Mr. Andrew Cuyes

Queen Street Dental Practice

Inspection Report

Queen Street Dental Practice
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Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

We carried out an announced comprehensive inspection on 1 September 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 not 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.

Queen Street Dental Practice provides NHS dental treatment and care for patients in and around the Great

Summary of findings

Harwood area of Blackburn. The practice has one full time dentist and three dental nurses who also cover reception. In the 12 months leading to this inspection the practice had treated 2700 patients.

Mr Andrew Cuyes is the sole dentist at this practice and is the registered person. The dentist is supported by three registered dental nurses who also share reception duties. 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 is situated on the high street in a converted commercial property. There is a reception and waiting area, a treatment room and a dedicated decontamination room on the ground floor and a toilet and staff room/kitchen on the first floor. The practice is generally open from 9.00 am to 5:00 pm Monday to Friday.

Seven patients provided feedback about the service. The feedback from patients was overwhelmingly positive about the treatment and care they received at the practice. Patients were complementary about the staff and told us they were respectful, compassionate and kind.

Our key findings were:

- There were safeguarding processes in place and staff understood their responsibilities to protect patients from harm.
- There were maintenance contracts in place to ensure all equipment had been serviced regularly, including, autoclave, fire extinguishers, the suction compressor, oxygen cylinder and X-ray equipment.
- Patients were provided with information and guidance relating to good oral health.
- Staff were supported to maintain their continuing professional development (CPD) and had undertaken training appropriate to their roles.
- The patients we spoke with and all comment cards we reviewed indicated staff were respectful and treated patients with kindness.
- Patients told us they had good access to the practice with emergency appointments available the same day.

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

- Ensure there are robust procedures in place for assessing the risk of, and preventing, detecting and controlling the spread of, infections in accordance with the Health Technical Memorandum 01-05 (HTM01-05) guidance.
- Ensure there are protocols in place to protect patient safety during root canal treatments where a rubber dam is not used.

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

- Provide patients with a written treatment plan that includes the proposed treatment and the estimated cost. The plan should be provided before treatment begins and a copy should be retained in their dental care records. You should also ask patients to sign the treatment plan.
- Review the practice's selection criteria for dental radiography for patients with high risk of periodontal disease giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 and the Faculty of General Dental Practice – good practice guidelines.
- Where verbal consent to treatment is given a clear record of the conversation should be written in the patients' dental care records.
- The results of extra oral examinations should be recorded in dental care records.

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 not providing safe care in accordance with the relevant regulations.

The systems in place to monitor infection control, clinical waste management, maintenance

of equipment used at the practice and the management of medical emergencies were not robust enough.

Relevant recruitment checks had been carried out to ensure staff had the appropriate skills and qualifications to carry out their role.

X-rays were not always taken in accordance with the Faculty of General Dental Practice (FGDP) Good Practice Guidelines.

Are services effective?

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

Staff maintained their continuing professional development (CPD) in order to meet the requirements of their professional registration with the General Dental Council (GDC).

Consultations and dental recall intervals were carried out in line with current National Institute for Health and Care Excellence (NICE) guidance.

Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation.

Are services caring?

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

We received feedback from seven patients all of whom felt they were treated with respect and consideration. Patients told us they were involved in decisions about their treatment options and the treatment was explained to them.

Patients spoken with on the day of our inspection told us that all of the staff were very helpful and friendly. We saw a number of thank you cards received in relation to care and treatment staff had provided.

We saw that privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Are services responsive to people's needs?

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

Patients were provided with emergency contact numbers via the telephone answering machine to enable them to access care and treatment when the practice was closed. The appointments system was effective and patients told us they were usually able to get an appointment at a time that suited them.

We saw that emergency appointments were scheduled in for each day. Two of the patients we spoke with were attending for an emergency appointment.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

The staff we spoke with told us they enjoyed working at the practice and would be happy to

Summary of findings

discuss any issues with dentist who was very approachable. We saw evidence in the minutes of staff meetings that the dentist shared learning from patient feedback and complaints with staff.

