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Brighton Smile Clinic

Inspection Report

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Overall summary

Brighton Smile Clinic is a general dental practice in Brighton offering both NHS and private dental treatment. The practice treats adults and children.

The premises consists of a waiting area adjacent to the reception area and one treatment room. There is also a separate decontamination area.

The staff structure of the practice consists of the provider (who works part time at the practice), an associate dentist and two dental nurses. The practice sometimes receives support from an 'interim' practice manager who is based at the provider's sister practice in Brighton.

We spoke with one patient on the day of our inspection and reviewed 21 comment cards that had been completed by patients which reflected very positive views about the care and treatment they had received. Patients felt the dentists (in particular the associate dentist who treated most of the patients seen at the practice) took a lot of time to explain care and treatment options in a way they understood. Common themes were patients felt they received excellent care in a calm and clean environment by friendly and caring staff.

Our key findings were:

We found that this practice was providing safe, effective, caring and responsive care in accordance with the relevant regulations. However we found that this practice was not providing well-led care in accordance with the relevant regulations.

- The practice provided care and treatment in a clean, hygienic, calm and welcoming environment.
- The practice had systems to assess and manage risks to patients for infection prevention and control and the management of medical emergencies.
- Patients told us through comment cards they were treated with kindness and respect by staff. The practice ensured there was always enough time to explain fully the care and treatment they were providing in a way patients understood.
- Patients were able to make routine and emergency appointments when needed. There were clear instructions for patients regarding out of hours care.
- Records we reviewed showed dentists did not always record oral health assessments and planned treatment.
- There were not clearly defined leadership roles within the practice. Although staff told us they felt able to raise concerns or make suggestions. It was unclear who these should be directed to or who was responsible for the day to day running of the practice.

We identified regulations that were not being met and the provider must:

- Establish and implement a process to regularly identify, assess and manage risks to the health, welfare and safety of patients, staff and visitors to the practice.

Summary of findings

- Assess, monitor and improve the quality and safety of the services provided.
- Ensure a full and accurate clinical record is kept in respect of each patient's care and treatment.

You can see full details of the regulations not being met at the end of this report

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

- Ensure the infection control policy is updated with current guidance.
- Ensure all staff are familiar with the Mental Capacity Act 2005 and its relevance to dental practice.
- Establish a process to record and monitor decisions made at staff meetings and during informal discussions about how the service could be improved.
- Ensure all staff are familiar with their responsibilities under the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).
- Ensure the practice always follows the provider's recruitment and selection procedures when employing new staff members.
- Consider the guidance issued in the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients.
- Undertake an assessment of the practice compliance with the requirements of the Disability Discrimination Act 2005.
- Ensure there are clear and established lines of accountability and responsibility in the practice.

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 effective systems in place in the areas of infection control, clinical waste management, management of medical emergencies and dental radiography. We also found the equipment used in the dental practice was well maintained and in safe working order. There was a good staff skill mix across the whole practice for the provision of care and treatment. However, there were limited systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The staff were not always up-to-date with current guidance but received professional development appropriate to their role and learning needs. Staff, who were registered with the General Dental Council (GDC), had frequent continuing 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.

Patients told us (through comment cards) they had very positive experiences of dental care provided at the practice. Patients felt well supported and involved with the discussion of their treatment options which included risks and benefits. Staff displayed compassion, kindness and respect at all times. Staff spoke with enthusiasm about their work and told us they were proud of what they did.

Are services responsive to people's needs?

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

The practice provided friendly, personalised dental care. Patients could access treatment and urgent and emergency care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

There were not clear lines of accountability and responsibility within the practice. Staff felt somewhat supported in their roles and could raise any issues or concerns but were unclear at times who they should refer to. The culture within the practice was seen as open and transparent. All staff told us they enjoyed working at the practice and would recommend to a family member or friends.

Overall we found the practice did not have effective clinical governance and risk management structures in place.

