Dr. Jonathan Poznansky

Tregenna Hill Dental Surgery

Inspection Report

Tregenna Hill
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Ratings

Overall rating for this service

Overall summary

Dr Jonathan Poznanski provides NHS dental treatment at Tregenna Hill Dental Surgery to approximately 4,300 people in west Cornwall. The surgery is run as an expense sharing partnership between two dentists who are registered as independent providers. The providers share policies, procedures and the majority of support staff. In this report, we will use the word 'surgery' when referring to the whole service, and 'practice' when referring to the individual provider.

The surgery is on an upper floor of an end terrace property in St Ives with access via steps and there are also some steps within the building. There is no wheelchair access.

Nine patients completed our comment cards and we spoke with two by phone following this visit. Some patients had been coming to the practice for over twenty years and were very happy with the care and treatment they received. One had called in because they suffered a toothache while on holiday and had been pleased to get attention promptly. Patients said the staff were very helpful, discreet and always polite and caring. They found the environment relaxing, warm and comfortable. Some patients said their treatment had always been satisfactory in spite of complex dental problems.

Summary of findings

Safe systems were in place for dealing with medical emergencies and fire safety. Infection control measures were in place but the required audits had not been carried out, so the team had not determined where improvements were needed.

We saw that improvements had been made to the arrangements for supporting staff since our visit in 2013. There were records of staff training that had been achieved and of staff appraisals that included their plans for future development.

However, there were also areas of practice where the provider must make improvements;

- The provider must monitor the quality of their service, including audits of record keeping and audits of the quality of their X-rays. Infection control measures must be audited at six monthly intervals.

There were areas of practice where the provider should make improvements;

- Training or guidance should be provided for staff about the Mental Capacity Act 2005 so they know how to obtain professional support where necessary for a patient who could not give informed consent to treatment and whose carer may not make decisions in their best interest.
- An assessment should be carried out in accordance with the Disability Discrimination Act. This would identify action that could be taken to help patients with varying disabilities, even with the constraints posed by a historic building.
- The provider should carry out a patient survey and record minor concerns so the practice may respond and demonstrate any action taken in response.
- There should be a structured induction for new staff.

We will ask the provider to send us an action plan showing how and when the practice will be compliant with the regulations.

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 safe practice in respect to dealing with medical emergencies. Staff had received training and showed good awareness of health and safety issues. There was a good track record of fire safety arrangements with up to date records of professional servicing of the alarm system and extinguishers.

There was generally a good awareness of principles of infection control. The work of cleaning the clinical area between patients and decontaminating instruments used in dentistry was carried out with care but no audits of the processes had been carried out for the team to check their own practice and identify any improvements needed. These audits must be carried out at six monthly intervals in accordance with guidance from the Department of Health to ensure safe procedures are maintained.

Staff had received training about child protection and safeguarding vulnerable adults, so they could identify potential abuse and knew how to respond to any allegation.

Are services effective?

Patients' care and treatment was planned and delivered in a way that ensured patients' safety and welfare. A written medical history was always obtained prior to the commencement of dental treatment**.** Patients' personal records including medical records were accurate and sufficient to support safe practice.

Are services caring?

Patients said the staff were very helpful, discreet and always polite and caring. They found the environment relaxing, warm and comfortable. Some patients said their treatment had always been satisfactory in spite of complex dental problems. Patients who had suffered toothache while on holiday had been grateful for the attention of the staff who enabled them to see a dentist in a very short space of time.

Are services responsive to people's needs?

Patients were given appointments promptly when they needed one. Information about the out of hours service was available. There was an arrangement with a neighbouring practice to provide emergency treatments in the absence of the dentist.

There had not been a patient survey, which would give patients an opportunity to give their views on the service. There had not been an assessment under terms of the Disability Discrimination Act that would identify improvements that could help patients with disabilities other than wheelchair users to access the service.

There was a complaints policy and we saw that the practice had responded to complaints. Though some compliments had been received, they had not been recorded and there was no method of recording minor complaints or grumbles. Such a record would help the team identify problems and help them understand how patients were affected. They could then demonstrate what they had done in response.

There was no guidance for staff about the relevance of the Mental Capacity Act 2005 to the dental team and how to obtain support if necessary for patients who were unable to give informed consent for their own treatment.

Are services well-led?

The provider worked well with his own staff. However, there was inadequate communication with the other provider at this location. Future planning was curbed, for example the partners were not planning for progress towards best practice in decontamination work.

Summary of findings

Staff were supported with encouragement through performance appraisal. Staff meetings continued to be held, with speakers and discussions to promote good practice.