There were a system of quality audits in place such as; infection control, emergency medicines and dental care records. We looked at a sample of dental care records and found the auditing system had not identified inconsistencies in record keeping such as; consent and treatment planning.

Queen Street Dental Practice

Detailed findings

Background to this inspection

This inspection was carried out on 1 September 2015. The inspection was led by a CQC inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider including any notifications. During the inspection we were given a tour of the premises and spoke with the dentist and the dental nurses. In order to assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

The practice provided a statement of purpose, staffing levels and a summary of complaints or compliments they had received in the last 12 months.

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

We received feedback from seven patients and we spoke with all of the staff on duty. We looked at the practice policies and procedures and maintenance contracts to ensure the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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

The practice had an open and transparent way of working and staff were encouraged to raise concerns to the dentist. If there was an accident or incident that affected a patient they would be given an apology and informed of any actions taken to prevent a reoccurrence. We saw evidence that incidents were documented, investigated and reflected on by the practice. For example we looked at the incident/accident report logs and saw that two separate records of incidents where dental nurses had splashed cleaning solution into their eyes had been recorded. There was a reminder for all staff to use eye protection when decontaminating instruments.

The dentist and dental nurses were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). There was reference to this in the practice health and safety policy.

Staff told us there was good communication systems within the practice and any learning from incidents or changes in guidelines were made available to them.

Reliable safety systems and processes (including safeguarding)

The practice had both adult and children safeguarding policies in place to guide staff that had been reviewed in August 2015. The staff we spoke with were able to accurately describe the safeguarding processes in place for children and adults who may be vulnerable and gave examples of what may constitute a safeguarding concern. We saw minutes of staff meetings where safeguarding had been a topic for discussion. There had been no incidents that needed a referral to the local safeguarding teams.

Staff working at the practice were aware of whistleblowing procedures and which external agencies to contact if there was a concern.

There were systems in place to help ensure the safety of staff and patients including policies and procedures on; infection control, and health and safety and the Control of Substances Hazardous to Health 2002 (COSHH) regulations.

The dentist told us they had used rubber dams but found them difficult to fit. 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. This prevents contamination, inhalation and ingestion of instruments and prevents irrigating solutions escaping into the oral cavity. However we found there was no risk assessment in place when not using a rubber dam and no protocol about the measures taken to ensure patient safety, for example by securing the instruments. The rationale for not using a rubber dam should be noted in the patients dental care records. This was a breach of Regulation **12(2) (a) (b) (e)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medical emergencies

There were policies and procedures in place to guide staff in the event of a medical emergency. The practice followed guidelines about how to manage emergency medicines in dental practice in accordance with the British National Formulary (BNF a pharmaceutical reference book that gives information and advice on Medicines).

The practice had an automatic external defibrillator (AED) on site and we saw documentary evidence to show staff had received training in cardiopulmonary resuscitation (CPR) and were able to respond to a medical emergency.

Staff knew where to locate emergency medicines and oxygen cylinders and these were readily available. Emergency medicines were safely stored and stocks checked regularly to ensure medicines were within the expiry date and safe to use. Oxygen cylinders were tested and checked on a regular basis to ensure the levels and flow rate were sufficient for use in the event of a medical emergency.

Staff recruitment

There was a practice recruitment policy in place that set out the standards to be followed when recruiting new staff. All staff had a Disclosure and Barring Service (DBS) check in place to ensure they were not barred from working in the health and social care sector.

We saw recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and proof of registration with the appropriate professional body.

Are services safe?

We spoke with the most recently appointed member of staff who told us they started at the practice as an apprentice and had recently qualified. They told us there was an induction process and they had been supported by colleagues.

Monitoring health & safety and responding to risks

There was an infection control policy that provided guidance to staff on; decontamination of dental instruments, blood-borne viruses, sharps injuries, good hand hygiene and the segregation and disposal of clinical waste. The practice had a service contract with a clinical waste collection contractor. There were protocols for the management of clinical waste and sharp instruments.

