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Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 February 2016 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

The Dental Surgery provides mostly private dental treatment to adults and has about 2,000 patients on its list. In addition to general dentistry, some cosmetic procedures are also provided including dental implant restoration and teeth whitening. The practice also has a small contract with the NHS to provide general dentistry to children.

The practice has one dentist, two hygienists and a nurse/ practice manager. The practice opens from Monday to Thursday between 8am and 5.30pm, and on Friday by appointment only.

The practice's premises consist of two treatment rooms, a patient waiting area and a small reception office. At the time of our inspection, there were building works in process to enlarge the practice.

We spoke with two patients during our inspection and also received 49 comments cards that had been completed by patients prior to our inspection. All the comments received reflected that patients were very satisfied with the staff, their dental assessments, the explanation of their treatment and the quality of the dentistry.

Our key findings were:

- We received consistently good feedback from patients about the quality of the practice's staff and the effectiveness of their treatment.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation. Patients' dental care records provided an accurate, thorough and contemporaneous record of patient care.

Summary of findings

- The practice was clean and well maintained.
- Infection control and decontamination procedures were robust, ensuring patients' safety.
- Staff had received training appropriate to their roles and were supported in their continued professional development
- Patients were treated in a way that they liked and information about them was treated confidentially.
- Patients received their care and treatment from well trained and supported staff. These staff received regular appraisal. Staff enjoyed their work.

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

- Improve the recording of, and learning from, significant events.
- Have the gel form of midazolam available so it can be administered quickly in the event of a patient having a fit.
- Secure sharps' bins to a wall to ensure their safety.
- Cover and protect loose medical items such as matrix bands in treatment room drawers.
- Monitor the fridge temperature used to store the medicine glucagon or change the expiry date on the medication to reflect the fact it has not been kept at the required temperature.
- ensure all equipment needed to summons assistance in the event of an emergency in the disabled toilet is working correctly
- Implement a system to monitor and track referrals made on patients' behalf to other dental care providers.
- Provide seating with arms and different heights to support people with mobility problems.
- Display information about the practice's opening times and out of hours services on the front door in case patients visit when the service is closed.

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 to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse and maintaining the required standards for sterilising dental instruments. Risks had been identified and control measures put in place to reduce them. Emergency equipment was available and medicines were checked to ensure they did not go beyond their expiry dates. Records showed that the equipment was in good working order and was effectively maintained. However, not all incidents had been reported correctly as significant events and it was not clear how learning from events had been shared with staff to prevent their reoccurrence.

Are services effective?

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

Staff assessed patients' needs and delivered care in line with current evidence based guidance. The practice kept detailed dental care records of the treatment carried out and monitored any changes in the patient's oral health. Patients were referred to other services appropriately. Good information was available to support patients' oral hygiene.

Staff were suitably trained and skilled to meet patients' needs and there were sufficient numbers of staff available at all times.

Are services caring?

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

Patients spoke highly of the dental treatment they received, and of the caring and empathetic nature of the practice's staff. Patients told us they were involved in decisions about their treatment, and didn't feel rushed in their appointments. Patient information and data was handled confidentially.

Are services responsive to people's needs?

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

Routine dental appointments were readily available and appointment slots for urgent appointments were available each day for patients experiencing dental pain.

There was an easily understood, well publicised and accessible complaints procedure to enable patients to raise their concerns.

Are services well-led?

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

The practice had a number of policies and procedures to govern activity and held regular staff meetings. Staff received inductions, and regular performance reviews. The practice team were an integral part of the management and development of the practice. The practice proactively sought feedback from staff and patients, which it acted on.

Dental Surgery

Detailed findings

Background to this inspection

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

The inspection took place on 23 February 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the dentist, the practice manager and a dental hygienist. We received feedback from 49 patients about the quality of the service, which included comment cards completed and patients we spoke with during our inspection. We reviewed policies, procedures and other documents relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff we spoke with had an adequate understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and there were specific forms for staff to complete when something went wrong**.** We viewed the practice's accident book and saw that two incidents had been recorded in the last year. These had been recorded properly and there was evidence that appropriate action had been taken in response to them. However, neither of these incidents had been recorded correctly as significant events and there was no evidence that learning from these incidents had been proactively shared with staff to prevent their reoccurrence.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation. Policies were available to all staff, and clearly outlined who to contact for further guidance if they had concerns about a patient's welfare. Contact numbers for the agencies involved in protecting people were easily accessible.

