MDANZ Limited

Total Dentalcare Cathedral Square

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 January 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

Total Dentalcare Cathedral Square provides private dental treatment to children and adults and had about 1800 active patients at the time of our inspection. In addition to general dentistry, the practice also provides a full range of cosmetic procedures such as porcelain crowns, bridges, orthodontics, tooth whitening and implants.

The practice employs four dentists, two hygienists and has visiting periodontist and orthodontist specialists. They are supported by four dental nurses, a receptionist and a practice manager. It opens Monday, Tuesday, Wednesday and Fridays from 8.30am to 5.30 pm; and from 8.30am to 6pm on a Thursday.

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'. 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.

Summary of findings

The practice is based on the third floor and shares its premises with other businesses. It has four treatment rooms, a decontamination room for cleaning, sterilising and packing dental instruments, a radiation room and a large staff room.

We received feedback from 10 patients about the service who told us that appointments were easy to book, that treatment options were explained well to them well, and that staff treated them in a way that they liked.

Our key findings were:

- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, responding to medical emergencies and maintaining equipment.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were actively involved in making decisions about it.
- Staff received training appropriate to their roles and told us they felt well supported to carry out their work.
- The practice sought feedback from staff and patients and used it to improve the service provided.
- Patients were treated in a way that they liked and information about them was treated confidentially.
- There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.
- Governance systems were effective and there was a range of audits and patient surveys to monitor the quality of services

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

- Regularly monitor the temperature of the fridge in which medicines are kept.
- Implement a system to ensure that MHRA alerts are disseminated to dental clinicians if relevant
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Provide boxes in treatment rooms so that sharps can be disposed of safely.
- Ensure that staff are aware of the Department of Health's publication Delivering Better Oral Health- an evidence based toolkit to support dental practices in improving their patients' oral and general health.
- Close treatment room doors whilst care is being delivered to patients to maintain their privacy and confidentiality
- Provide all staff with regular appraisal of their performance.

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 and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risk. Sufficient quantities of equipment to meet patients' needs were in use at the practice. However fridge temperatures where medicines were stored were not monitored and some practices compromised good infection control.

Are services effective?

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

Staff assessed patients' needs and delivered care in line with current evidence based guidance. The practice kept detailed dental care records of the treatment carried out and monitored any changes in the patient's oral health. Patients were referred to other services appropriately.

Staff had the skills, knowledge and experience to deliver effective care and treatment and clinical audits were completed to ensure patients received effective and safe care.

Are services caring?

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

Patients spoke highly of the dental treatment they received, and of the caring and empathetic nature of the practice's staff. Patients told us they were involved in decisions about their treatment, and didn't feel rushed in their appointments. Patient information and data was handled confidentially. However treatment room doors were not always closed to ensure patients' privacy.

Are services responsive to people's needs?

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

Appointments were easy to book and appointment slots for urgent appointments were available each day for patients experiencing dental pain. The practice opened until 6pm one day a week to accommodate the needs of patients who found it difficult to attend during normal opening hours.

The practice had made some adjustments to accommodate patients with a disability, although did not have a disabled toilet facility.

The practice had systems in place to obtain and learn from patients' experiences, concerns and complaints in order to improve the quality of care.

Are services well-led?

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

There was an overarching governance framework which supported the delivery of good quality care. The dentists and practice manager were approachable and the culture within the practice was open and transparent. There was a clear leadership structure and staff were well supported and told us that it was a good place to work. The practice sought feedback from its patients and staff which it acted on.

Total Dentalcare Cathedral Square

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection took place on 26 January 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with three dentists, the practice manager, two dental nurses and an hygienist. We received feedback from surveys completed by 10 patients about the quality of the service. We observed one patient consultation, reviewed policies, procedures and other documents relating to the management of the service.

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

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). An accident book was easily available in the practice to record any events. Staff told us of a recent serious incident that had occurred and when we checked we saw it had been recorded fully in the accident book. Staff gave us examples of how learning from incidents had been implemented. For example following the collapse of one patient, the location of the practice's medical emergency equipment had been moved to make it more accessible. Three staff had undertaken first aid training following a patient who had fallen outside the practice and sustained some minor injuries.

