Dr. Ibrar Saleem

Dr I Saleem and Colleagues

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Dr I Saleem and Colleagues dental practice is situated on a main road in the Longsight area of Manchester. The practice provides predominantly (99%) NHS and some private (1%) dental care and treatment to patients of all ages. There are two treatment rooms and the reception/ waiting area on the ground floor of the premises with a further two treatment rooms and a waiting area on the first floor. The dedicated decontamination room is located on the ground floor. The practice occupies a converted commercial premises and has street level access.

The registered provider is the registered person. 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.

We received 35 completed Care Quality Commission (CQC) comment cards and spoke with three patients during our inspection and all of the feedback was very positive. Patients' commented about the politeness and friendliness of the staff. The patients we spoke with told us the practice was always clean and tidy.

Our key findings were:

- The practice had appropriate equipment for staff to undertake their duties, and equipment was well

Summary of findings

maintained. The practice did not have access to an automated external defibrillator (AED). Following the inspection the practice manager confirmed they had ordered an AED.

- There were emergency medicines available for use in the event of a medical emergency. This was in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Governance arrangements were in place for the smooth running of the practice including a system of auditing the quality and safety of the service.
- Staff were aware of the requirements of the Mental Capacity Act (MCA) 2005 and their responsibilities under the Act as it relates to their role.
- There were effective safeguarding processes in place and staff understood their responsibilities to protect patients from harm.
- There were effective systems in place to reduce the risk and spread of infection. The premises were visibly clean and well maintained.
- Patients gave signed consent before treatment commenced. Patient treatment records were detailed and demonstrated on-going monitoring of patients' oral health.
- Staff were knowledgeable about patient confidentiality and we observed good interaction between staff and patients during the inspection.
- Patients were able to make routine and emergency appointments when needed.
- Patient's needs were assessed and care was planned and delivered in line with current best practice guidance for example from the National Institute for Health and Care Excellence.
- Staff were supported to maintain their continuing professional development (CPD) and had undertaken training appropriate to their roles.
- Patients told us they were treated with kindness and respect by staff.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure they follow their recruitment policy when recruiting and employing new staff.

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 for the decontamination of dental instruments, child protection and safeguarding patients who may be vulnerable and the management of medical emergencies.

The X-ray equipment was suitably sited and only used by trained staff. Local rules were displayed clearly where X-rays were carried out. Emergency medicines in use at the practice were stored safely and checked to ensure they were within their expiry dates.

There were systems in place to identify, investigate and learn from incidents relating to the safety of patients and staff members.

Staff were suitably trained and skilled to meet patients' needs and there were sufficient numbers of staff available at all times. Staff induction processes were in place and had been completed by new staff.

Are services effective?

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

Patients received a comprehensive assessment of their dental needs that included a review of their medical history. Dentists ensured that patients consented to treatment in line with legislation and guidance. Dentists were aware of the Department of Health - Delivering Better Oral Health Toolkit (DBOH) with regards to fluoride application and oral hygiene advice. The dentists provided patients with advice to improve and maintain good oral health.

Patients told us they received clear explanations about their planned treatment, costs, benefits and risks so they were able to make an informed decision.

Staff who were registered with the General Dental Council (GDC) were supported by the principal dentist and practice manager in continuing their professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

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

We looked at 35 CQC comment cards patients had completed prior to the inspection. Patients were positive about the care they received from the practice. We spoke with three patients during the inspection who told us they were satisfied with the dental care provided at the practice.

Are services responsive to people's needs?

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

Consultations were carried out in line with best practice guidance such as those from the National Institute for Health and Care Excellence (NICE).

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients.

There was an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots each day for patients experiencing dental pain which enabled them to receive treatment quickly.

Summary of findings

Are services well-led?

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

Staff reported that the principal dentist and practice manager were approachable. They felt supported in their roles and could raise issues or concerns. Staff demonstrated an awareness of the practice values and were proud of their work.