Staff had received appropriate training in safeguarding patients and were aware of the different types of abuse a vulnerable adult could face, and also signs of possible neglect in a child. Staff were aware of external agencies involved in protecting children and adults.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The dentist we spoke with confirmed that they used rubber dams as far as practically possible.

Medical emergencies

The practice had arrangements in place to manage emergencies and records showed that all staff had received regular training in basic life support. In addition to this, the dentist had undertaken specific training in anaphylaxis treatment, asthma in general dentistry and airways obstruction. The dental nurse was a qualified first aider. However, emergency medical simulations were not regularly rehearsed by staff so that they had a chance to practice what to do in the event of an incident.

Emergency equipment, including oxygen and an automated external defibrillator was available. 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. Records confirmed that it was checked monthly by staff. However, we found that there were no child face masks or automated blood glucose measuring device available. The manager assured us she would order these immediately.

Medicines were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and all medicines were checked monthly to ensure they were within date for safe use. However the practice did not have the correct form of midazolam available so it could be administered quickly in the event of a patient having a fit.

Staff recruitment

We reviewed three recruitment files and found that appropriate checks had been undertaken for staff, including the temporary nurse, prior to their employment. For example, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The practice manager reported that interview notes were retained and a scoring system was used to ensure consistency and fairness when recruiting potential staff. All staff underwent an induction when they started working at the practice to ensure they had the knowledge and skills for their role.

Monitoring health & safety and responding to risks

The practice had a specific health and safety hand book which all staff had signed to indicate that they had read and understood the polices.

We looked at a sample of policies and risk assessments which described how the practice aimed to provide safe care for patients and staff. These covered a wide range of areas including fire safety, cleaning instruments and assisting the dentist. Risks had been clearly identified and control measures put in place to reduce them. There was a comprehensive control of substances hazardous to health

Are services safe?

folder in place containing chemical safety data sheets for products used within the practice. Electrical equipment was checked each year and hazardous waste was managed well. The practice had a sharps risk assessment in place and had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by using a sharps safety system which allowed staff to discard needles without the need to re-sheath them. However, we found that sharps bins were not adequately secured in treatment rooms to ensure their safety.

A legionella risk assessment had been carried out and there was regular monitoring of water temperatures to ensure they were at the correct level. Regular flushing of the water lines was carried out in accordance with current guidelines, at the start and end of each day, and between patients to reduce the risk of legionella bacteria forming.

Fire detection and firefighting equipment such as extinguishers were regularly tested, and we saw records to demonstrate this**.** Fire evacuations were practiced monthly.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice manager was the lead for infection control and there were infection control policies in place to guide staff.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area and reception office. The toilet was clean and contained liquid soap and paper hand towels so that people could wash their hands hygienically. We checked both treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and modern sealed work surfaces so they could be cleaned easily. However we noted some features that compromised good infection control. For example, some of the flooring in the treatment rooms was badly marked; there was carpeting in the reception area which only accessible via a treatment room and treatment room sinks were not compliant with national guidance. The practice did not have a separate decontamination room within which to clean dirty instruments. However the dentist assured us all that all these issues would be resolved as part of the forthcoming refurbishment of the practice. Some loose medical items such as matrix bands were not adequately covered and protected in treatment room drawers to ensure their hygiene.

All dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection. Staff wore appropriate personal protective equipment when treating patients including visors, masks and gloves. We noted particularly good hand hygiene procedures.

On the day of our inspection, a dental nurse and hygienist demonstrated the decontamination process to us and used the correct procedures. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. However we noted that the emergency pull-cord in the disabled toilet had recently been broken and was unable to be used by patients as a result.

Staff told us they had suitable equipment to enable them to carry out their work, and a new dental chair, hand pieces and ultrasonic baths had recently been purchased for the practice. One staff member told us that any breakdowns were repaired quickly and requests for new types of equipment were met.

We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' clinical notes. Staff were aware of Medicines and Healthcare Products Regulatory Agency alerts and these were disseminated at team meetings if appropriate. However staff did not use the yellow card scheme to report any adverse medication reactions. Blank prescription forms were stored securely, and their reference numbers recorded in patients' notes. However, the fridge where glucagon was kept was not monitored to ensure it was being stored at the correct temperature.

Are services safe?

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we reviewed demonstrated that the X-ray equipment was regularly tested and serviced.

A Radiation Protection Advisor and Radiation Protection Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only.