There was a fire risk assessment in place and there were service contracts in place to test and maintain fire extinguishers. Staff were able to demonstrate how they would respond in the event of a fire.

The practice had a business continuity plan in place to deal with any emergencies that may disrupt the safe and smooth running of the service such as a failure in the water or electricity supplies.

We saw maintenance records to demonstrate the autoclave (a high temperature high pressure vessel used for sterilisation) was regularly checked and maintained to ensure it was fit for use. The autoclave had a digital printout which produced a report to indicate whether the required temperature had been reached for sterilisation.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. These included hand hygiene, health and safety, safe handling of instruments, managing clinical waste and decontamination guidance.

Adequate supplies of liquid soaps and hand towels were available throughout the practice. Posters demonstrating good hand washing techniques were displayed in the treatment room decontamination room and the toilet.

The practice had an up to date risk assessment in place relating to Legionella (a bacteria which can contaminate water systems in buildings). A legionella risk assessment was carried out in March 2015. There was documentary evidence to show that in order to prevent the growth and spread of Legionella bacteria the dental unit water lines were flushed for two minutes at the start of the day and after each patient.

We saw evidence that staff were immunised against Hepatitis B (a blood borne virus that can be transmitted through blood and saliva) to ensure the safety of patients and staff.

There was a policy and procedure for dealing with inoculation /sharps injuries. Sharps bins were properly located, signed, dated and not overfilled. There was a contract in place for the safe disposal of clinical waste and sharps instruments. Clinical waste was safely stored between collections.

The practice had a dedicated decontamination room adjacent to the treatment room. There was an obvious flow from dirty to clean areas to minimise the risks of cross contamination. Staff gave a demonstration of the decontamination process which was in line with health Technical Memorandum 01-05 (HTM 01-05) published guidance.

Contaminated instruments were transferred in a closed container from the treatment room to the decontamination room. Instruments were placed into an ultrasonic bath and then into a washer disinfector. Once the cleaning process was complete the instruments were checked under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required). Clean instruments were then sterilised in the autoclave after which they were placed in a sealed pouch and dated with an expiry date. Dental hand pieces were sprayed, scrubbed and rinsed then examined and sterilised.

Personal protective equipment such as; glasses to protect the eyes from splashes, heavy duty gloves and aprons were provided. We observed the decontamination process and saw eye protection was not worn by the dental nurse, this was despite two previous incidents involving eye splashes being recorded in the accident book. This shows that the staff at the practice had not learned from these incidents.

We found the work surfaces in the treatment room were cluttered. There were several plastic cups of undiluted mouthwash prepared for patient use that were stored uncovered on top of a unit. There were uncovered cotton wool buds close to the treatment area with the risk of contamination from splatter during treatments. We also

Are services safe?

found dental cement on the inside of cupboard door handles and traces of dental cement on instruments after sterilisation. We showed the dentist what we had found and they acknowledged our findings and told us they would speak with staff and carry out more detailed checks.

The dental nurses were responsible for cleaning and this was carried out when the practice was closed. We saw a cleaning schedule that showed completion of weekly and daily tasks however this had not identified the contaminated door handles in the treatment room.

The registered person had not ensured that people who use services and staff were protected by the practice infection prevention and control measures. This was in breach of Regulation **12(2)(h)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Equipment and medicines

Medicines for use in the event of a medical emergency were stored and disposed of in line with published guidance. We looked at the emergency medicines and found they were in date and safe to use.

We saw documentary evidence to demonstrate equipment was serviced on a regular basis. There were service records for the stair lift, autoclaves and air compressor. Equipment was maintained in accordance with manufacturers' guidance.

We found that portable appliance testing (PAT the processes for checking electrical appliances are routinely safe to use) was completed in accordance with good practice guidance.

Radiography (X-rays)

The practice worked in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). There was a radiation protection file which was well maintained. The dentist was named as radiation protection supervisor (RPS) and there was a named external radiation protection adviser (RPA). We saw regular audits of the quality of X-ray images had been undertaken and these showed ongoing improvements in quality.