There was a range of clinical and non-clinical audits taking place. Risks to health and safety had been identified, which were monitored and reviewed regularly. The practice had evidence of open leadership and a culture of continuing improvement.

The practice used the NHS Family and Friends Test (FFT this is a survey to establish if patients would recommend the practice to friends and family) to get feedback about the quality of the service which they provided.

Dr I Saleem and Colleagues

Detailed findings

Background to this inspection

The inspection took place on 23 November 2015 and was conducted by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

We informed NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

On the day of the inspection we toured the premises, spoke with two dentists, three dental nurses, the decontamination lead and the practice manager. We reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of any complaints received in the last 12 months.

Information regarding the practice opening hours was available in the premises. The practice was open Monday to Thursday 9am until 5.30pm and Friday 9am until 2pm.

We reviewed 35 CQC comment cards completed by patients prior to the inspection and we spoke with three patients on the day of our inspection.

led find

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

There was an effective system in place for reporting and learning from incidents. Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no incidents reported in the past year. Staff were encouraged to raise safety issues to the attention of the principal dentist or practice manager.

The practice manager and principal dentist received national and local safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Information relevant to the practice was shared with all staff as and when they arrive or at practice meetings.

The principal dentist was aware of their responsibilities under the new Duty of Candour regulation (Duty of candour is a requirement on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity). They told us if there was an incident or accident that affected a patient, they would be given an apology and inform the patient of any actions taken to prevent a reoccurrence.

Reliable safety systems and processes (including safeguarding)

The practice had effective safeguarding policies and procedures in place and staff understood their responsibilities in relation to child protection and safeguarding adults living in vulnerable circumstances. These provided staff with guidance about identifying, reporting and referring suspected abuse. The policy and procedure was available to all staff and included the contact details for the local adult safeguarding and child protection teams.

The dentist told us that they routinely used a rubber dam to protect a patient's airway during root canal treatment. This is in accordance with guidance issued by the British Endodontic Society. A rubber dam is a small rectangular sheet of latex (or other similar material if a patient has a latex allergy) used to isolate the tooth operating field and prevent small instruments from being swallowed or inhaled.

Medical emergencies

The practice did not have access to an automated external defibrillator on its premises, in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). However the practice manager contacted us after the inspection to inform us they had ordered an AED.

The practice had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that all medicines were within their expiry date.

The oxygen cylinder was in date (expires December 2016) and was regularly checked to ensure the levels and flow rates were appropriate for use in the event of a medical emergency. The oxygen cylinder was last serviced in January 2015. Staff were trained to deal with medical emergencies and undertook regular practice sessions. The last training was undertaken in December 2014 with the next session planned for 9 December 2015.

Staff recruitment

The practice had a recruitment policy and procedure that outlined the pre-employment checks that were carried out before new staff were appointed to work in the practice. This included confirming professional registration details, proof of address, proof of identification, references and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice requested a DBS check for all clinical staff.

We did find some gaps in the recruitment files of long standing staff, for example, one of the files we looked at did not contain references. The practice manager said they would ensure they followed their recruitment policy and obtain all relevant documentation for any new staff employed.

Monitoring health & safety and responding to risks

A fire risk assessment had been undertaken in January 2015. Regular fire tests and drills were carried out to ensure

Are services safe?

staff were aware of the procedure to follow in the event of a fire. The fixed electrical appliances and portable electrical appliances had been tested by an external contractor within the last 12 months.

The practice manager maintained a Control of Substances Hazardous to Health (COSHH) file.

COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. This included information and risk assessments on all of the dental materials and substances used in the practice. In addition a COSHH file for the domestic cleaning products was maintained separately.

There was a business continuity plan for use in the event of an emergency such as a power failure, flooding or loss of the water system in the premises. The plan contained the contact details of tradesman and utility providers to contact in the event of an emergency including a local dentist who would take on patient care.

Infection control

Legionella risk assessment had been undertaken by an external contractor in June 2015 (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). In addition staff carried out daily, weekly and monthly tests on the water quality.

