wash hand basins in all consulting rooms, the decontamination room and toilets. There was an adequate supply of hand washing soap and paper towels adjacent to all hand wash hand basins.

The practice was designed in a way that meant cold and hot water was not stored in tanks. It had therefore been identified as a low risk environment for legionella (legionella is a bacteria found in the environment which can contaminate water systems in buildings). There were records of water tests being undertaken by approved contractors.

Equipment and medicines

Records we reviewed showed the practice had a programme for servicing equipment. There were service records for pressure vessels, autoclaves and other items of dental equipment. Equipment was maintained in accordance with manufacturers' guidance and legal requirements and was safe for use. On the day of inspection we saw one of the x-ray machines was being replaced with an up to date model which showed us the practice replaced equipment as and when necessary.

We checked medicines held for use in an emergency and for day to day treatment all were within their expiry dates and there was a system in place for monitoring the expiry dates and ensuring medicines were held safely and securely.

Radiography (X-rays)

The practice maintained a comprehensive radiation protection folder. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. The folder contained details of those qualified staff and evidence of their training. All staff working at the practice had been required to sign the local rules to indicate that they understood the correct procedures and the local rules relating to the use of X-ray equipment. This kept staff and patients safe from unnecessary radiation exposure. X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules that were relevant to the

Are services safe?

practice and equipment. Each piece of X-ray equipment had their own individual local rules relevant to their use and location. We viewed documentation that demonstrated that the X-ray equipment was serviced and calibrated at the recommended intervals.

If the provider required x-rays to support treatment they were able to access these from the dental practice at the same location.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients completed a full medical history and asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken. The four records we reviewed showed medical history had been checked.

The provider used current guidelines when making decisions on treatment and clinical risk. For example the requirement to take x-rays. Adjustments to orthodontic appliances were carried out based on clinical assessment. Each time the patient saw the provider for an appointment their records were updated and decisions about their future treatment were noted.

Patients were given advice on how to maintain their oral hygiene whilst wearing an orthodontic appliance.

Health promotion & prevention

There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene. The patient's usual dentist or hygienist held primary responsibility for giving oral hygiene advice and support. The provider supported this by giving additional advice on maintenance of oral hygiene whilst wearing an orthodontic appliance.

Staffing

Dental nursing staff who were allocated to work with the provider were appropriately trained and registered with their professional body. Staff were encouraged to maintain their continual professional development (CPD) to regularly update their skills. CPD is a compulsory requirement of registration as a general dental professional and its activity contributes to their professional development. Records showed details of the number of hours they had undertaken and training certificates were also in place. This showed the provider ensured all relevant training was attended so that staff were working within their sphere of competency. Training certificates we saw also evidenced that staff attended off site training as a team for example training in basic life support. This demonstrated that the provider was supporting the staff to deliver care and treatment safely and to an appropriate standard.

We spoke with members of staff who confirmed they had their learning needs identified and they were encouraged to maintain their professional expertise by attendance at training courses.

Working with other services

The provider delivered a secondary care service which received referrals from local dentists. Treatment was not commenced without a referral. Due to the nature of orthodontic procedures the provider rarely required to refer patients on but systems were in place to do so should the need arise. For example if oral cancer was suspected.

Consent to care and treatment

The provider supplied patients with a treatment plan which they were required to consent to before treatment was commenced. The provider was aware of the implications of the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The provider was also aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge. These two legal safeguards were employed by the provider in both their work at the practice and the local hospital.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff greeting patients on arrival at the practice and dealing with booking appointments. We saw that patients were treated professionally. We observed staff handling patient telephone calls. They were polite and professional with patients and offered options for the date and time of appointment. We were told that all patients were treated similarly. We were unable to observe how patients of the provider were treated because they were not holding a clinic on the day of inspection.

A data protection and confidentiality policy was in place and staff who were allocated to work with the provider signed confidentiality agreements linked to their contract of employment. The policy covered disclosure of patient information and their conditions and the secure handling of patient information. Patient records were held securely in lockable filing cabinets. These cabinets were locked every evening and the keys held securely.

Involvement in decisions about care and treatment

When a course of orthodontic treatment was proposed patients were given a treatment plan which set out the details, and costs, of the treatment. The patient was given a copy of the plan and a second copy was retained in their records**.** Patients were required to consent to the treatment plan before treatment was commenced. We were unable to gain patient feedback on involvement in decisions on pursuing orthodontic treatment because the provider was not holding a clinic on the day of inspection and comment cards did not identify any patients who had received this course of treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information regarding orthodontic treatment undertaken at the practice was not available on the main practice website. The service operated on a referral only basis with the majority of referrals provided by the two dentists registered at the same location. The costs of treatment were set out in treatment plans. The price of an initial consultation was provided to patients at the time referral to the service was proposed.

