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Alexander House Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 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.

Alexander House Dental Practice is a general dental practice in St Albans, Hertfordshire offering NHS and private dental treatment to adults and children. The premises are located on the ground and first floor and consist of three dental treatment rooms, a reception area, two waiting rooms and a designated decontamination room.

The staff at the practice consist of a practice manager, a principal dentist, two associate dentists, a dental hygienist, and seven dental nurses, who also cover reception duties. One of the dental nurses is the deputy practice manager, and another is the lead dental nurse.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. 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.

Our key findings were:

- There was an induction and training programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients.

Summary of findings

- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- There were effective systems in place to reduce the risk and spread of infection. We found the treatment rooms and equipment were visibly clean.
- There were systems in place to check equipment had been serviced regularly, including the dental air compressor, autoclaves, fire extinguishers, dental laser and the X-ray equipment.
- We found the dentists and dental hygienist regularly assessed each patient's gum health and dentists took X-rays at appropriate intervals.
- The practice kept up to date with current guidelines when considering the care and treatment needs of patients.
- The practice placed an emphasis on the promotion of oral and general health and the prevention of dental disease. Appropriate information and advice was available according to patients' individual needs.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.
- Staff demonstrated knowledge of the practice whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.
- At our visit we observed staff were kind, caring and professional. Some staff had worked at the practice for a long time and demonstrated they knew patients well when they greeted them.
- There was an effective system in place to act on feedback received from patients and staff.

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

- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000. This includes the operation of a robust X-ray image quality assurance process.
- Ensure that all staff are familiar with the practice's fire safety evacuation procedures and that these are practiced regularly.
- Replace the clinical and household waste bins in the decontamination room with pedal operated bins in accordance with current guidance.
- Ensure all staff are familiar with the practice waste segregation and disposal policy and procedures.

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.

The practice had systems in place for the management of infection control, clinical waste segregation and disposal, management of medical emergencies and dental radiography. We found the equipment used in the practice was well maintained and in line with current guidelines. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The staffing levels were suitable for the provision of care and treatment.

Some staff we spoke with were unclear about how they would respond in the event of a fire. The practice management team resolved to provide additional training to ensure they were confident in knowing how to respond.

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

The practice provided evidence based dental care which was focussed on the needs of the patients. We saw examples of effective collaborative team working. The staff were up-to-date with current guidance and 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) training 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 commented they had positive experiences of dental care provided at the practice. Patients felt they received excellent care and detailed explanations of treatment options. Patients told us the practice staff were kind, caring and professional which we observed on the day of our inspection. Many staff had worked at the practice for several years and demonstrated they understood patients' individual care and support needs. Staff spoke with enthusiasm about their work and 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 and personalised dental care. Patients could access routine treatment and urgent or emergency care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain. There was an effective system in place to acknowledge, investigate and respond to complaints made by patients.

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

Summary of findings

The dental practice had effective risk management structures in place. Staff told us the practice management team were always approachable and the culture within the practice was open and transparent. All staff were aware of the practice ethos, philosophy and values and told us they felt well supported and able to raise any concerns where necessary. Staff told us they enjoyed working at the practice, felt part of a team and would recommend the practice to a family member or friends.

However, the practice needed to improve the robustness of its quality assurance process for dental X-rays.

Alexander House Dental Practice

Detailed findings

Background to this inspection

The inspection was carried out on 4 February 2016 2016 by a CQC inspector with remote access to 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, clinical patient records and other records relating to the management of the service. We spoke with the registered manager (who was the principal dentist), the practice manager, an associate dentist, the deputy manager and two dental nurses. We reviewed 46 Care Quality Commission (CQC) comment cards that had been completed by patients and spoke to three patients on the day of our inspection.

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

There was a system in place to learn from and make improvements following any accidents, incidents or significant events.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence.

Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result such as further staff training.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority's safeguarding team, social services and other agencies including the Care Quality Commission. Staff demonstrated to us their knowledge of how to recognise the signs of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them. This included and identified the practice's safeguarding lead.

Staff demonstrated 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). Only dentists or the dental hygienist were permitted to re-sheath needles where necessary in order to minimise the risk of inoculation injuries to staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included face masks for both adults and children. Oxygen and medicines for use in an emergency were available. Records completed showed regular checks were done to ensure the equipment and emergency medicine was safe to use.

Records showed staff regularly completed training in emergency resuscitation and basic life support including the use of the automatic external defibrillator (AED). 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. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

There were effective recruitment and selection procedures in place. We reviewed the employment files for three staff members. Each file contained evidence that satisfied the requirements of relevant legislation. This included application forms, employment history, evidence of qualifications and photographic evidence of the employee's identification and eligibility to work in the United Kingdom where required. The qualification, skills and experience of each employee had been fully considered as part of the recruitment process.