We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were displayed in each treatment room. Those staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training. Dental care records demonstrated the justification for taking X-rays, as well as a report on the X-rays findings and its grade. This protected patients who required X-rays as part of their treatment.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Dental care records we reviewed contained a comprehensive written patient medical history which was updated on every examination. Patients' dental records were detailed and clearly outlined the treatment provided, the assessments undertaken and the advice given to them. Our discussions with the dentist and hygienist demonstrated that they were aware of, and worked to, guidelines from National Institute for Heath and Care Excellence (NICE) and the Faculty of General Dental Practice about best practice in care and treatment. Dental care records evidenced clearly that NICE guidance was followed for patients' recall frequency and that that routine dental examinations for gum disease and oral cancer had taken place. Dental decay risk assessments had been completed for patients. Appropriate action had been taken for patients with advanced gum disease.

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping and the quality of dental radiographs and infection control. We viewed good action planning in place to address any issues identified by these audits. The dentist told us he would also be undertaking a prescribing audit in the near future.

Health promotion & prevention

A number of oral health care products were available for sale to patients including interdental brushes, toothpaste and floss.

We found that clinicians had applied guidance issued in the Department of Health's publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Patients were asked about their smoking and drinking habits as part of their medical history, and during their consultations. The hygienist had undertaken specific training in alcohol awareness.

During our observations we noted the hygienist gave one patient detailed advice about flossing and also issued them with a free sample of toothpaste. The dentist told us he regularly used computer generated images and also dental models as patient education tools.

Staffing

One dental nurse had left recently to train as a dental hygienist but the practice had recruited a temporary nurse to provide cover whilst a permanent staff member was being recruited. Staff we spoke with told us the staffing levels were suitable for the small size of the service and the dentist always worked with a dental nurse. However, the hygienist worked alone and without support of a dental nurse.

Files we viewed demonstrated that staff were appropriately qualified, trained and where required, had current professional validation. We viewed the practice's training logs which showed that staff had undertaken a range of training including asthma in general dentistry, laser dentistry and restoring traumatic occlusion. The dentist regularly attended the Norwich Dental Group to help keep his skills and knowledge up to date.

All staff received an appraisal of their performance which covered amongst other things their communication skills, customer care, competencies and knowledge. Staff told us they found these appraisals useful.

Professional registration, insurance and indemnity checks were undertaken to ensure dental clinicians were fit to practise and the practice had appropriate employer's liability in place.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. We viewed a small sample of referral letters and found that they contained good details about the patient and the reason for the referral. However, there was no system in place to check that referrals had been received by other organisations, once sent. Therefore the practice was not able to follow up these referrals until the patient themselves raised a concern that they had not heard anything. Patients did not automatically receive a copy of their referral for information.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Patients we spoke with told us that they were provided with good information during their consultation and that they always had the opportunity to ask questions before agreeing to a particular treatment. The practice had a range of treatment information leaflets that could be given to patients to aid their understanding about the different options available to them. Dental records we examined demonstrated that treatment options, and their potential risks and benefits had been explained to patients in detail. Evidence of their consent had also been recorded.

The practice had a specific patient consent policy in place which covered informed consent and also requirements for children under 16 years. Training records we reviewed showed that staff had received specific training in the Mental Capacity Act 2005 (MCA) in October 2015.Those staff we spoke with demonstrated a thorough understanding of the MCA and its relevance in obtaining patients' consent. 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 dentist also showed good awareness of Gillick competence and told us how he had applied its principles when considering the request for tooth whitening treatment from a young person.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before our inspection, we sent comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 49 completed cards and received many positive comments about the empathetic and supportive nature of the practice's staff. Patients told us that staff were good at making them feel relaxed during their treatment and reassured them well when they felt anxious. Patients described their treatment as prompt, careful and caring.

We spent time in the reception area and observed a number of interactions between the reception staff and patients coming into the practice. The quality of interaction was good, and staff were consistently helpful, friendly and professional to patients both on the phone and face to face. The practice's patient waiting area could be separated from the reception area by glass screens to allow privacy for staff to make telephone calls to patients.

Computers were password protected and patients' dental care records were computerised. Practice computer screens were not overlooked which ensured patients' information could not be seen at reception. All consultations were carried out in the privacy of the treatment rooms.

Involvement in decisions about care and treatment

Patients told us that their dental health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients received and signed written plans which outlined their treatment.

Dental care records we reviewed demonstrated that clinicians recorded the information they had provided to patients about their treatment and the options available to them. Feedback from the practice's own survey showed that patients particularly liked the time taken by clinicians to explain their treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In addition to general dentistry, two hygienists also worked at the practice to support patients with treating and preventing gum disease.

