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Berwick Smile Dental Care

Inspection Report

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Date of inspection visit: 07 February 2017
Date of publication: 30/03/2017

Overall summary

We carried out an announced comprehensive inspection on 07 February 2017 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

Berwick Smile Dental Care was initiated in 2010 and provides private treatment to patients of all ages. The purpose-built practice consists of two treatment rooms, two consultation rooms, a dedicated decontamination room for sterilising dental instruments, a reception with waiting area, a staff room and general office. Car parking is available in front of the practice. Access for wheelchair users or pushchairs is possible via the ground-floor entrance.

The practice is open Monday – Thursday 0900 -1700 and Friday 0900 -1300 with extended opening hours to 1900 once a week on alternate Mondays and Wednesdays.

The dental team is comprised of the principal dentist (who is also the registered provider), an associate dentist, a dental hygienist and five dental nurses (one of whom is a trainee). The senior dental nurse is also a treatment co-ordinator and all dental nurses undertake administration and reception duties.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

The practice offers general and specialised dental treatments including dental implants and simple orthodontics.

Summary of findings

We reviewed 15 CQC comment cards on the day of our visit; patients were very positive about the staff and standard of care provided by the practice. Patients commented they felt involved in all aspects of their care and found the staff to be helpful, respectful, friendly and were treated in a clean and tidy environment.

Our key findings were:

- Staff were very friendly, caring and enthusiastic.
- The practice was visibly clean and an Infection prevention and control policy was in place.
- We saw sterilisation procedures followed recommended guidance.
- The practice had systems for recording incidents and accidents.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Patient feedback was regularly sought and reflected upon.
- Patients could access urgent care when required.
- Dental professionals were maintaining their continued professional development (CPD) in accordance with their professional registration.
- Complaints were dealt with in an efficient and positive manner.
- Staff received annual medical emergency training.
- Equipment for dealing with medical emergencies mostly reflected guidance from the resuscitation council.
- Staff were aware on how to escalate safeguarding issues for children and adults should the need arise. Contact details were available within their safeguarding policy.
- Staff were involved in charity work, providing oral health education and dental treatment abroad.

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

- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the 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
- Review the responsibilities with regards to the Control of Substances Hazardous to Health (COSHH) Regulations 2002 and ensure all documentation is up to date.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the system for training, assessment and supervision of all staff.
- Review the system for identifying and disposing of out-of-date medicines and equipment.
- Review the storage of medicines requiring refrigeration to ensure the fridge temperature is monitored and recorded.

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?

No action

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

Infection prevention and control procedures followed recommended guidance.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions.

Emergency medicines and equipment were not fully in accordance with guidelines; we found two items had expired and two items were missing.

The practice had processes for recording and reporting any accidents and incidents. The practice did not give full regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 with respect to their sharps procedures.

The practice's Control of Substances Hazardous to Health (COSHH) file did not contain risk assessments for all the materials held within the practice. The practice had not implemented the required actions from their legionella risk assessment.

Are services effective?

No action

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

Dental professionals referred to resources such as the National Institute for Health and Care Excellence (NICE) guidelines and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations.

Staff obtained consent and made referrals to other services in an appropriate and recognised manner.

Staff who were registered with the General Dental Council (GDC) met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD).

Are services caring?

No action

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

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 15 responses all of which were very positive, with patients stating they felt listened to and received the best treatment at that practice.

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

The waiting area was equipped with dental advice and practice information leaflets, tea and coffee facilities and a child play area.

Summary of findings

Dental care records were kept securely and computers were password protected.

Are services responsive to people's needs?

No action

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

The practice had dedicated slots each day for urgent dental care and every effort was made to see all emergency patients on the day they contacted the practice.

The practice had considered the needs of various population groups and could accommodate wheelchair users/pushchairs within their ground floor surgeries and patient toilet.

Privacy and confidentiality were maintained for patients at all times.

Are services well-led?

No action

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

The principal dentist was on-site every day of the week. There were dedicated leads in infection prevention and control and safeguarding as well as various policies for staff to refer to.

The principal dentist kept all staff files, training logs and certificates on the premises; we found training logs were not completed for all staff.

There were regular quality checks of clinical and administration work; the practice undertook a range of audits and risk assessments.

