Welldene Dental Care Ltd

Welldene Dental Care

Inspection Report

Canterbury Road
Ashford
Kent
TN24 8JY
Tel:01233 635323
Website: www.southerndental.co.uk

Date of inspection visit: 28 October 2015
Date of publication: 28/01/2016

Overall summary

We carried out an announced comprehensive inspection on 28 October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Welldene dental practice provides general dentistry. The practice provides NHS and private services for patients in Ashford, Kent and the surrounding area.

The practice staff include three dentists, three dental nurses a dental hygienist and receptionists. Those are supported by a practice manager and an assistant practice manager. Dental services are provided Monday to Friday 8.30am to 5.30pm,

We talked to five patients. We looked at 73 comment card completed by patients specifically for this inspection. The patients said, and the comment cards supported this, that the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff had time to spend with them, they said that it was easy to get appointments and that if they needed emergency treatment staff made time to fit this in. They said that staff took time to explain procedures to them and give advice on the prevention of dental problems. They said that staff treated patients with dignity and respect

The practice manager is also 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.

Summary of findings

Our key findings were

- There were effective systems to reduce the risk and spread of infection. We found that all the treatment rooms and equipment appeared clean.
- There were systems to check all equipment had been serviced regularly including, autoclaves, fire extinguishers, oxygen cylinder and the X-ray equipment.
- Dentists regularly assessed each patient's gum health and took X-rays at appropriate intervals.
- The practice ensured staff maintained the necessary skills and competencies to support the needs of patients.
- The practice was aware of current guidelines.
- Patients were provided with information and were involved in decision making about the care and treatment they received. We observed staff to be kind, caring, and responsive to patient's needs.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- The practice should review and check that all staff carry out decontamination following the agreed process.
- Check all audits, including radiographic audits, have learning points documented so that the resulting improvements can be demonstrated.
- Review at appropriate intervals the training, learning and development needs of individual staff members and have an effective process established for the appraisal of all staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were systems for the management of infection control, clinical waste, medical emergencies and dental radiography, although the practice should review the results of radiographic audit to check that any necessary equipment is supplied. Staff had received training in safeguarding and knew the signs of abuse and how to report this. There was a whistleblowing policy and staff were aware of it. The equipment used in the practice was well maintained and in line with current guidelines. There were systems for identifying, investigating and learning from incidents. The staffing levels were safe for the provision of care and treatment provided.

Are services effective?

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

The practice provided evidenced based dental care which was focussed on the individual needs of each patient. Consultations were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE), Faculty of General Dental Practice (FGDP) and the General Dental Council (GDC). Patients received a comprehensive assessment of their dental needs and their medical history was kept up to date. Staff registered with the GDC had continuing professional development and were meeting the requirements of their professional registration. Consent to care and treatment was obtained from patients and recorded appropriately.

Are services caring?

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

Patients told us that they had found the practice supportive. They said they were listened to, treated with respect and were involved in the discussion of their treatment options which included risks, benefits and costs. There was provision to see patients with urgent dental needs on the day they called and this almost always happened.

Are services responsive to people's needs?

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

Appointment times met the needs of patients. Patients with mobility issues were accommodated at the practice. There were interpretation services available for those who needed them. The practice handled complaints openly and transparently. The complaints procedure was readily available to patients and the practice responded to complaints and learned from them.

Are services well-led?

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

The practice had clinical governance and risk management systems. There was a pro-active approach to dealing with safety issues and the practice learned and made improvements. There was a range of audits but in not all cases could the resultant learning and improvement be demonstrated. The practice management were approachable and supportive of staff. Staff felt that they could raise concerns with any member of the management team. The practice sought the views of staff and patients and acted on them.

Welldene Dental Care

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection of Welldene Dental Practice on 28 October 2015. Our inspection team was led by a CQC Lead Inspector. The team included a Dentist specialist advisor.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England, to share what they knew. We did not receive any information of concern.

During our visit we spoke with a range of staff including dentists, dental nurses, receptionists and the practice manager. We spoke with five patients and reviewed 73 comment cards. We reviewed practice documentation.

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 used a range of information to identify risk and improve quality regarding patient safety. For example, reported incidents and accidents, national patient safety alerts as well as comments and complaints received. All staff had responsibility for reporting significant or critical events and staff we spoke with understood this. We looked at some of the reported incidents and complaints. They had been properly recorded and investigated. Staff were made aware of any changes to practise that resulted from the incidents at regular staff meetings.

Reliable safety systems and processes (including safeguarding)

The practice had systems to safeguard vulnerable children and adults. There were policies and procedures to support staff to report safeguarding concerns. The practice had a named person responsible for safeguarding issues and staff knew who this was. All staff we spoke with told us they were up to date with training in safeguarding and records confirmed this. Staff were able to describe the different types of abuse patients might experience, how to recognise them and report them. There were flow charts on display in the treatment rooms and offices to assist staff on who to contact and how to report concerns. There had been no safeguarding incidents recently reported.