Systems were not in place to check on the quality and safety of the practice, to identify any shortfalls and take action in response. The provider had not audited their record keeping, the quality of their X-rays or their infection control measures. They had not carried out a patient survey, kept a record of minor concerns or commissioned an assessment of the facilities in accordance with the Disability Discrimination Act.

Tregenna Hill Dental Surgery

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection followed up on an inspection of 19 November 2013 when the service was found to be non-compliant in respect to the following regulation;

Regulation 23 – the provider had failed to ensure that staff were appropriately supported.

- This inspection was carried out on 9 December 2014 by an inspector and a specialist dental advisor.
- Before the inspection we reviewed the report from the inspection of 13 November 2013. We received information from NHS England about their visit to the practice in January 2014. We saw views that had been provided by patients via the NHS Choices website. Dr Poznanski gave us his up-dated statement of purpose.
- During the inspection we toured the premises, interviewed the dentist and staff, observed methods of working and reviewed documents.
- Nine patients gave their views via our comment cards and we spoke with two patients by telephone following the visit.

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?

Are services safe?

Our findings

Learning and improvement from incidents

We saw that two accidents had been recorded. The record included immediate action taken as well as recommendations to avoid similar events. Following a needle stick injury there should have been a referral to Occupational Health for advice in line with their policy or a risk assessment to record why this was not appropriate. No other significant events had been recorded.

Reliable safety systems and processes including safeguarding

Risk assessments had been carried out with respect to situations of possible danger including scalds, biological agents, slips, trips and falls, and actions to reduce identified risk had been highlighted and carried out. Advice from the British Dental Association (BDA) was available for staff guidance with respect to the control of substances hazardous to health (COSHH) materials.

The surgery had a policy for child protection and safeguarding vulnerable adults, recognising the responsibilities of the dental team. It included dealing with allegations against a team member and it included a number to call to discuss concerns. The policy had been signed by staff but not updated since 2012. Staff had all received training in child protection and safeguarding vulnerable adults and told us how they would identify potential abuse. There was guidance within the surgery. It should be better organised to be easily available if staff had concerns as staff could not quickly locate all sections for us to see. One file held contact details for making a referral and a flow chart for raising child protection queries. Another file held contact details for access to the team who supported vulnerable adults with advice on making a referral and a form to complete if staff needed to raise an alert.

The dentist had observed a child exhibiting signs of neglect, and asked the parents to take them to hospital. He alerted the hospital to his concerns in accordance with the policy.

Infection control

The surgery had a comprehensive policy for infection prevention and control (IPC) covering minimising blood borne virus transmission; hand hygiene, personal protective equipment (PPE) – generally gloves, masks, protective eye wear and aprons, clinical waste management, blood spillage and environmental cleaning, and decontamination of instruments used in dentistry.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections.

Staff demonstrated that after donning their PPE they scrubbed each item manually, rinsed it in a separate bowl then put it through a cycle in an ultrasonic cleaner. Following this, the nurse rinsed each item again then checked it under a magnifying lamp. If there were no visible dirt the nurse loaded the instruments into the non-vacuum autoclave to be sterilised. In the clean area, the nurse bagged and dated the sterilised instruments.

The surgery should have a plan to work towards best practice with these processes, which involves separating the decontamination process from the clinical area.

We asked to see a record of an audit of the decontamination process but none had been carried out. The HTM01-05 states that audits must be carried out at six monthly intervals in order that a safe system is maintained.

Clinical waste and hazardous waste were stored in a locked cupboard near an external door.

We saw documents showing they were collected by a registered waste contractor for disposal in line with current legislation.

A legionella risk assessment had been carried out by a professional water testing company, followed by monthly checks of water temperatures by staff in the practice.

Equipment

The pressure vessels, that is, the autoclave and the compressor, had been serviced by an engineer and records demonstrated that the equipment had been passed as fit for purpose. We saw the annual service records of the surgery's supply of oxygen and checks of medical face masks. The nurse carried out weekly checks for cleanliness and effectiveness on the ultrasonic cleaner which was subject to an annual check and service by an engineer.

The surgery computer system had been serviced and repaired under contract.

Are services safe?

Rubber dams protect patients from inhaling or swallowing debris or small instruments used during root canal work, as well as isolating the tooth being treated. The dentist should use this method, as it is recommended practice.