Staff were encouraged to provide feedback on a regular basis through staff meetings and informal discussions.

Patient feedback was also encouraged verbally and online. The results of any feedback were discussed in meetings for staff learning and improvement.

Berwick Smile Dental Care

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 9 February 2017. It was led by a CQC inspector and supported by a dental specialist advisor.

We informed the NHS England area team and Healthwatch England that we were inspecting the practice; we received no information of concern from them.

During the inspection we spoke with the principal dentist, associate dentist and three dental nurses.

We reviewed policies, protocols, certificates and other documents to consolidate our findings.

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 told us they were aware of the need to be open, honest and apologetic to patients if anything was to go wrong; this is in accordance with the Duty of Candour principle which states the same.

The practice had systems in place for recording accidents and incidents. Staff were clear on what needed to be reported, when and to whom as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR). There was one accident recorded by the practice within the last twelve months. We reviewed the record and found it contained a detailed explanation of what occurred, when and what measures took place.

The dental practice received safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS). These were fully distributed amongst all staff within the practice.

Reliable safety systems and processes (including safeguarding).

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice had carried out a sharps risk assessment as part of their overall practice risk assessment in November 2016. The risk assessment did not account for the use of traditional re-useable sharps (such as scalpels and needles) without any protective measures. There were disposable needles and syringes also available for those staff who wished to use them. We discussed the need for a detailed risk assessment with the principal dentist who agreed to review this.

Flowcharts were displayed in the decontamination room and in each surgery describing how a sharps injury should be managed. Staff advised us of their local policy on occupational health assistance.

The dentists told us they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We reviewed the practice's policy for adult and child safeguarding; contact details of the local authority and safeguarding teams for children and vulnerable adults were detailed in the policy. Staff told us their practice protocol and were confident to respond to issues should they arise. The principal dentist was the safeguarding lead and had undergone appropriate training.

The practice had a whistleblowing policy which all staff were aware of. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations with the principal dentist.

The practice had employers' liability insurance (a requirement under the Employers Liability (Compulsory Insurance) Act 1969) and we saw their practice certificate was up to date (expiry April 2017).

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff had received training in basic life support including the use of an Automated External Defibrillator (An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

The practice kept medicines and equipment for use in a medical emergency; these were mostly in line with the 'Resuscitation Council UK' and British National Formulary guidelines. We found two items of emergency equipment (portable suction and self-inflating bag for children) were not present. We also saw two items of equipment were past their expiry date; breathing masks and needles.

We saw the practice was storing their Glucagon (used for diabetic emergencies) in the fridge and had not ensured the temperature was maintained between 2 and 8 degrees as recommended by the manufacturer's guidance.

We notified the principal dentist of our findings and they immediately ordered items on the inspection day.

We saw the practice kept logs which indicated the emergency equipment, emergency medical oxygen cylinder and emergency drugs were checked monthly. We

Are services safe?

found the AED was not being checked and other equipment checks were not weekly as per the Resuscitation Council (UK) guidance. We brought this to the principal dentists' attention who agreed to change this.

Staff recruitment

We reviewed the staff recruitment files for three members of staff to check that appropriate recruitment procedures were in place. We found files held proof of identity, qualifications, references, immunisation status, indemnity and where necessary a Disclosure and Barring Service (DBS) check. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children.

Monitoring health & safety and responding to risks

We reviewed various risk assessments (a risk assessment is a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) within the practice.

We looked at the Control of Substances Hazardous to Health (COSHH) file, the practice risk assessment, health and safety risk assessment and fire risk assessment. These were carried out in accordance with the relevant legislation and guidance.

COSHH files are kept to ensure providers contain information on the risks from hazardous substances in the dental practice. We found the practice had not carried out risk assessments for all materials on-site as required by the Health and Safety Executive. They did keep all the products' safety data sheets (these provide information on the general hazards of substances and give information on handling, storage and emergency measures in case of accident) and ensured us all risk assessments would be carried out as appropriate.

We saw annual maintenance certificates of firefighting equipment including the current certificate from April 2016. Six-monthly fire drills were carried out to ensure staff were rehearsed in evacuation procedures. The practice had clear signs to show where evacuation points and fire exits were.