There was a whistleblowing policy. Staff were aware of the procedures and whom to contact outside the practice if they felt that they could not raise issues internally. However staff we spoke with, felt confident that any issue they raised would be taken seriously.

Staff maintained their professional registration for example, professional registration with the General Dental Council. We looked at the practice records of all dentists, and dental nurses and saw that they were up to date with their professional registration and there was a systematic process to monitor this.

Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. All patient records that we examined had an up to date medical history including any allergies and any medicines being taken. A questionnaire to update their history was completed each time a patient attended.

There was no rubber dam on the premises. 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. We spoke with one dentist about this. The dentist explained that only rotary instruments were used for root canal treatment and felt that there was no need to use a rubber dam because it was impossible for an instrument to come loose from the drill hand piece. The practice should complete a risk assessment documenting the review of the use of rubber dams to help ensure the most effective and safe root canal treatment for patients.

Medical emergencies

There were arrangements to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including medical oxygen. There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

The emergency medicines available included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff knew the location of the equipment and medicines. There was clear signage to show where the emergency medicines were kept. Equipment and medicines were checked regularly and there was a robust process to help ensure that this was completed.

Staff recruitment

The practice had policies and other documents that governed staff recruitment. There were comprehensive staff files that contained evidence that appropriate checks had been undertaken, for example proof of identification, references and professional qualifications.

All relevant staff had Disclosure and Barring Service (DBS) clearance (A DBS check identifies whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable). or an assessment of the potential risks involved in using those staff, together with action taken to mitigate the risk, without DBS clearance.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and accompanying procedures. This information was available

to staff on the practice computer system. This dental practice was part of a larger organisation and policies and practice were kept up to date corporately. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety such as the appointment of a fire marshal. Fire extinguishers had been recently serviced and staff knew how to respond in the event of a fire.

We saw that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). This also was managed corporately and the information was available to all staff through the practice's computer system. Staff we spoke with were knowledgeable about COSHH matters where they impacted on that staff member. There were measures to reduce such risks such as the wearing of personal protective equipment and safe storage.

Infection control

Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness. The premises were clean and tidy. The practice had an identified infection control lead. All relevant members of staff were up to date with infection control training.

There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste. There were sufficient supplies of cleaning equipment, appropriately stored. There was a detailed cleaning schedule that covered what areas should be cleaned, how frequently and what equipment to use.

We looked at the treatment rooms and waiting areas. The treatment rooms were fitted with hard flooring so that spillages were easily cleared up. All surfaces of the dental chairs were intact and covered in non-porous material so that the chairs could be effectively cleaned. The rooms were uncluttered. Antibacterial hand wash, paper towels and posters informing staff how to wash their hands were available at all clinical wash-hand basins in the practice. Personal protective equipment (PPE) including disposable gloves, aprons, face masks and visors were available for staff to use. All clinical staff wore uniforms dedicated for use whilst at work.

We looked at the decontamination room and went through the decontamination procedures with staff. There was a procedure, which met the current guidance, for moving instruments between surgeries and the decontamination area to help prevent the spread of infection. There was a system to help ensure that reusable items of equipment were only used for one patient before being decontaminated and sterilised. Dental instruments were cleaned and decontaminated in a dedicated decontamination room.

The facilities were compliant with the essential standards for decontamination. namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices' (HTM 01-05). There were three sinks in the decontamination room. The layout of the room allowed staff to easily work in zones moving from the dirty area through to the clean. We observed two members of staff doing this. They demonstrated the process for cleaning and sterilising instruments. An illuminated magnifier was used to check for any debris or damage throughout the cleaning stages. Staff wore appropriate personal protective equipment throughout the procedure. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers.

Although the infection prevention control process was on display in the decontamination room there were some discrepancies between how the two staff members carried out the process. The practice should review and check that all staff carry out decontamination following the agreed process.

Daily, weekly and monthly records were kept of decontamination cycles and tests. We checked these and the equipment was in working order and being effectively maintained

Many instruments were for single use only and the packaging indicated this. We looked at the dental instruments which had been decontaminated prior to reuse. These were stored in sterile pouches which were marked with expiry dates. All the instruments we saw in the treatment rooms were within their expiry dates.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

Are services safe?

There were procedures to help ensure that water used in the practice complied with purity standards. The practice had a current assessment of the risk of legionella (Legionella is a bacterium found in the environment which can contaminate water systems in buildings) and acted upon it.