However there was no formal protocol in place to manage safety alerts from the Medicines and healthcare products regulatory agency, or to report any patients' adverse reactions to medicines.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The policies were available to all staff, and clearly outlined who to contact for further guidance if they had concerns about a patient's welfare. Posters were on display in every treatment room giving the contact details of relevant agencies involved in protecting people. The policy also provided staff with very recent guidance on their responsibility to report suspected cases of female genital mutilation.

Staff demonstrated they understood their responsibilities in relation to safeguarding and all had received training in how to recognise and respond to concerns. One of the hygienists was the lead for safeguarding, and had undertaken additional training for this role.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. 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. The dentist we spoke with confirmed that they used rubber dams as far as practically possible.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments) and only dentists were permitted to re-sheath needles in order to minimise the risk of sharps injuries to staff. However there were no appropriate sharps' bins available in treatment rooms so they could be disposed of, and staff had to transport them through to the decontamination room, thereby compromising their safety.

Medical emergencies

The practice had arrangements in place to manage emergencies and records showed that all staff had received training in basic life support within the last year. Emergency equipment, including oxygen and an automated external defibrillator (AED) (this is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available. Records confirmed that it was checked each day by staff.

Emergency drugs were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and all drugs were within date for safe use. However, emergency medical simulations were not regularly rehearsed by staff so that they could be clear about what to do in the event of an incident at the practice.

Staff recruitment

We reviewed personnel files and found that appropriate recruitment checks had been undertaken for staff prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). Staff without a DBS check were not allowed to work unsupervised until the check had been received to ensure patient safety. However notes were not kept of recruitment interviews in line with good employment practice and to demonstrate fairness and consistency in the process.

Are services safe?

All staff underwent a thorough three month induction to ensure they had the skills and knowledge for their role. Professional registration and insurance checks were undertaken each year to ensure dental clinicians were still fit to practice.

Monitoring health & safety and responding to risks

We looked at a range of policies and risk assessments which described how the practice aimed to provide safe care for patients and staff. These were comprehensive and covered a wide range of areas including Legionella, lone working, display screen equipment, pregnant and nursing mothers, and business continuity. It was clear that managers took health and safety concerns seriously and had lowered one staff member's computer screen to help them better manage a trapped nerve.

The practice maintained a safe environment for patients within the building. We noted that there was good signage throughout the premises clearly indicating fire exits, the location of emergency equipment and x-ray warning signs to ensure that patients and staff were protected. Fire detection and firefighting equipment such as fire alarms and fire extinguishers were regularly tested, and we saw records to demonstrate this. Full evacuations of the premises were practiced every six months with the staff from other businesses that shared the premises. A fire risk assessment had been undertaken in December 2015 and we saw that its recommendations had already been implemented to ensure staff and patients' safety in the event of a fire.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for products used within the practice. We viewed evidence in relation to hazardous waste, portable appliance testing and electrical installation, which showed that the practice maintained a safe environment for staff and patients.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice had a named lead for infection control and also conducted its own comprehensive infection control audits, evidence of which we viewed. The practice has scored 96% in its most recent audit, indicating that good standards were maintained. However this audit had failed to identify a number of shortfalls we found.

Staff had received appropriate training in infection prevention and control and told us they had forthcoming refresher training booked for February 2016.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area, corridors and treatment rooms. Patient and staff toilets were clean and contained liquid soap and electronic hand dryers so that people could wash their hands hygienically. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and sealed work surfaces so they could be cleaned easily. There were posters providing prompts above sinks reminding staff of the correct way to wash their hands. There were foot operated bins and personal protective equipment available to reduce the risk of cross infection. However we noted a number of shortfalls that compromised good infection control in the environment:

- one treatment chair was ripped making it difficult to clean effectively
- some of the staff had long fingers nails which compromised good hand hygiene and risked damaging latex gloves
- shelving and flooring in the cleaner's cupboards was dusty
- mops used to clean surgical areas were not stored correctly to ensure that they air dried quickly
- computers leads and electrical wires were within the splatter zone and risked contamination from aerosols
- walls in the decontamination and treatment rooms were not smooth surfaced but tiled, making them difficult to clean.

We noted good infection control procedures during the consultation we observed. Staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection. The hygienist wore appropriate personal protective equipment and patients were given eye protection to wear during their treatment. The hygienist talked us through her cleaning and infection control procedures between patients which was in line with national guidance.