We saw the business continuity plan from had details of all staff, contractors and emergency numbers should an unforeseen emergency occur.

Infection control

We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures. All were in accordance with the The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health which details the recommended procedures for sterilising and packaging instruments.

We spoke with dental nurses about decontamination and infection prevention and control; the process of instrument collection, processing, inspecting using a magnifying light, sterilising and storage was clearly described and shown. We also saw the daily and weekly tests were being carried out by the dental nurses to ensure the sterilisers were in working order.

We inspected the decontamination and treatment rooms. The rooms were clean, drawers and cupboards were clutter free with adequate dental materials. There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. Staff described the method used and this was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out in August 2015. We saw recommended measures (such as monthly temperature recording) were not implemented and /or documented. The principal dentist told us they would review their risk assessment and ensure the necessary control measures were actioned.

The practice stored clinical waste in a secure manner and an appropriate contractor was used to remove it from site. Waste consignment notices were available for the inspection and this confirmed that all types of waste including sharps and clinical waste was collected on a regular basis.

We saw the practice was clean and uncluttered. There were designated mops for cleaning of specific areas within the practice.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations.

Are services safe?

We saw evidence of servicing certificates for sterilisation equipment in December 2016, X-ray machines in July 2016 and Portable Appliance Testing (PAT) in June 2016. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use).

Medicines were stored in a secure and appropriate manner.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice kept a thorough radiation protection file which included the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, Health and Safety Executive notification, the local rules and maintenance certificates.

We saw all staff were up to date with their continuing professional development training in respect of dental radiography. The principal dentist showed us the practice was undertaking regular analysis of their X-ray through an annual audit cycle. We saw audit results from 2011 to 2016 were in line with the National Radiological Protection Board (NRPB) guidance. The principal dentist worked closely with all staff members to ensure the audit process evolved in each cycle.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found the dental professionals were following guidance and procedures for delivering dental care.

A comprehensive medical history form was filled in by patients and this was checked verbally at every visit. A thorough examination was carried out to assess the dental hard and soft tissues including an oral cancer screen. Dental professionals also used the basic periodontal examination (BPE) to check patients' gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are.

Patients were advised of the findings and any possible treatment required.

The dentists told us they were familiar with current National Institute for Health and Care Excellence (NICE) guidelines for recall intervals, wisdom teeth removal and antibiotic cover. Recalls were based upon the patients' risk of dental diseases.

Dentists used their clinical judgement and guidance from the Faculty of General Dental Practitioners (FGDP) to decide when X-rays were required. A justification, grade of quality and report of the X-ray taken was documented in the patient dental care record.

We used guidance from the Faculty of General Dental Practice (FGDP) to help us make our decisions about whether the practice records and record keeping were meeting best practice guidelines. We found evidence to suggest the practice had systems in place that were equal to what was recommended in the FDGP guidance.

Health promotion & prevention

We found the practice was proactive about promoting the importance of good oral health and prevention.

Staff were aware of the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' and oral preventive measures were in place. These included providing patients with oral hygiene advice such as tooth brushing technique, fluoride varnish applications and dietary advice. Smoking and alcohol consumption was also checked where applicable.

The practice reception displayed a range of dental products for sale and information leaflets were also available to aid in oral health promotion.

Staffing

There were dedicated leads for infection prevention and control, safeguarding adults and children, whistleblowing and complaints.

Prior to our visit we checked the registrations of all dental professionals with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dental professionals.

Staff told us they were supported and encouraged to maintain their continuous professional development (CPD) and we saw evidence of this in most staff files.

Working with other services

Dentists we spoke with confirmed they would refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. Referral letters were either typed up or pro formas were used to send all the relevant information to the specialist. Details included patient identification, medical history, reason for referral and X-rays if relevant.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

Consent to care and treatment

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. Staff explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. The patient would sign this and take the original document. A copy would be retained in the patients' dental care record.

Staff were clear on the principles of the Mental Capacity Act 2005 (MCA). The MCA is designed to protect and empower individuals who may lack the mental capacity to make their

Are services effective?

(for example, treatment is effective)

own decisions about their care and treatment. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the treatment options.