Equipment and medicines

Staff said that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. There were equipment logs that showed that equipment (including clinical equipment) was tested, calibrated and maintained in accordance with the manufactures' schedules.

Medicines were stored securely in areas accessible only by practice staff. The practice kept records of the ordering and receipt of medicines. There were records showing the batch numbers and expiry dates of medicines. Medicines that we checked were within their expiry date and fit for use. Appropriate temperature checks for refrigerators used to store medicines had been carried out and records maintained.

Prescription pads were securely stored and their use recorded. Patients were required to submit their prescriptions to reception to have them validated with the practice stamp.

Radiography

Radiography was carried out at the practice safely and followed current legislation. There was a well maintained radiation protection file. There was an inventory of radiography equipment and the equipment had been regularly checked by service engineers. There were clear lines of responsibility and accountability recorded in the local rules for each X-ray unit. (The local rules set out who is responsible for the oversight and safety of radiography in the practice and what to do in the event of an equipment failure). These rules were displayed on the walls of each consulting room.

X-rays were justified, graded and reported on in clinical notes. There had been audits of radiography over the last year. One of the audits identified that the practice did not have a radiographic device used to hold the X-ray plate in place. We were told that the device had been requested several times but had not, so far, been delivered. The practice should review the results of radiographic audit to check that any necessary equipment is supplied.

The radiation protection file contained information to show how the practice complied with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R2000). The file contained the names and contact details of the radiation protection advisor and the radiation protection supervisor.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists regularly assessed each patient's gum health and took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). The assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and the General Dental Council (GDC). Assessments included an examination covering the condition of patients' teeth, gums and soft tissues as well as signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

We looked at three patient computer records for each dentist and hygienist. They were kept in accordance with the National Institute for Health and Clinical Excellence (NICE) guidelines, the FGDP Clinical Examination and Record-Keeping guidance and Department of Health Delivering Better Oral Health toolkit. Dentists also recorded the justification, findings and quality assurance of X-ray images taken as well as each patient's basic periodontal examination (BPE).

Health promotion & prevention

The practice promoted the maintenance of good oral health. There was a copy of the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' available to guide staff and we saw that this was regularly used.

The practice asked new patients to complete a health questionnaire which included further information for health history. The practice then invited patients for consultation with one of the dentists for review. Records showed that patients were given advice appropriate to their individual needs such as smoking cessation. Information displayed in the waiting areas promoted good oral health. This included information on tooth sensitivity.

Staffing

There was an induction programme for staff to follow which helped to ensure they were skilled and competent to deliver safe and effective care and support to patients. There was an immediate induction programme to help to ensure staff understood the critical polices and safety aspects, for example of the building itself. The induction programme covered issues such as the practices' goals, vision and ethos and the new staff's longer term needs such as training.

We reviewed four staff files. Staff development was addressed, for example there were records of extensive training that staff had undertaken. Staff were up to date with their continuing professional development requirements (CPD). They were encouraged to maintain their CPD and their skill levels. There was an effective appraisal system for administrative staff but dentists and hygienists had not had appraisals. The corporate provider was in the process of introducing appraisals for all dentists and hygienists. We saw the preliminary document which had been sent to these staff (September 2015) which was to be used to identify training, development needs and personal objectives as well as examining individuals' achievements over the previous year.

Working with other services

There was a comprehensive referral policy which had recently been reviewed and improved by the practice management and dentists. The policy supported a process of referral to other professionals and specialists in the care and treatment of patients where it was in the patient's best interest. One dentist within the practice had extensive surgical experience in the extraction of impacted third molars and accepted in-house referrals for this procedure. This reduced the time patients had to spend waiting for treatment had they been referred elsewhere.

Consent to care and treatment

The practice had a consent policy that governed the process of obtaining patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment. When patients needed treatment a treatment plan was developed. Patients were given time to make informed decisions about the treatment they chose to receive. We saw examples of where patients were encouraged to not to have immediate treatment but to spend some time considering their decision.

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 to make particular decisions for themselves. Staff showed a basic understanding of the Act and some staff had had formal training on the subject.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at 73 patient comment cards. Of these three had wholly negative comments, four had both positive and negative comments and 66 had wholly positive comments. There were no themes running through the negative comments save that patients did not like having to fill out a medical questionnaire on each occasion they attended. However this is considered best practice within the profession and is the practice policy. We spoke with five patients, their comments were wholly positive. Both in the cards and conversation patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a treatment room. We noted that treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The waiting room was relatively large. Telephone calls and private conversations between patients and reception staff that took place at the reception desk could not easily be overheard. Additionally in discussions with patients' staff were careful to keep confidential information private.

Involvement in decisions about care and treatment

Patients we spoke with told us that health issues and medicines were discussed with them and they felt involved in decision making about the care and treatment they received. Patients said that they felt listened to and supported by staff.