We saw that staff had attended infection control training in October 2015 and dedicated decontamination training in August 2015.

We observed the processes for the cleaning, sterilising and storage of dental instruments and reviewed the policies and procedures.

The practice was following the guidance on decontamination outlined in the Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05) and the Code of Practice on the prevention and control of infections and related guidance.

There was a dedicated decontamination room on the ground floor and a dedicated infection control lead responsible for all decontamination of instruments. The practice had developed a secure instrument transportation system to ensure used instruments were moved safely between treatment rooms and the decontamination room.

There were clearly defined dirty and clean zones in operation in the decontamination room to minimise the risk of cross contamination. Staff wore appropriate personal protective equipment (PPE) such as aprons, protective eye wear with a face visor and heavy duty gloves to reduce the risks of injury from sharp instruments. The decontamination lead explained the cleaning process to us. Instruments were scrubbed and rinsed prior to being placed in an autoclave (a high temperature sterilising machine). Instruments were cleaned using an illuminated magnifier to check for any debris or damage throughout the cleaning stages. Sterilised instruments were then pouched labelled with an expiry date in accordance with current guidelines and stored appropriately until required.

The practice conducted an infection control audit every six months in accordance with HTM 01-05 guidance.

There was a contract in place with a clinical waste contractor. Clinical waste was appropriately segregated and securely stored between collections.

The practice was using a safe sharps system where used needles were not re-sheathed after use (using safe sharps is a preventative measure to minimise the risk of injuries to healthcare staff caused by used needles or sharp instruments). Sharps disposal boxes were secured to the walls and were dated. These were collected for safe disposal by the clinical waste carrier.

Treatment rooms were visibly clean and clutter free. There were good stocks of personal protective equipment for both staff and patients such as gloves, safety glasses and disposable aprons.

Equipment and medicines

Maintenance contracts were in place for equipment, such as the air compressor, autoclave (A high temperature steriliser), ultrasonic cleaner, and X-ray equipment. We saw the equipment had all been checked for effectiveness and had been regularly serviced.

We reviewed the annual maintenance records and certificates. Records showed the service had had an efficient system in place to ensure all equipment in use was safe to use, and in good working order.

Portable appliance testing (PAT) took place on all electrical equipment in April 2015 (PAT is the name of a process where portable electrical appliances are routinely checked for safety). Fire safety systems such as fire extinguishers and

alarm were checked and serviced regularly by an external company. We looked at training records and saw fire marshals had been nominated and had received training in the use of equipment and evacuation procedures.

Prescription pads were individually numbered and securely stored to prevent misuse. There was a system of checking the expiry dates of medicines and oxygen cylinders. Emergency medicines and equipment were checked on a daily, weekly and monthly basis using a recording sheet that helped identify out-of-date drugs and equipment promptly.

Radiography (X-rays)

A radiation protection advisor (RPA) and a radiation protection supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. This was in accordance with Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical

Exposure Regulations 2000 (IRMER).The staff responsible for taking X-rays were listed in the radiology training register dated October 2015.

We reviewed the radiation protection file and saw records including a list of X-ray equipment, the maintenance history of X-ray equipment and the critical examination and acceptance test report. Local rules were displayed in the surgery and included in the radiation protection file.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The Patient's needs were assessed and care was planned and delivered in accordance with current best practice guidance for example, from the National Institute for Health and Care Excellence (NICE). NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

All new patients were asked to complete a medical history form which included any health conditions, medication or allergies. Dentists and dental nurses told us they asked about the patients' present medical condition before offering or undertaking any treatment. The patients we spoke with confirmed that their medical history was updated at each visit to ensure there were no changes.

The dentists we spoke with told us they discussed their diagnosis with the various treatment options with the patient. Dental care records were then updated with the proposed treatment. We saw the justification for taking an x-ray was recorded in line with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 and X-ray images were reviewed in the practice's programme of audits.

We reviewed a sample of six dental care records and saw evidence that an assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums).