Brighton Smile Clinic

Detailed findings

Background to this inspection

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

The inspection was carried out on 6 May 2015 by an inspector and a dental specialist advisor. We reviewed information received from the provider prior to the inspection. On the day of our inspection we looked at practice policies and protocols, ten clinical patient records

and other records relating to the management of the service. We spoke to the interim practice manager, the associate dentist, two dental nurses and one patient. We reviewed 21 comments cards completed by patients.

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?

This informed our view of the care provided and the management of the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood the process for accident and incident reporting however, there was limited evidence staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We reviewed the accident book and although we saw a small number of accidents had been recorded, there was limited evidence to demonstrate that any learning from accidents occurred or any improvement actions were taken. For example, we saw a recent accident had occurred when a patient had banged their leg on the table in the waiting room. Although the practice had identified improvements they could make to mitigate any risk of injury, no further action had been taken. The interim practice manager agreed this should have been actioned and resolved to address this.

Reliable safety systems and processes (including safeguarding) We looked at the documentation around safeguarding and abuse. The practice had policies and procedures in place for child protection and safeguarding people using the service which included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. All staff had completed recent safeguarding training and demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

All staff demonstrated a knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments). Information available for staff detailed the actions they should take if an injury from using sharp instruments had occurred. The practice had adopted the use of safety syringes in accordance with guidance to minimise the risk of inoculation injuries to staff members.

Staff we spoke with told us dentists did not routinely use 'rubber dam' when providing root canal treatment to patients. Rubber dam is a small rectangular sheet of latex (or other material if patient latex sensitive) used to isolate

the tooth operating field to increase efficacy of treatment. The dentist we spoke with told us patients sometimes chose not to have rubber dam and agreed this should be recorded in the patient's clinical record.

Medical emergencies

The practice had suitable emergency resuscitation equipment and medicines in accordance with guidance issued by the Resuscitation Council UK and the British National Formulary (BNF). This included face masks for both adults and children. The practice kept and maintained oxygen, medicines for use in an emergency and an automatic external defibrillator (AED) which ensured patients could be provided with appropriate support in a timely manner. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Records completed showed regular checks were done to ensure the equipment and emergency medicine was safe to use.

Staff had recently completed training in emergency resuscitation and basic life support including the use of the AED. Staff we spoke with demonstrated they knew how to respond if a patient suddenly became unwell. Staff told us this training was undertaken at the provider's sister practice and resolved to practice emergency scenarios at Brighton Smile Clinic to ensure they could respond appropriately in a timely manner.

Staff recruitment

There were effective recruitment and selection procedures in place; however, these were not always followed in all cases. We reviewed the employment files for three staff members. Two files contained evidence that satisfied the requirements of current regulations. This included application forms, employment history and evidence of qualifications. The qualification, skills and experience of each employee had been fully considered as part of the recruitment process.

We found these details had not been requested for a staff member who had recently started working at the practice and who was previously known to the provider. The interim practice manager agreed that a documented assessment of the person's qualifications, skills and experience should be recorded in line with the practice recruitment policy and in order to demonstrate a robust recruitment process. They resolved to address this for the new staff member.

Are services safe?

Appropriate checks had been made before staff commenced employment including evidence of professional registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service had been carried out.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for risk of fire. Fire extinguishers had been recently serviced and staff were able to demonstrate to us they knew how to respond in the event of a fire.

We reviewed a document which indicated the practice had carried out an assessment of risks to the health, safety and welfare of patients, staff and visitors to the premises. We saw the document was a generic risk assessment which had been downloaded from the British Dental Association website and although the practice had dated the document to indicate the risk assessment had been completed in March 2013, there was no evidence to show this was being implemented. Therefore we could not confirm whether or not there was an effective risk management system in place.

We noted the rear fire escape (also the exit leading to the secure clinical waste storage facility) was hazardous in that the handrail used to support people descending the steep stairs was missing. We discussed this with the interim practice manager who told us this had been removed in the last week and the maintenance person was returning the following week to fix this. We received assurances that preventive actions would be taken in the interim period to minimise the risks to people's health and safety.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. The practice maintained a COSHH file in order to manage risks (to patients, staff and visitors) associated with substances hazardous to health.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments and hand hygiene.