Are services safe?

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. Dental instruments were cleaned and sterilised in line with published guidance (HTM 01-05). On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. Staff signed each package to show they had been responsible for processing the instruments.

A legionella risk assessment had been carried out and we saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of legionella.

Regular flushing of the water lines was carried out in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice, and we saw the necessary waste consignment notices.

All dental staff had been immunised against Hepatitis B.

Equipment and medicines

The practice did not have a washer disinfector in line with best practice guidance, however staff told us the they had the equipment they needed to enable them to carry out their work. We saw the practice had an adequate amount of instruments and each surgery had 2-3 sets of hand pieces available. The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this.

We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes. However, we found loose anaesthetics in one surgery drawer that risked becoming contaminated, and the fridge which held some medicines was not monitored to check it was at the correct and safe temperature to ensure their integrity. There was no protocol in place for disseminating safety alerts from the MHRA, or for reporting adverse reactions to medicines via the yellow card reporting scheme.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced.

A Radiation Protection Advisor and Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in the radiation protection folder and in each surgery for staff to reference if needed. Those authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training. This protected patients who required X-rays as part of their treatment.

There were regular audits of the quality of the dentists' x-rays. This included assessing the quality of the X-rays which had been taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. During our observation we saw that the hygienist went through the patient's medical history form in depth to ensure they were aware of any medical condition that might affect the treatment. We saw that dental care records contained a written patient medical history which was updated for every course of treatment. Patients' dental records were detailed and clearly outlined the treatment provided, the assessments undertaken and the advice given to them. Our discussions with the dentist showed that that they were aware of, and worked to, guidelines from National Institute for Heath and Care Excellence (NICE) and the Faculty of General Dental Practice about best practice in care and treatment. Dental care records we viewed evidenced clearly that NICE guidance was followed for patients' recall frequency and that that routine dental examinations for gum disease and oral cancer had taken place. Dental decay risk assessments had been completed for patients.

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping and the quality of dental radiographs.

Health promotion & prevention

There were leaflets in the waiting room, giving patients information on a range of dental health topics including oral cancer, plaque and periodontal disease. A number of oral health care products were available for sale to patients including interdental brushes, toothpaste and floss. Free samples of toothpaste were available on the reception desk for patients to take.

Staff told us they regularly held oral health promotion months and put up displays in the waiting room for patients. Staff also visited the local shopping centre to promote the practice's services and give out 'goodie bags' of dental health care products to shoppers. Two of the practice's nurses had visited a local primary school to provide oral hygiene advice to pupils there. Staff were aware that it was the 'Stop Smoking' month in March, and knew of the local facilities that could assist patients with this.

During our observation, we noted that the hygienist asked about the patient's smoking and alcohol intake. However staff were unaware of the NHS England's publication Delivering Better Oral Health- an evidence based toolkit to support dental practices in improving their patients' oral and general health. The practice manager told us she would download the guidance and ensure it was disseminated to staff.

Staffing

There was a stable and established staff team at the practice, many of whom had worked there a number of years. Staff told us there were generally enough of them to maintain the smooth running of the practice and the dentists never undertook any work without the presence of a dental nurse. Additional trainees nurses were always available to help if needed, however the dental hygienist always worked alone without a dental nurse to assist her and ensure patient safety.

We looked at three staff personnel files, training records and revalidation logs. We saw evidence that all staff were appropriately qualified, trained and where appropriate, had current professional validation.

There was a structured system for providing staff in all roles with yearly appraisals of their work and for planning their training needs. However neither of the practice's hygienists had received an appraisal, despite one of them having worked there for many years.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and always kept a copy of the referral. However patients did not get a copy of the referral letter and there was no system in place to check that referrals had been received, once sent.

Consent to care and treatment

Patients we spoke with told us that they were provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment. Staff told us that all patients were given a treatment plan, which they then signed to show that they were happy for the treatment to be given. Dental care records we viewed demonstrated that patients' consent to their treatment had been obtained and was recorded.

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive policy in place in relation to the Mental Capacity Act (MCA) which clearly outlined the procedure for staff to follow if they thought a patient might not be able to consent to their treatment. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. We spoke with staff and found they had a good understanding of the Mental Capacity Act 2005 (MCA) and its relevance in obtaining consent.