The provider took a medical history from the patient during their first attendance or this was provided with the referral letter. Due to nature of orthodontic treatment further updating of medical history and an understanding of any medicines the patient was taking was only required if a tooth required extracting to enable the treatment to proceed.

The provider entered information on the patients records when treatments took place and provided the dentists with information upon completion of treatment.

Tackling inequity and promoting equality

The practice was accessible to patients in wheelchairs and those with walking difficulties. We saw that a dedicated entrance was available for this group of patients which avoided accessing the practice via steps. Staff were aware of patients with mobility difficulties and there was a system in place for patients requiring assistance with access to call ahead to alert a member of staff to greet them and support their entrance to the practice. The consulting room was on the ground floor and the door was wide enough to enable wheelchair access.

The provider did not have access to online or telephone translation services. Most patients had English as their first language and that the need for translation was very rare. If a patient required translation they were able to bring a friend or relative with them.

Patients who were nervous about orthodontic treatment could bring a friend or relative to accompany them during treatment. The service was available on a Saturday morning which enabled most patients with work or educational commitments to access the service.

Access to the service

The service was similar to other orthodontic practices and was accessed via an appointment system. The need to obtain emergency orthodontic treatment was rare. Appointments were available on Saturday mornings and could be booked by either attending or telephoning the main practice during the hours of 8.30am to 5pm Monday to Friday.

On the rare occasion that a patient experienced a problem with an orthodontic appliance, and required urgent assistance, they could contact the provider via the practice. An arrangement could be made for the patient to be seen at the local hospital, where the provider held clinics, or at the practice at a mutually convenient time.

Concerns & complaints

There had not been any complaints received regarding orthodontic care and treatment in the last year. If a complaint was received regarding the provider's work at the practice the complaint would be dealt with using the practice complaints procedure. The practice had a system for dealing with complaints. Information on how to lodge a complaint was held at reception and there was written information available. The complaints procedure set out who would deal with a complaint and timescales for investigation and response. It also detailed who to contact if the patient was unhappy with the outcome of the complaint investigation. The provider would be asked to investigate and provide evidence to enable any complaint regarding their service to be responded to.

Are services well-led?

Our findings

Governance arrangements

The management and governance functions at the practice were run by the dentists who owned the premises. Due to the small team working at the practice a formal management structure was not felt necessary. A significant amount of the day to day management of the practice was undertaken by the senior dental nurse who also acted as the practice manager.

There were policies and procedures in place to govern the practice and we saw that these covered a wide range of topics. For example, control of infection, health and safety and training and development. The provider operated within the practice policies when working at the practice.

We noted that management policies were kept under review and had been updated in the last year. Staff were aware of where policies and procedures were held and we saw that these were easily accessible if the dentist or senior dental nurse were absent from the practice.

The provider's clinical performance was subject to review at the local hospital where they also worked. They took part in appraisal and revalidation and were subject to peer review.

Leadership, openness and transparency

The provider had a statement of purpose. Clinics were held three times a month and the provider worked with dental nursing staff allocated by the practice. These staff were able to seek advice and support from the provider during the time the clinics were in progress. Supervision and leadership was therefore available immediately. Staff we spoke with told us were well supported to carry out their roles and responsibilities. Staff had job descriptions and were clear on the duties that were expected of them.

Staff we spoke with told us the practice had a 'no blame' culture and that they would have no hesitation in bringing any problems or issues with their work to the attention of the provider. None of the staff we spoke with recalled any instances of poor practice that they had needed to report.

Management lead through learning and improvement

The provider showed us evidence of their personal continuous professional development (CPD) and we heard that they were subject to peer review as part of their hospital consultant role. The provider was also a trainer in orthodontics. The staff allocated by the practice to support the provider maintained their CPD as required by the General Dental Council (GDC). Training was completed through a variety of media and sources. Staff were given time to attend local training seminars and sourced other training opportunities online or through professional journals.

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

The provider undertook sample patient surveys on an annual basis. They showed us the results of the last survey. The patients surveyed were very positive about the service they received and there was no improvement actions identified from the responses. Staff were able to pass their comments directly to the provider when they worked with them during clinics. Staff we spoke with told us they felt confident they would be listened to if they spoke with any of the three providers who worked at the practice.