We found the practice had followed the guidance on decontamination and infection control issued by the

Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. The practice policy and procedures on infection prevention and control were accessible to staff. However; we found the policy had not been recently updated nor did it always give clear guidance for staff to follow. For example, although staff were aware of and implementing the most recent changes in the HTM 01-05 2013 guidance, the practice policy still referred to pre 2013 guidance.

We examined the facilities for cleaning and decontaminating dental instruments. We found there was a clear flow from 'dirty' to 'clean.' A dental nurse with responsibilities for the decontamination of instruments explained to us how instruments were decontaminated and sterilised. They wore eye protection, an apron, heavy duty gloves and a mask while instruments were decontaminated prior to being placed in an autoclave (sterilising machine).

We noted that dental nurses we spoke with gave differing accounts of the manual cleaning of instruments process in that one dental nurse used washing-up liquid and another used a detergent designated for the manual cleaning of instruments. Both had been supplied by the provider and this had caused confusion as to the correct detergent to use. The provider's policy for manual cleaning simply stated that 'detergent' should be used but did not indicate what type. HTM01-05 guidance states that 'washing up-liquid should not be used.' We discussed this with the practice team who agreed the correct detergent would be used and the policy changed to reflect this.

We found the practice infection control policy stated the temperature of the water used for manual cleaning should not exceed 45 degrees however there was no thermometer available to monitor this.

Instruments were inspected to check for any debris or damage throughout the cleaning stages using an illuminated magnifier in line with essential quality standards.

An autoclave was used to ensure instruments were decontaminated ready for the next use. We saw instruments were placed in pouches after sterilisation and dated to indicate when they should be reprocessed if left unused. We found daily, weekly and monthly tests were performed to check the steriliser was working efficiently

Are services safe?

and a log was kept of the results. We saw evidence the parameters (temperature and pressure) were regularly checked to ensure equipment was working efficiently in between service checks.

In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination area which minimised the risk of infection spread.

The practice had an on-going contract with a clinical waste contractor. We found the practice managed clinical waste and the safe disposal of sharps appropriately. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of. This was in line with the recommended guidance.

We looked at the treatment room where patients were examined and treated. The room and equipment appeared uncluttered and clean.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near to the sink to ensure effective decontamination. Patients were given a protective bib and safety glasses to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spreading.

The practice identified the risks of Legionella bacteria developing in water systems within the premises and had

taken preventive measures to minimise the risk to patients and staff of developing Legionnaires' disease. (Legionella is a term for particular bacteria which can contaminate water systems in buildings.)

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the suction compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment. We were shown the annual servicing certificates. The records showed the service had had an efficient system in place to ensure all equipment in use was safe, and in good working order.

A recording system was in place for the prescribing, stock control and dispensing of the medicines used in clinical practice. The systems we viewed provided an account of medicines prescribed, and demonstrated patients were given their medicines when required. However, we found the batch numbers and expiry dates for local anaesthetics were not always recorded in the clinical patient records we reviewed.

Radiography (X-rays)

We checked the provider's radiation protection file as X-rays were taken and developed at the practice. We also looked at X-ray equipment in use at the practice and talked with staff about its use. We found there were suitable arrangements in place to ensure the safety of the equipment and we saw local rules relating to the X-ray machine was displayed in accordance with guidance.

We found procedures and equipment had been assessed by an independent expert within the recommended timescales. The practice had a radiation protection advisor and appointed a radiation protection supervisor.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for people using best practice

The associate dentist told us they regularly assessed each patient's gum health and took X-rays at appropriate intervals although they were unaware of guidance issued by the Faculty of General Dental Practice (FGDP) relating to selection criteria for dental radiography. We reviewed a total of ten clinical records for patients that had received care and treatment from the provider and/or the associated dentist. The records demonstrated dentists did not always record an examination of a patient's soft tissues (including lips, tongue and palate) or their use of alcohol and tobacco. The dentist we spoke with told us they always carried out these checks and staff we spoke with confirmed this. These measures demonstrated to us a risk assessment process for oral disease was carried out.