Are services caring?

Our findings

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Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered a range of services in additional to general dentistry including orthodontics, periodontics, teeth whitening and dental implants.

Information was available about appointments on the practice's website and also in its patient information leaflet. This included opening times, how to book appointments, details of the staff team and the services provided. Appointments could be booked in person, by telephone or via email. Staff told us that each dentist held two to three slots open every day to accommodate patients who needed an urgent appointment. The practice was open Mondays, Tuesday, Wednesday and Fridays from 8.30 to 5.30pm, with extended opening times on a Thursday till 6pm to meet patients' needs. The practice occasionally opened on a Saturday subject to appointment only. Our visit was on the 26 January, and the next available routine appointment was available at 5.10pm that afternoon, or there were several available slots the following day. Patients told us they could easily get an appointment at a convenient time for them. They also told us they particularly liked the location of the practice, which allowed them to combine a trip to the dentist with shopping.

Tackling inequity and promoting equality

The practice was located on the third floor of a large building that was shared with other businesses. Access to it was by lift for those patients with mobility problems, however the internal doors were not automated and the practice did not have a disabled toilet for wheelchairs users. There was no information available to patients to inform them of this.

Peterborough, where the practice was based, has sizeable minority ethnic population groups, who do not have English as a first language. However the practice did not supply any information or leaflets in the languages common to those groups.

Concerns & complaints

We viewed the practice's patients' complaints procedure which detailed the process to be followed, the timescales within which complaints would be dealt with, and also listed external agencies patients could contact if they were not satisfied with the practice's response.

We saw that information was available to help patients understand the complaints system in the patient information leaflet and on the practice's website. Staff showed a good understanding of the practice's complaints' procedure and told us these were discussed at their monthly meetings. We viewed paperwork in relation to two recent complaints and found they had been investigated and responded to in an appropriate and empathetic manner.

Are services well-led?

Our findings

Governance arrangements

The practice had a range of policies and procedures in place to govern its activity and these were available to staff on its intranet system. These were updated centrally and any new or amended polices were emailed to the manager for disseminating to staff.

The practice manager had responsibility for the day to day running of the practice and was fully supported by the practice team. There was an established leadership structure within the practice, with clear allocation of responsibilities amongst the staff. For example there was a lead for infection control and one for safeguarding patients. Staff we spoke with were all clear about their own roles and responsibilities. The practice manager was supported by a chief operations manager who visited every two weeks to assist her and oversee the running of the practice.

Communication across the practice was structured around a monthly meeting involving the whole staff group. Staff told us these meetings were useful and ensured key issues were discussed and shared. There were also operations meetings with the managers of the provider's other three practices to ensure consistency across the company.

Leadership, openness and transparency

Staff clearly enjoyed their work citing good team work, support and training as the reason. They told us the new practice manager had introduced many positive improvements since taking over. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. They reported that the practice manager and dentists were very approachable.

The provider was aware of the requirements of the Duty of Candour and had a specific procedure to ensure it meet its obligation in relation to this.

Learning and improvement

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. Staff told us they had good access to training and the practice monitored it, to ensure essential training was completed each year. The hygienist told us she regularly attended the Eastern region's meetings of the British Dental Hygiene and Therapy group to keep her learning and skills up to date.

Regular audits were undertaken to ensure standards were maintained in radiography, infection control and the quality of clinical notes. These audits were regularly reviewed by the senior clinical team at Total Dental Care to ensure each practice within the company was meeting required standards.

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

The practice encouraged and valued feedback from patients. A box was available in the waiting area with a form for patients to complete. This form was comprehensive and asked for patients' comments in relation to the quality of staff, the cleanliness of the practice and the complaints procedure. The forms were collected each month by the practice manager and feedback shared at the next staff meeting.

The practice had gathered feedback from staff through staff meetings, appraisals and discussion. The chief operations officer told us the company was about to introduce anonymous staff surveys as another way of receiving feedback about the service. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were given many examples from staff where managers had listened to them, and implemented their suggestions to improve the service. For example, one staff member's request to have additional Denplan training had been actioned; staff's suggestion to introduce colour coding to packaged instruments had been implemented and a more comfortable seat had been bought for a pregnant employee.