Appropriate checks had been made before staff commenced employment including evidence of their professional registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service had been carried out. The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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 safety signs were clearly displayed and fire extinguishers had been recently serviced. However, when we asked staff how they would respond in the event of a fire, they gave us slightly different responses. We had concerns that staff may be unclear about actions they should take and discussed this with the practice management team. We were assured that staff would be given further training to ensure they were confident in responding appropriately in the event of a fire.

The practice had a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. There was a business continuity plan in place.

Are services safe?

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found that some risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them. However, the file was not comprehensive or regularly updated when new materials or chemicals where introduced to the practice. We discussed this with the practice management team who resolved to address this.

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 which included Hepatitis B. The policy also described processes for the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste. 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)'. This document and the practice policy and procedures on infection prevention and control were accessible to staff.

We examined the facilities for cleaning and decontaminating dental instruments. A dental nurse showed us how instruments were decontaminated. They wore appropriate personal protective equipment (including heavy duty gloves and a mask) while instruments were decontaminated and placed in an automatic washer-disinfector. This is an automatic instrument washing machine which is considered 'best practice' in accordance with HTM 01-05 standards prior to the use of an autoclave (steriliser). Instruments were then inspected prior to being placed in an autoclave (sterilising machine).

We saw instruments were placed in pouches after sterilisation and dated to indicate when they should be reprocessed if left unused. We found daily and weekly tests were performed to check the steriliser was working efficiently 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.

We observed how waste items were disposed of and stored. The practice had an on-going contract with a clinical waste contractor. We saw the different types of waste were appropriately segregated and stored at the practice. This included clinical waste and safe disposal of sharps. During the inspection we had concerns that a staff member was unclear about how to dispose of amalgam waste when cleaning the suction filter. We discussed this with the practice management team who assured us that staff would receive further training to ensure they understood how to dispose of waste in accordance with guidance and the practice policy. We also observed that the clinical waste and household waste bins in the decontamination room were not pedal operated which could have posed a risk of infection spreading if staff were manually opening the lids each time. The practice management team told us they would replace the bins to reduce this risk.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of which was in line with guidance.

We looked at the treatment rooms where patients were examined and treated. The rooms and equipment were visibly clean. Separate hand wash sinks were available with good supplies of wall-mounted liquid soap and alcohol gel. 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.

Records showed a risk assessment process for Legionella had been carried out in October 2013. This process ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

There was a good supply of environmental 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.

Equipment and medicines

Are services safe?

There were systems in place to check equipment had been serviced regularly, including the dental air compressor, autoclave, fire extinguishers, oxygen and the X-ray equipment. We were shown the annual servicing certificates.

An effective system was in place for the prescribing, administration and stock control of the medicines used in clinical practice such as local anaesthetics. These medicines were stored safely for the protection of patients.

Staff told us that prescriptions pads were stored overnight in the treatment rooms. We discussed this with the practice management team who agreed that in future, they would be locked away for safety and security.

Radiography (X-rays)

We checked the practice's radiation protection records as X-rays were taken and developed at the practice. We also looked at X-ray equipment and talked with staff about its use. We found there were arrangements in place to ensure the safety of the equipment. We saw local rules relating to each X-ray machine were available.

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

In order to keep up to date with radiography and radiation protection and to ensure the practice is in compliance with its legal obligations under Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000, the General Dental Council recommends that dentists undertake a minimum of five hours continuing professional development training every five years. We saw evidence that the dentists were up to date with this training.

Dental care records we reviewed showed the practice was justifying, reporting on and grading X-rays taken; however, there was no formal quality assurance process in place to ensure that X-rays taken were of a consistently high diagnostic standard. This meant the practice was not in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for people using best practice

The dentists told us they regularly assessed each patient's gum health and the dentists took X-rays at appropriate intervals. We asked the dentists to show us some dental care records which reflected this. Records showed an examination of a patient's soft tissues (including lips, tongue and palate) had been carried out and dentists had recorded details of the condition of patients' gums using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). In addition they recorded details of treatment options offered to or discussed with patients as well as the justification, findings and quality assurance of X-ray images taken.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to 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.

The practice held regular meetings to discuss ways in which they could improve the care and treatment offered to patients.

Health promotion & prevention

The practice placed an emphasis on oral disease prevention and the maintenance of good oral health as part of their overall philosophy. A range of leaflets were available to patients in the waiting room including information on caring for teeth and gums, how to care for a dry mouth, how diabetes affects oral health and children's oral health.

Staff we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice. This was also recorded in the dental care records we reviewed. Several patients told us through feedback that the dentists and especially the dental hygienist always took time to give individualised oral hygiene advice that was appropriate for them.

Staffing

There was an induction and training programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients. For example, trainee dental nurses were able to shadow a more experienced dental nurse until they felt competent to assist the dentist on their own.

The practice did not keep comprehensive training records for staff and therefore we had concerns they were unable to demonstrate to us that staff kept up to date with the core training and registration requirements issued by the General Dental Council. We discussed this with the practice manager who showed us that staff were currently registered to undertake their core training with an online company and told us they would monitor this more closely in future. We were assured that staff were up to date with training in responding to medical emergencies as this had been undertaken as a team at the practice within the last year.