We looked at a sample of 15 dental care records and saw in five patient's records X-rays were not taken in accordance with recognised guidelines. We found that X-rays were not always fully reported in dental care records. For example; we saw one patients' dental care records mentioned 'bone damage' but there was no additional information about the possible cause, where the damage was or the treatment offered.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients were asked to provide information about their medical history when they registered and asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken.

We found a basic periodontal examination was consistently carried out (BPE a screening tool which is used to assess the periodontal condition and treatment needs of an individual). Justification for the taking of an X-ray was generally recorded in the patient's dental care record. X-rays were audited and graded.

Staff understood their responsibilities around information sharing, record management, the Mental Capacity Act 2005 and consent to care and treatment. The dentist told us that treatment options were discussed with patients and verbal consent was gained prior to treatment commencing. However, we did not see any records of these conversations within the dental care records we reviewed. The patients we spoke with confirmed that they understood their treatment options and had consented to treatment.

We looked at the minutes of regular clinical team meetings and found best practice was discussed and protocols were produced and updated as required.

Health promotion & prevention

There was evidence to show advice on maintaining good oral health such as smoking cessation and the risks of high sugar diets was discussed with patients in accordance with the Department of Health – Delivering Better Oral Health(an evidence based toolkit used by dental teams for the

prevention of dental disease in a primary and secondary care setting).

There were various health promotion leaflets in the waiting area some of which were multilingual. These included information about good oral hygiene.

The frequency of patient recall followed the National Institute for Health and Care Excellence (NICE).

Staffing

There was a dentist who was the owner/provider supported by three dental nurses who also covered reception duties. We looked at the training records for three of the clinical staff and found that they were appropriately trained and registered with the General Dental Council (GDC). Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. This included essential training such as; health and safety, safeguarding, medical emergencies, cardiopulmonary resuscitation (CPR) and infection control.

All of the dental nurses at the practice had an appraisal booked for September 2015. The staff we spoke with felt supported by the dentist and had been given time to prepare for their appraisal. There was no system of formal supervision but dental nurses worked alongside the dentist on a daily basis and felt they were well supported.

Working with other services

There was evidence to show the practice worked with other professionals in the care of their patients. We saw referrals were made to hospitals and specialist dental services for further investigations or specialist treatment.

Where a patient required specialist treatment the practice completed referral forms to ensure others service had all the relevant information required to deliver treatment.

Consent to care and treatment

There was a consent policy to guide staff on the types of consent which could be obtained; including implied, written and verbal. The staff we spoke with had a good understanding of consent and that this could be withdrawn at any time.

Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and told us they would seek advice from other professionals where they believed a patient did not have capacity to give informed consent.

The dentist told us consent to treatment was usually given verbally and this was not routinely recorded in dental care records. A conversation where a patient gives verbal consent should be properly documented in the patient's dental care records. This should include the explanation of the treatment, whether the patient understood what the treatment involved and the patient's agreement to the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff treating patients with respect, dignity and maintained their privacy. We observed staff on reception speaking with patients on the telephone and found they were polite and professional with patients.

The reception area was adjacent to the waiting room and had two access points for patients. Sliding glass doors on the waiting room side of reception were closed to provide privacy for patients booking in at the entrance. The computer screen was positioned so that it could not be seen from either access points ensuring confidentiality.

The practice had a data protection and confidentiality policy in place of which staff were aware. The policy included; disclosure of patient information and the secure handling of patient information. Patients' dental care records were held in paper format and were securely stored in a locked cabinet.

Feedback from patients was very positive about the care and treatment provided. They gave examples of care being provided with compassion and sensitivity.

Involvement in decisions about care and treatment

All of the patients we spoke with told us they felt their treatment options were explained to them and they were involved in decisions about the type of treatment they received. The practice displayed information in the waiting area that gave details of NHS dental charges.

The dental care records we looked at contained evidence that treatment options were discussed with patients but there were no written treatment plans in the dental care records we looked at.