The concept of Gillick competence was clearly described to us. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 15 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

We observed all staff maintained privacy and confidentiality for patients on the day of the inspection. Practice computer screens were not overlooked in reception and treatment rooms which ensured patients' confidential information could not be viewed by others. If further privacy was requested, patients were taken to a spare surgery or consultation room to talk with a staff member.

We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored electronically and in paper form. Paper record cards were kept securely in locked cabinets behind reception and computers were password protected. Computers were backed up and passwords changed regularly. Staff were confident in data protection and confidentiality principles.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and costs. Posters showing private treatment costs were displayed in the waiting area. The practice's website provided patients with information about the range of treatments which were available at the practice.

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. We looked at dental care records with clinicians which confirmed this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw the practice waiting area displayed a variety of information including the practice opening hours, emergency 'out of hours' contact details, complaints and safeguarding procedures and treatment costs. Leaflets on oral health conditions and preventative advice were also available.

The practice had dedicated slots each day for emergency dental care and every effort was made to see all emergency patients on the day they contacted the practice. Reception staff had clear guidance to enable them to assess how urgently the patient required an appointment.

We looked at the appointment schedules and found that patients were given adequate time slots for different types of treatment.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place to support staff in understanding and meeting the needs of patients.

The practice had made reasonable adjustments to prevent inequity to any patient group. The practice had carried out their own disability access audit in 2016. A disability access audit is an assessment of the practice to ensure it meets the needs of disabled individuals, those with restricted mobility or with pushchairs. Staff had access to a translation service where required and large print leaflets and glasses of varying prescription were available to aid vision. There was suitable access for wheelchair users and people with pushchairs in the downstairs surgeries. The patient toilet was spacious and was fitted with a safety alarm and hand rail for support. The reception desk was reduced in height to enable access for wheelchair users.

Access to the service

The practice's opening hours were displayed in the premises, in the practice information leaflet and on the practice website.

Patients commented they had good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

Concerns & complaints.

The practice had a complaints policy which provided guidance to staff on how to handle a complaint. The policy was detailed as recommended by the GDC. Staff told us they raised any patient comments or concerns with the practice manager immediately to ensure responses were made in a timely manner.

The practice did not display the complete complaints procedure for patients and we referred the principal dentist to the appropriate guidance with regards to this.

The practice received four complaints in the last twelve months. We saw records that showed the complaints had been effectively managed and also shared with the whole practice to enable staff learning.

Are services well-led?

Our findings

Governance arrangements

The principal dentist showed us their practice policies, procedures, certificates and other documents. We viewed documents relating to safeguarding, whistleblowing, complaints handling, health and safety, staffing and maintenance. We noted policies and procedures were kept under review by on an annual basis and updates shared with staff to support the safe running of the service.

There were regular quality checks of clinical and administration work. The practice had an approach for identifying where quality or safety was being affected and addressing any issues. Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members.

The practice had dedicated leads and various policies to assist in the smooth running of the practice.

Leadership, openness and transparency

The overall leadership was provided by the principal dentist.

The ethos of the practice was clearly apparent as being able to provide the best service possible. Staff commented there was an 'open-door policy' and could discuss matters with other members in a transparent and mature manner.

Learning and improvement

Staff meetings took place every six weeks. We saw minutes of meetings from the last two months were typed up and reflected a range of subjects being discussed. In addition to these formal meetings, staff had a 'daily huddle' to discuss any urgent matters.

A regular audit cycle was apparent within the practice. An audit is an objective assessment of an activity designed to improve an individual or organisation's operations.

Clinical and non-clinical audits were carried out by various members of staff. Topics included staff and patient feedback, radiography, infection prevention and control and record keeping audits. We saw audits were carried out very thoroughly with results and action plans clearly detailed.

Improvement in staff performance was monitored by personal development plans and appraisals. These were carried out either on an annual or bi-annual basis. We looked at training files and found these were not consistent for all staff. The principal dentist could not confirm whether all staff had training in safeguarding, medical emergencies and radiography; there was no system to identify this. The principal dentist told us they would review this and implement a system of monitoring.

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

The practice had systems in place to seek and act upon feedback from staff members and people using the service.

Patients were encouraged to provide feedback on a regular basis either verbally, online and using the suggestion boxes in the waiting rooms. Patients were also encouraged to complete the practice surveys.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the practice manager.