There was an appraisal system in place which was used to identify training and development needs. Staff told us they had found this to be a useful and worthwhile process; they felt well supported by the practice management team and they were given opportunities to learn and develop.

Working with other services

Referrals for patients when required were made to other services. The practice had a system in place for referring patients for dental treatment and specialist procedures such as oral surgery and sedation. Staff told us where a referral was necessary, the care and treatment required was fully explained to the patient. Referrals made were recorded and monitored to ensure patients received the care and treatment they required in a timely manner.

Consent to care and treatment

The practice ensured informed consent from patients was obtained for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. We asked the dentists to show us some dental care records which reflected this. Patients were given time to consider and make informed decisions about which option they wanted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity

Are services effective?

(for example, treatment is effective)

to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff explained how they ensured information about patients using the service was kept confidential. Patients' electronic dental care records were password protected and paper records were immediately shredded once they had been scanned to the patients' electronic record. Staff members demonstrated their knowledge of data protection and how to maintain confidentiality. Staff told us patients were able to have confidential discussions about their care and treatment in one of the treatment rooms if it was required.

Comments we reviewed from patients included that they received excellent care from a practice team who were kind, caring and professional. Several patients commented that they enjoyed coming to the practice. On the day of our inspection, we observed staff being polite, friendly and welcoming to patients.

Some staff members had worked at the practice for several years and demonstrated they understood and cared about patients' support needs.

Involvement in decisions about care and treatment

The dentists and dental hygienist 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. A treatment plan was developed following examination of and discussion with each patient.

Staff told us the dentists and dental hygienist took time to explain care and treatment to individual patients clearly and were always happy to answer any questions. Patient feedback also confirmed that the dentists and dental hygienist took time to explain dental treatment and options in a way the patient 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 under pressure to complete procedures and always had enough time available to prepare for each patient.

There were systems in place to ensure the equipment and materials needed were in stock or received well in advance of the patient's appointment. This included checks for laboratory work such as crowns and dentures which ensured 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 different backgrounds, cultures and religions. Staff told us if they were unable to communicate fully with a patient due to a language barrier they could encourage a relative or friend to attend who could translate or they would contact a translator. The practice team spoke a number of languages which also supported patients to understand treatment options.

The practice had completed a disability discrimination audit to ensure patients with a disability were supported to access care and treatment.

Access to the service

We asked staff 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. Each day the practice was open, emergency treatment slots were made available for people with urgent dental needs. Staff told us patients requiring emergency care during practice opening hours were seen the same day. This was reflected in patients' feedback we reviewed. Patients told us that they appreciated the text service which reminded them when their appointment was.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's 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

The governance arrangements of the practice were developed through a process of continual learning. The practice manager liaised regularly with the staff team and the principal dentist in order to identify where any improvements were needed. A set of practice policies were in place which staff had signed to indicate they had read and understood them. We observed that many policies had key words highlighted to support staff in remembering them.

The principal dentist and practice manager shared responsibility for the day to day running of the practice and was fully supported by the practice team, including the deputy manager. There were clear lines of responsibility and accountability with individual staff members identified as leads in certain areas such as infection control, fire safety and safeguarding. Staff knew who to report to if they had any issues or concerns.

A 'key contacts' folder was kept at reception for staff to access if necessary. This included contact details for all staff as well as local adult safeguarding and child protection services. The folder also included key responsibilities for staff working on reception.

Leadership, openness and transparency

Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the practice manager or principal dentist without fear of recriminations. There was a high staff retention rate at the practice and many staff had worked at the practice for several years.

Management lead through learning and improvement

The practice carried out regular audits every six months on infection prevention and control to ensure compliance with government HTM 01-05 standards for decontamination in dental practices. The most recent audit undertaken June 2015 indicated the facilities and management of decontamination and infection control were managed well.

The practice did not have a robust quality assurance process in place for X-rays taken. The most recent X-ray audit was carried out in 2014 and had demonstrated that dentists were meeting the required standards on most occasions. However, the practice had not analysed the results to identify where improvement actions may be needed or carried out a further audit to monitor improvements. We discussed this with the practice management team who resolved to address this in order to reduce the risk of patients being subjected to further unnecessary X-rays. They told us that they felt the risk was very low as they did use digital X-ray equipment and always assessed and recorded the quality grading of each image at the time of taking it and would have addressed any discrepancies immediately. They agreed that regular audits would make the process more robust.

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

The practice had recently sought feedback from patients through a satisfaction survey and was in the process of collating and analysing the results. The practice management team told us they would discuss the results with the practice team in order to identify and act upon any areas for improvement.

The practice held regular staff meetings each month where they discussed a range of topics in order to learn and improve the quality of service provided. Staff members told us they found these were a useful opportunity to share ideas and experiences which were listened to and acted upon.

Staff were encouraged to add items to the agenda for discussion. This included articles or information of interest they had read which they considered may be useful to share with the rest of the practice team.