Monitoring health & safety and responding to risks

The surgery had a fire drill arrangement but this was not current as the original designated area of safety for patients and staff to congregate at in the event of a fire was no longer accessible. Staff told us that they had requested a visit from a fire officer to risk assess the building and to give further advice with regard to fire safety. We looked at records that demonstrated the fire alarm and fire extinguishers had been checked and serviced. We noted that the practice did not have any emergency lighting but the signage that identified fire exits was florescent and would be visible in reduced lighting.

Medical emergencies

The surgery was prepared to deal with medical emergencies, as the whole team were trained in basic life support and resuscitation. However, there should also be a qualified first aider to respond to accidents and injuries.

The emergency medicines were kept in a side room out of public view but easily accessible for staff. Medications were kept in accordance with the guidelines of the Resuscitation Council UK. An epi-pen was on order, which is a medicine used in the event of a severe allergic reaction, meanwhile adrenaline was available which could be used for an allergic reaction. The emergency medicines were checked monthly.

The oxygen cylinder was kept beside the emergency medicines in the manufacturer's bag with pocket masks and tubes, and a bag valve mask used to help patients who are not breathing adequately. The oxygen cylinder had been inspected annually by the manufacturer and checked at three monthly intervals by staff to make sure it was available when needed.

Staff were trained in use of the automatic external defibrillator (AED) but the surgery did not have one. There was an informal arrangement with a local store who held an AED for public use that staff from the surgery were able to use, in the event of a medical emergency.

The practice had a blood pressure monitor. There should also be a method to check patients' blood sugar level.

Staff recruitment

The dentist jointly employed with the other partner a practice manager and a receptionist who was a qualified dental nurse and covered nursing duties when needed. The dentist also employed his own nurse and a dental hygienist.

Staff files had been produced since our last visit which represented good progress. They contained training certificates, and some contained contracts of employment, immunisation records and completed performance appraisal forms. Criminal record bureau (CRB) checks had been carried out on behalf of all members of the team. The provider should check to ensure that all staff files contained immunisation records and references that had been taken up from a previous employer.

One staff member had been recruited recently. They said they had been well introduced to their role at the practice but we saw there had been no structured induction programme. Staff had shown them all matters concerning health and safety in the practice, then they had shadowed a qualified and experienced staff member for a week, before starting work under supervision.

Radiography

The surgery had a radiation protection file which contained the necessary documentation pertaining to the maintenance of the X-ray equipment. The maintenance contract with the radiation protection adviser (RPA) had been updated on 4 April 2014, their name was printed at the front of the file along with their contact details. The dentist was recorded as radiation protection supervisor (RPS). The equipment performance report was in date (expiry 2017) for the unit that was in use. There was a report from a risk assessment to reduce and manage staff exposure to X-rays which was good practice.

Local rules to provide guidance for staff were displayed. The provider had not updated them or shown the names of the RPA and the RPS. There had not been an audit of the quality of images.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The surgery had a policy on consent processes. The dentist said he discussed treatment options with patients for consent and agreement in drawing up their treatment plan. The dentist demonstrated a clear understanding of the consent process and had involved family members in discussion about recommended treatment for a patient with memory problems.

The consent policy said that where there may be doubts about a patient's capacity to understand the decision needed about their treatment the dentist would seek advice from their defence organisation. There was no knowledge of the Mental Capacity Act 2005 (MCA), of its relevance to dental teams or of support available to help make decisions in a patient's best interest. No staff training had been provided.

Monitoring and improving outcomes for people using best practice

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. A written medical history was obtained prior to the commencement of dental treatment and updated at subsequent visits**.** This meant that the dentist and staff were aware of risks to patients so they could help ensure that patients were safe during treatment.

Clinical records were kept which showed the type and dose of local anaesthetic used when patients had treatment. The dentist recorded patients' concerns, carried out comprehensive examinations and drew up treatment plans according to the patient's individual needs, and confirming treatment to be done at each visit. He recorded periodontal scores for patients and determined their recall interval according to their gum health.

Working with other services

The dentist provided care to anxious patients by prescribing oral diazepam for them to take the evening before their appointment, for which no special precautions were needed, but if they needed further sedation he referred them to the local community service. He carried out root canal treatment to the extent of his competence and advised patients they had the option of referral to private practice for specialist treatment should they wish.

Health promotion & prevention

The dentist focussed on preventive care and employed a dental therapist to support this work. There was information in the waiting room from the British Dental Association (BDA) about oral health including child oral health. There was information about a local hypnotherapist who helped patients who were dental phobic to attend for their treatment.

Staffing

The dentist had an agreement with a neighbouring dentist to cover for each other's patients' emergency care.