Patients told us they were made aware of any costs by the dentist and they were given time to decide about the proposed treatment but were not given a written treatment plan.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There were appointment slots available for emergencies each day and we spoke with two patients who were attending for an emergency appointment arranged that morning. Staff told us they had enough time to treat patients. The patients we spoke with told us they could generally book an appointment in good time to see a dentist.

We observed that patients were not kept waiting for long periods before being called for their appointment. We spoke with patients who told us they were usually seen on time and if there were any delays they were told of this when they booked in.

Tackling inequity and promoting equality

We were given a tour of the premises and found facilities were appropriate for the services that were planned and delivered. The practice was accessible to patients with limited mobility the treatment room was located on the ground floor. There was no space to provide a disabled toilet and this was explained to patients wanting to register with the service. If these facilities were needed, patients would be given information about other dentists in the area where disabled toilet facilities were available.

We saw reasonable adjustments had been made to the premises in accordance with The Equality Act 2010; for example a stair lift was provided to access the toilet facilities on the first floor for patients and/or staff who had limited mobility.

Access to the service

The practice was open from 9:00 am to 5:00 pm Monday to Friday. The practice displayed its opening hours at the front of the premises. Contact numbers were displayed so that patients could access treatment when the practice was closed.

Feedback in CQC comment cards and from patients we spoke with told us that they were able to get a routine appointment when needed. Patients told us that they were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaint procedure that was available in the reception area. There had been no complaints in the last 12 months. The dentist would respond to complaints and any lessons learned would be cascaded to all staff during meetings.

The patients we spoke with told us they had not had any cause to complain but if they did they felt staff at the practice would deal with their concerns in a professional manner.

Are services well-led?

Our findings

Governance arrangements

The practice had a range of policies and procedures in place that included; confidentiality, safeguarding, infection control, complaints and consent.

We saw systems were in place to monitor the quality of the service and to identify where improvements could be made. The practice had identified a number of lead roles in relation to governance that included audits of the infection control procedures and dental care records. We found that the audit of dental care records had not identified the lack of written treatment plans. A treatment plan should be given to the patient and a copy retained within the patient's records to provide an audit trail.

Leadership, openness and transparency

There was a statement of purpose that described the services values and objectives. Staff told us there were clear lines of accountability in place within the practice. The staff we spoke with told us that although there was no formal supervision they felt supported and were clear about their areas of responsibility.

We saw documentary evidence that regular staff meetings were taking place and saw these were minuted in addition informal discussions were held at lunchtimes. Staff advised us they were able to raise any issues or concerns with the dentist during meetings and felt confident that issues raised would be dealt with professionally.

We spoke with a dental nurse who had been employed for a number of years who was enthusiastic and complimentary about the support they received from the dentist. We spoke with the most recently appointed member of staff who had completed their apprenticeship at the practice. They told us about their induction and training they had received in the first few weeks including; fire safety, safeguarding, hand washing techniques and infection control.

Management lead through learning and improvement

Staff working at the practice were supported to maintain their continuing professional development (CPD) this was a requirement of their registration with the General Dental Council (GDC). We looked at the continuing professional development (CPD) files for two members of staff. There were certificates in place to demonstrate staff had attended appropriate training for their role including; responding to medical emergencies, infection control and safeguarding.

The staff we spoke with told us that they felt they were a valued member of the team, their opinion was listened to and where practicable their ideas were acted upon.

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

The practice carried out an annual patient survey the results of which were analysed to identify areas for improvement. In addition the practice used the NHS Friends and Family test (FFT) cards which were available in the waiting room. We looked at the completed FFT cards and found patients were extremely likely to recommend the practice to friends and family members.

The staff we spoke with told us if patients made any suggestions to improve the patient experience these were passed on to the dentist for discussion at practice meetings.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation **12(2) (a) (b) (e) (h)** HSCA 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: There were no risk assessments in place when not using a rubber dam during root canal treatments and no protocol about the measures taken to ensure patient safety, for example by securing the instruments. **Regulation 12(2) (a) (b) (e)** The procedures in place for assessing the risk of, and preventing, detecting and controlling the spread of, infections were not robust enough. Regulation **12(2)(h)**