We found the justification, findings and quality assurance of X-ray images taken was not always recorded. We discussed this with the practice team who agreed this information should be included to ensure a full record is kept.

The practice kept up to date with current guidelines and research when considering care and treatment options for patients. The associate dentist considered National Institute for Health and Care Excellence (NICE) guidelines in relation to wisdom teeth removal and in deciding when to recall patients for examination and review.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy however, staff we spoke with demonstrated a limited application of guidance issued in the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients.

The interim practice manager (who was also a dental nurse) had undertaken a course in the application of topical fluoride as part of an overall dental public health prevention programme.

Staff we spoke with confirmed dentists routinely gave appropriate dietary and smoking cessation advice but did not always record this.

Staffing

There was an induction programme for new staff to follow to ensure they had the necessary knowledge and competence to effectively support the provision of care and treatment to patients. New staff members shadowed more experienced staff members to gain knowledge and experience of how to support patients. Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going continuous professional development. Mandatory training included basic life support and infection prevention and control. Records showed staff had completed this within the last year.

One dental nurse employed at the practice had been awarded a Certificate in Oral Health Education from the National Examining Board for Dental Nurses (NEBDN) and the provider had supported the interim practice manager to undertake a practice management course.

There was an effective appraisal system in place which was used to identify training needs. Staff told us they had found this to be a useful and worthwhile process.

Working with other services

The practice had a system in place for referring patients for dental treatment and specialist procedures to other colleagues where appropriate. The associate dentist told us the practice involved other professionals and specialists in the care and treatment of patients where it was in the patient's best interest. We found the practice monitored their referral process to ensure patients had access to treatment they needed within a reasonable amount of time.

Consent to care and treatment

The dentists we spoke with explained to us how valid consent was obtained for all care and treatment. We reviewed a random sample of ten clinical patient records. The records showed and staff confirmed individual treatment options, risks, benefits and costs were discussed

Are services effective?

(for example, treatment is effective)

with each patient and documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they wanted. This was reflected in comment cards completed by patients.

The practice asked patients to sign consent forms for some dental procedures to indicate they understood the treatment and risks involved.

The practice demonstrated a limited understanding of how the Mental Capacity Act 2005 applied in considering whether or not patients had the capacity to consent to dental treatment. Most staff members had not undertaken any relevant training. However, staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice manager and staff explained to us how they ensured information about patients was kept confidential. Patients' clinical records were stored securely. Staff members demonstrated to us their knowledge of data protection and how to maintain confidentiality. They told us security of information was a top priority for the practice. Staff told us patients were able to have confidential discussions about their care and treatment in the treatment room.

Patients told us through comment cards of their very positive experiences of the care and treatment at the practice. Common themes were they felt they received excellent care in a calm environment from practice staff who were very friendly and caring.

Three comment cards reflected the associate dentist and dental nurse had been very mindful of the patients' anxieties when providing care and treatment. They indicated the practice team had been very respectful and responsive to their anxiety which had meant they were no longer afraid of attending for dental care and treatment.

Involvement in decisions about care and treatment

The dentist told us they used a number of different methods including tooth models, display charts, pictures and leaflets to demonstrate what different treatment options involved so that patients fully understood.

These were used to supplement a treatment plan which was developed following examination of and discussion with the patient. Seven patients told us in comment cards that their dentist had taken time to listen to their concerns, answer any questions and fully explain treatment options in a way they understood.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff reported (and we saw from the appointment book) the practice scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel rushed or under pressure to complete procedures and always had enough time available to prepare for each patient.