Patients that required specialist treatments not provided at the practice such as conscious sedation or orthodontics were referred to other dental specialists. Once the treatment was completed patients were referred back to the practice for on-going monitoring and treatment.

Health promotion & prevention

We found staff were using the guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

The waiting rooms and reception area at the practice contained a range of health promotion leaflets these included information on maintaining good oral hygiene both for children and adults and the effects of diet and alcohol consumption on oral health.

Staffing

All the clinical staff had current registration with their professional body, the General Dental Council (GDC), had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration. We reviewed a sample of four staff training records and saw that staff were up to date with attending core training. This included areas such as responding to medical emergencies and infection prevention and control.

There was an induction programme for staff to follow which ensured they had the skills and competence to deliver safe and effective care and support to patients.

There was an effective and on-going appraisal system in place which was used to identify training and development needs. The most recent staff appraisals were undertaken between 5 October and 11 November 2015.

Staff we spoke with told us they were clear about their roles and responsibilities, had access to the practice policies and procedures, and were supported by the principal dentist and practice manager.

Working with other services

There was a system in place to refer patients for specialist treatments such as intravenous sedation, orthodontic specialists and where cancer was suspected in accordance with cancer referral guidelines. Where a referral was necessary, the type of treatment required was explained to the patient and they were given a choice of healthcare professional who was experienced in undertaking the type of treatment required. Once the specialist treatment was completed patients were referred back to the practice for on-going monitoring and review.

Consent to care and treatment

The dentists had developed the practice policy to ensure valid consent was obtained for all care and treatment. We

Are services effective?

(for example, treatment is effective)

reviewed a random sample of three dental care records. We found individual treatment options, risks, benefits and costs were documented. Patients told us they were given time to consider their options and make informed decisions about the treatment they wanted.

The staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005 and how this applied when considering whether or not a patient had the capacity to consent to dental 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.

The dentists we spoke with were also aware of and understood the use of Gillick competency in young persons (below the age of 16). Gillick competency test is used to help assess whether a child has the maturity to make their own decisions without the need for parental permission or knowledge and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 35 patients about their care and treatment. The feedback was consistently positive. Patients commented in CQC comment cards that they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The patients we spoke with commented positively on the caring and helpful attitude of staff. Patients also commented that staff were understanding and sensitive to their anxieties and needs.

Patients' dental care records were stored electronically and in paper form. Access to computers was password protected and systems were regularly backed up to secure storage with paper records stored in lockable metal filing cabinets. The staff we spoke with understood the need to handle patient information securely and had read and signed a confidentiality policy that was in place to support them.

Treatment room doors were closed to ensure that patients' privacy and dignity was maintained during examinations, investigations and treatments. Conversations taking place in these rooms could not be overheard in the reception or waiting areas.

Involvement in decisions about care and treatment

Patients' told us that they felt well informed and involved in decisions about their treatment and care. They said the information they were given was clear and anything they did not understand was always explained.

Information leaflets were available which provided guidance about a wide range of treatments and conditions such as gum disease and good oral hygiene.

Staff confirmed that treatment options, risks and benefits were discussed with each patient to ensure the patient understood what treatment was available so they were able to make an informed choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered NHS and a small amount of private treatment. The practice leaflet was available in reception and contained details about the costs of treatment available.

Appointment times and availability met the needs of patients. Patients with emergencies were seen within 24 hours of contacting the practice, sooner if possible. Patients were directed to contact the NHS emergency out of hours service when the practice was closed. The practice answering machine gave contact details of the out of hours service.

The practice had effective systems in place to ensure the equipment and materials needed such as crowns or dentures were in stock or received in advance of the patient's appointment.

Longer appointments were also made available for nervous patients to allow the dentist and nurse time to relax and reassure the patient.

Tackling inequity and promoting equality

The practice had an equality and diversity policy. Staff we spoke with were aware of these policies.