The receptionist was a registered dental nurse who covered for the absence of the nurse as required. She had maintained her training for her continuous professional development. We saw certificates for training on infection control, safeguarding and safety in radiation. Annual performance appraisals included personal objectives.

The dentist employed a dental therapist/hygienist. He referred patients for preventive work and also for therapy, for example, work on deciduous (baby) teeth.

The practice manager had no time dedicated to management, having to fit these responsibilities around supporting the reception duties and administrative tasks including payroll. Impact on the practice was seen in a lack of quality monitoring.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff treating patients with respect and friendliness and patients told us they were treated with dignity and respect. Doors to treatment rooms were closed during appointments. The waiting room was comfortable and there was a box of books that children found attractive. A radio was playing in the office space beside the waiting room, to mask conversations with the receptionist and incoming phone calls.

Children from Chernobyl visited St Ives every summer for a month. This dentist had invited the children to come for dental examination and treatment each year that was not available to them at home.

Holiday makers had come for emergency care. One patient told us they had suffered toothache while on holiday and had been grateful for the attention of the staff who enabled them to see a dentist in a very short space of time.

Involvement in decisions about care and treatment

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. The dentist said and records showed that he discussed treatment options with patients to get their consent and agreement in drawing up their treatment plan. If patients who spoke little or no English came without an interpreter, the dentist and staff were confident in using non-verbal communication to ensure the patient understood and could give consent.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Tackling inequity and promoting equality

There was a policy on equal opportunities, signed by staff on 6 February 2012, and another on equality and diversity. We did not see any evidence of discrimination in offering appointments or providing treatment.

Access to the service

A steep lane beside the practice gave access to the side door. There were three steps at this entrance and further steps within the building. New patients were advised of the access before they registered. No assessment had been carried out in accordance with the Disability Discrimination Act. This should be done to identify action that could be taken to help patients with varying disabilities, even with the constraints posed by a historic building.

Concerns & complaints

The surgery had a clear policy on how complaints were handled and it was displayed in the waiting room. It included the contact details for organisations that support patients in making complaints and the Parliamentary and Health Service Ombudsman who could help them should they be dissatisfied with the response from the provider.

The practice manager told us that no formal complaints had been received. Though some compliments had been received, they had not been recorded. There should be a method of recording minor complaints or concerns to help the team identify problems.

Are services well-led?

Our findings

Leadership, openness and transparency

The provider worked well with his own staff. However, there was inadequate communication with the other provider at this location. In July 2014, joint funding had been agreed by the partners in order to carry out repairs to the toilet floor and an external step. At the time of this inspection, future planning was curbed and the partners were not investing in the service, for example in planning for progress towards best practice in decontamination work.

Governance arrangements

The provider had not been monitoring the quality and safety of the service. He had not carried out audits of the quality of X-rays or record keeping, which were needed to assure safe care. There had been no audits of infection control in accordance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health, which sets out in detail the processes and practices essential to prevent the transmission of infections. .

Staff appraisals had been carried out and recorded, during 2013 and 2014, including personal objectives.

Monthly staff meetings had been recorded. We looked at the minutes of the January meeting where the GDC standards for the dental team had been discussed. GDC standards are the principles of conduct, performance and ethics all dental professionals must abide by to maintain their registration with the GDC. We saw the standards had been discussed to make sure all staff were aware of their responsibilities. Another recent meeting had a presentation on oral health promotion by a supplier of dental care products while other discussion topics at meetings had included the reporting of incidents and accidents, including the procedure following a sharps injury. The most recent meeting had concentrated on infection control, with input from the dentist and the qualified dental nurse.

The surgery was registered with the Data Protection Register of the Information Commissioner's Office in accordance with the Data Protection Act 1998.

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

The practice should carry out patient surveys to give patients the opportunity to give feedback and influence how the service was run. Compliments had been received but not recorded, staff told us. There were no records of minor concerns that had been brought to staff attention.

Management lead through learning and improvement

The dentist worked at a dental school one day per week, ensuring continual consideration and updating of practice, also allowing the clinical space for the hygienist to practice.

We saw that staff had records of training in infection control, safeguarding adults and children, and radiation protection. Some staff appraisals had been carried out and recorded, including their aspirations for the future. One nurse had plans to train in oral education, to promote the health prevention ethos of the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met; The registered person had not audited their record keeping or the quality of their X-rays, or their infection control measures. They had not carried out a patient survey or recorded minor concerns. They had not commissioned an assessment of the facilities in accordance with the Disability Discrimination Act. Regulation 10(1)a&b and (2)b(I)