Patients were provided with written treatment plans that explained the treatment required and outlined any costs patients were required to pay. This allowed patients to consider the options, risks, benefits and costs before making a decision to proceed. We saw that patients were asked to take time to consider their decisions. Particularly with more complex issues they were encouraged not to have the treatment, unless urgent, on the same day.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice delivered personalised care to patients that took into account their individual needs. There were regular meetings where staff discussed the needs of individual patient and how they would meet them.

Staff told us that the practice always scheduled enough time to assess and undertake patients' care and treatment needs. Staff said they did not feel under pressure to complete procedures and had enough time available to prepare for each patient. This was corroborated by patients who were satisfied that enough time was afforded them for consultations.

Tackling inequity and promoting equality

The practice had considered different people's needs. There was a ramp to allow patients access with mobility problems. There were translation services for patients whose first language was not English. Some staff had received training in the Mental Capacity Act and other staff knew that they had to tell their of managers of any circumstances were they felt that an individual lacked the capacity to consent to any care or treatment.

Access to the service

Appointment times and availability met the needs of patients. The practice was open from Monday to Friday between 8.30am and 5.30pm. It was closed for an hour between 1pm and 2pm. Patients with emergencies were assessed and seen the same day if treatment was urgent. We spoke with one patient whose dentist was not working on the day of the inspection who had called in with urgent problems. This patient had been seen on that day by another dentist as an emergency.

Concerns & complaints

There was a complaints policy which guided staff through the handling of formal and informal complaints from patients. There was information for patients about how to make a complaint. Timescales for dealing with complaints were clearly stated and details of the staff responsible for investigating complaints were given.

There was a log of complaints received and we looked in detail at some complaints. They were well recorded and investigated. The practice apologised to the complainant if this was appropriate. We saw examples where some treatment had been unsatisfactory. The practice communicated clearly with the patient and rectified the problem without further cost to the patient.

Are services well-led?

Our findings

Governance arrangements

Staff members told us they felt supported by the practice manager and lead dentist and were clear about their roles and responsibilities. There were documents that set out the practice's governance strategy and guided staff, for example safeguarding, recruitment and confidentiality policies. There was a clinical governance policy and this was supported by regular meetings between the practice manager and dentists and by reviews from the clinical lead for the corporate provider. For example we saw that audits of dentists' information recording by the clinical lead had identified certain shortfalls. These had been raised with the dentist concerned. A further audit showed that the issues had been rectified. There were effective processes that followed a corporate system, to help ensure that policies and protocols were reviewed regularly.

There was a leadership structure with named members of staff in lead roles. For example, a dental nurse had lead responsibilities for infection control. The practice manager was responsible for the day to day running of the practice. The practice had an ethos of caring for and respecting patients. This was set out in a document "practice –patient responsibilities". Several staff members told us this meant ensuring that patients did not receive treatment that they did not want or did not need.

The practice had carried out a number of audits, for example there had been an audit of clinical record keeping. This had showed that the practice was compliant with the required minimum standards. Audits had resulted in action plans and in most, but not all, cases it was clear that the issues identified had been addressed. For example a health and safety audit identified the need for a new carbon monoxide monitor in July 2015 but it was not clear what had been done.

The practice identified, recorded and managed risks and there was a corporate system to support this. The practice had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, a fire risk assessment, control of substances hazardous to health and legionella (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Leadership, openness and transparency

The practice manager and lead dentist were visible in the practice and staff told us that they were always approachable and took time to listen to all members of staff. Staff told us they felt well supported by colleagues and management at the practice. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs.

All staff were involved in discussions about how to run and develop the practice. There were regular stall meetings and staff told us how they had influenced the running of the practice. For example one staff member had raised, at a staff meeting, issues about how records were maintained and, as a result, some recording practices were changed.

Management lead through learning and improvement

The practice valued learning. There was a culture of openness to reporting and learning from incidents. We saw a recent example concerning the treatment of an individual who had recently returned from an Ebola infected area and saw how this had been discussed and disseminated across the practice. Staff members we spoke with had had annual appraisals and valued the process. We saw that learning needs had been identified during the process and steps taken to book training for staff. The process for conducting annual appraisals for dentists and hygienists had begun but none had as yet had an appraisal, nor had the practice manager had an appraisal.

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

The practice took into account the views of patients and those close to them via feedback from patient surveys, as well as comments and complaints received when planning and delivering services. We saw that the practice reacted positively to feedback. The management involved the practice staff in recording and analysing the results of patients' surveys such as the NHS friends and family test. We were told by managers, and staff supported this, that this involvement in the process meant that the results had a greater impact on staff than if they had simply been posted on a staff notice board.