The practice was located in a converted commercial premises with level access to the front. There was enough space to accommodate a wheelchair in the reception and there were two treatment rooms on the ground floor. The principal dentist had made reasonable adjustments for patients who have restricted mobility in line with the Equality Act 2010. The practice did not have an adapted toilet and the principal dentist was considering how they could address this.

The practice was located in an area with a diverse cultural population. We asked staff how they communicated with people who spoke another language. We saw the practice leaflet was available in 14 different languages. They told us they would encourage a relative or friend to attend who could translate or if this was not possible they had access to a translation service.

Access to the service

Information regarding the practice opening hours was available in the premises. The practice was open Monday to Thursday 9am until 5.30pm and Friday 9am until 2pm. The practice had clear instructions for patients requiring urgent dental care when the practice was closed. CQC comment cards showed patients felt they had good access to routine and urgent dental care.

All of the patients we spoke with said the dentists advised them when their next appointment was due and they were able to book the next appointment before they left the practice. Patients told us the receptionist apologised if patients were kept waiting past their appointment time.

Concerns & complaints

The practice had a complaints policy and procedure in place for handling complaints which provided staff with guidance about how to support patients who may have wanted to complain. The policy also included the details of external organisations such as the General Dental Council (GDC) that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not fully investigated.

The practice manager told us that there had been no complaints made within the last 12 months. If the practice received a complaint they would record the detail, any investigation and what actions had been taken to resolve the issue.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place to ensure complaints or concerns were dealt with in a timely manner.

Are services well-led?

Our findings

Governance arrangements

There was a clear leadership structure and staff told us they felt supported by the principal dentist and practice manager. The staff we spoke with were aware of their roles and responsibilities within the practice.

There was a full range of policies and procedures in use at the practice to govern activity. All of the policies and procedures we saw had been reviewed and reflected current good practice guidance from sources such as the British Dental Association (BDA).These were accessible to staff in paper files. The practice had arrangements in place for monitoring and improving the service. Regular audits had been carried out in relation to infection control processes, X-ray quality, and record keeping quality. A Legionella risk assessment had been carried out by an external contractor.

There was a business continuity plan in place for use in the event of an emergency such as a failure of the electrical or water supplies or damage to the building or equipment. The principal dentist and practice manager held a copy of the plan off site. In the event of an emergency, patients would be seen at another practice in the area.

Leadership, openness and transparency

Staff told us that team meetings were held and topics such as audits, complaints and incidents were discussed. We saw from minutes of staff meetings that they were held every month. These were supplemented by informal meetings at the start of the day or during breaks.

There was a whistle blowing policy in place. All staff were aware of whom to raise any concerns with. Staff told us they would approach the principal dentist or practice manager and were confident they would be listened to and their concerns acted upon. All staff told us it was a nice practice to work in and they enjoyed coming to work.

The principal dentist was aware of their responsibilities under the Duty of Candour requirements. If there was an incident affecting a patient the principal dentist would be honest, offer an apology and inform them of the action taken to prevent a reoccurrence.

Learning and improvement

Registered dental professionals are required to complete a specific number of hours training in order to maintain their registration with the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours. The staff we spoke with told us they were supported by the principal dentist and practice manager to meet their professional standards.

The practice carried out infection prevention and control audits every six months to ensure compliance with the Department of Health guidance namely HTM 01-05 standards for decontamination in dental practices. The most recent audit was undertaken in July 2015. In addition an audit of radiographs was carried out to check the quality of X-rays and compliance with the Faculty of General Dental Practice (FGDP) regarding justification for taking X-rays.

We saw that the principal dentist reviewed their practice and introduced changes to practice through their learning and peer review.

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

The practice participated in the NHS Friends and Family test (The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients were happy with the service provided or where improvements were needed). This data was submitted and reviewed to identify any areas for improvement. The results from the last two months were very positive with all patients stating they were likely or extremely likely to recommend the practice to friends and family.

Regular team meetings were held with brief minutes taken. The staff we spoke with told us they had daily catch up where any important information was shared. The practice gathered and responded to feedback from patients through patient discussions and comments left by patients on the NHS Choices website.