Information was available about appointments on the practice's website and also in its patient information leaflet. This included opening times, details of the staff team and the services provided. The practice was open Mondays to Thursdays from 8am to 5.30pm, and on Fridays subject to availability. Emergency slots were available each morning to accommodate patients who needed an urgent appointment. Patients told us it was easy to get an appointment with the practice. They also particularly liked the fact that they could get a 'double' appointment on the same day with the dentist, immediately followed by another appointment with the hygienist. Patients were sent text or email reminders the day before their appointment to remind them of the date.

The dentist told us he also gave patients his mobile number in case they needed to contact him in an emergency, and this was covered by staff from another practice nearby if he was not available. The practice's answer phone message detailed how to access out of hours emergency care if needed, however this information was not available on the door to the practice should a patient attend when it was closed.

Tackling inequity and promoting equality

The practice had undertaken a disability audit to ensure it met the requirements of the Equality Act. All treatment rooms were on the ground floor and there was an adapted toilet facility. There were plans in place to lower the practice's reception desk in the middle to improve communication with wheelchair users as part of the practice's forthcoming refurbishment. However there were no chairs with arms, or at different heights in the waiting room to assist people with mobility problems.

Translation services were available to non-English speaking patients and these were well advertised in the reception office.

Concerns & complaints

Information about how to complain was available in the practice's patient information folder and also on the wall in the waiting area. It detailed the timescales in which complaints would be responded to, and also listed external agencies that patients could contact if they were not satisfied with the practice's response.

Patients we spoke with told us they felt confident that staff would respond appropriately to any concerns they had. Staff were aware of how to deal with a complaint should they need to.

The practice manager told us there had been no complaints received in the last year.

Are services well-led?

Our findings

Governance arrangements

The practice manager had responsibility for the day to day running of the practice. At the time of our inspection, she also worked as a dental nurse but had dedicated time on a Friday morning to undertake a range of managerial and administrative tasks. She reported that this was sufficient time and she could work additional time on the Friday if required.

The practice had a clear set of policies and procedures to support its work and meet the requirements of legislation. We viewed a sample of these which were comprehensive, dated, and monitored as part of the practice's quality assurance process. Staff understood and had access to the polices.

Daily and weekly check lists were in use to ensure that the practice met its requirements in relation to infection control, and other health and safety matters. Audits of the practice's X-rays and dental care records were undertaken by an external organisation. In addition to this, the dentist told us the practice's computer system could run audits on patient waiting times and length of treatments to help him monitor these aspects of the service.

Communication across the practice was structured around a monthly meeting involving all staff, which staff told us they found useful. However minutes of these meetings lacked detail, and only consisted of a few lines. There were no set standing agenda items, or record of action points for staff.

The practice completed an information governance tool kit every year to ensure it was meeting its legal responsibilities in how it handled patient information. It had scored 73% indicating it managed patients' information in a satisfactory way.

The practice was a member of the accredited dental insurance provider excel scheme which demonstrated its commitment to working to standards of good practice in its professional and legal responsibilities.

Leadership, openness and transparency

Staff told us they enjoyed their work and the small size of the practice which meant that communication systems were good. They told us they felt supported and were clear about their responsibilities within the practice. They reported there was an open culture and they had the opportunity to, and felt comfortable, raising any concerns.

Learning and improvement

All the staff we spoke with felt supported by the practice and reported that they were encouraged to develop their knowledge and skills.

Regular audits and checks were undertaken to ensure standards were maintained in a range of areas including radiography, infection control and the quality of clinical notes.

The practice manager attended a regular regional practice managers' forum, where a range of subjects relevant to the management of dental practices was discussed. The dentist attended a regional group for dentists where latest guidance and training on a range of issues was discussed.

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

The practice regularly sought feedback from patients who were provided with questionnaires asking them to rate their satisfaction level with various aspects of their oral care and quality of the service they received. The practice scored well when benchmarked against other dental services, achieving 82% against a national reference sample score of 76%. Patients' specific suggestions to re-install the fish tank in the waiting room and for bicycle racks to be purchased had been agreed as part of the practice's forthcoming refurbishment and extension. Patient survey results were displayed on the practice's website. A suggestion box was also available in the waiting area for patients to leave their comments or concerns.

The practice gathered feedback from staff through staff meetings, appraisals and discussion. Staff had been consulted about the forthcoming extension and their suggestions for a specific staff room and also microwave oven had been agreed. One staff member told us her suggestions for particular types of dental products to be stocked were always listened to and met.