The practice had effective systems in place to ensure the equipment and materials needed were in stock or received in advance of the patient's appointment. This included checks for laboratory work such as crowns and dentures so that delays in treatment were avoided.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from many different backgrounds, cultures and religions. They would encourage a relative or friend to attend who could translate or if not they would contact an interpreter through a local translation service.

The practice had several steps leading to the front door which made access unsuitable for patients with limited mobility. The practice offered access for people using wheelchairs or those with limited mobility at the provider's sister practice in Brighton.

Although the practice had made some consideration for patients who may have a disability to access the service, we

found the provider had not completed an audit to assess compliance with the requirements of the Disability Discrimination Act 2005. We discussed this with the practice team who agreed this would be a useful process to ensure patients' needs could be fully considered and identify any improvement actions needed.

Access to the service

We asked the receptionists how patients were able to access care in an emergency or outside of normal opening hours. They told us an answer phone message detailed how to access out of hours emergency treatment. We saw the practice information leaflet also included this information. Each day the practice was open, emergency treatment slots were made available for people with urgent dental needs.

Concerns & complaints

There was a complaints policy which provided staff with detailed information about all aspects of handling complaints and compliments from patients.

Information for patients about how to make a complaint was displayed and available in the practice waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

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 which ensured a timely response.

Are services well-led?

Our findings

Governance arrangements

Staff members told us it was difficult to know who to report things to sometimes as there were no clear lines of accountability. Staff told us there had been a practice manager in place around two to three years ago who was not replaced when they left. The day to day practice management issues were dealt with by the interim practice manager (who worked mainly at the provider's sister practice), the associate dentist and the provider (who also worked mainly at the sister practice). Although the associate dentist had agreed to oversee some management roles, they told us it had been difficult to implement and monitor appropriate clinical governance and risk management systems and processes whilst they were providing care and treatment for patients.

Appropriate records relating to the management of the practice were maintained. The practice ensured the information they held was kept secure.

Leadership, openness and transparency

The leadership of the practice encouraged candour and honesty. Staff reported there was an open culture at the practice and they felt valued although not always effectively supported by the practice management team. Staff felt they could raise issues without fear of discrimination. However, staff told us they were sometimes unsure who to approach as they did not always know who was managing the practice. Staff told us they worked well together as a team and it was a nice environment to work in.

Management lead through learning and improvement

The interim practice manager told us the provider's sister practice had achieved Denplan Excel accreditation (this is mark of quality which demonstrates a dental practice's continued commitment to quality improvement). It did not

appear that any learning and development achieved by the sister practice had been shared with Brighton Smile Clinic in order to identify any areas for improvement. For example the practice did not carry out any audits other than for infection prevention and control and radiography. The practice did not regularly assess and monitor the quality of service provided in order to learn and improve.

There had been audits of infection prevention and control to ensure compliance with government HTM 01-05 standards for decontamination in dental practices. The most recent audit indicated the facilities and management of decontamination and infection control were managed well. However, we noted some of the responses did not correspond with what we found during our inspection. For example, the audit indicated the water for manual cleaning of instruments was kept below 45 degrees. However, we observed (and staff confirmed) there was no thermometer available to monitor this.

The practice had completed an audit to assess the quality of X-ray images. This showed X-rays taken were an acceptable standard therefore minimising the risk of further (and unnecessary) X-ray exposure to patients.

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

Staff told us the practice conducted regular staff meetings although we saw no formal documented records to support this. Staff members told us they found these were a useful opportunity to share ideas and experiences which were listened to and sometimes acted upon.

The practice had carried out a patient satisfaction survey (23 respondents) during January to March 2015 which showed 100 per cent of patients were satisfied with the treatment they had received although five people reported they had not been seen on time. The practice had analysed the results and identified actions needed in order to improve the service.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The practice did not have effective systems in place to;</p> <p>Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.</p> <p>Assess, monitor and improve the quality and safety of the services provided.</p> <p>Ensure accurate and contemporaneous clinical patient records are always maintained.</p> <p>Regulation 17 (1)(2)(b)(c)(f)</p>