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180 Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 September 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was 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

One80 Dental Care is situated in the Totley area of Sheffield. It offers private dental treatments on a referral basis. The services provided included dental implants, endodontics, cosmetic dental treatment and conscious sedation.

The practice has three surgeries, a decontamination room, a waiting area, a reception area, a dedicated X-ray room and disabled toilet facilities. All the treatment facilities are on the ground floor of the premises.

There are three dentists, a dental hygienist, three dental nurses, a reception manager and a practice manager.

The opening hours are Monday to Friday 8-00am to 5-00pm. Evening and weekend appointments are available by prior arrangement.

The practice owners are the registered managers. A registered manager is a person who is registered with the Care Quality Commission(CQC) 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.

During the inspection we spoke with three patients who used the service and reviewed 14 completed CQC comment cards. Patients we spoke with and those who completed comment cards were positive about the care they received about the service.

Summary of findings

Our key findings were:

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention and control, health and safety and the management of medical emergencies.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to manage medical emergencies.
- Infection control procedures were in accordance with the published guidelines.
- 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 patients' needs.
- The practice was well-led and staff felt involved and supported and worked well as a team.
- The governance systems were effective.
- The practice sought feedback from staff and patients about the services they provided.

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 effective systems and processes in place to ensure that all care and treatment was carried out safely. For example, there were systems in place for infection control, clinical waste control, management of medical emergencies and dental radiography.

Staff had received training in safeguarding patients and knew how to recognise the signs of abuse and how to report them. Staff had also received training in infection control. There was a decontamination room and guidance for staff on effective decontamination of dental instruments.

Staff were appropriately recruited and suitably trained and skilled to meet patients' needs and there were sufficient numbers of staff available at all times. Staff induction processes were in place and had been completed by new staff.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and made referrals for specialist treatment or investigations where indicated.

On joining the practice, patients underwent a detailed assessment of their oral health and were asked to provide a medical history. This information was used to plan patient care and treatment. Patients were offered options of treatments available and were advised of the associated risks and benefits. Patients were provided with a written treatment plan which detailed the treatments considered and agreed together with the fees involved.

The practice liaised with the referring practitioner effectively to keep them informed of treatment decisions which had been made and also any after care which would be required.

Staff were supported to deliver effective care through training and supervisions. The clinical staff were up to date with their continuing professional development (CPD) and they were supported to meet the requirements of their professional registration.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. We looked at 14 CQC comment cards patients had completed prior to the inspection and spoke with three patients. Patients were positive about the care they received from the practice. They commented they were treated with compassion, kindness, respect and dignity while they received treatment.

We observed patients' privacy and confidentiality were maintained at all times in the waiting room and reception area. We observed surgery doors were closed during consultations which ensured patients' privacy was respected

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Summary of findings

Are services responsive to people's needs?

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

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

Patients could access routine treatment and urgent care when required and at a time which suited them. The practice offered same day appointments which enabled patients to receive treatment quickly.

Are services well-led?

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

There was a defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice.

The practice audited clinical and non-clinical areas as part of a system of continuous improvement and learning. All patients received a feedback form after completing a course of treatment.

The practice held monthly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues. The practice also held daily meetings to discuss urgent matters and upcoming treatments.

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Detailed findings

Background to this inspection

This announced inspection was carried out on 8 September 2015 by a dentally qualified CQC inspector.

During the inspection we spoke with three patients, one dentist and one dental nurse and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records 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

The practice had clear guidance for staff about how to report incidents and accidents. We saw evidence that they were documented, investigated and reflected upon by the dental practice. Patients were given an apology and informed of any action taken as a result.

The practice manager understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy. The practice responded to national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The practice manager was the safeguarding lead in the practice and all staff had undertaken safeguarding training in the last 12 months. There had not been any referrals to the local safeguarding team; however staff were confident about when to do so. Staff told us they were confident about raising any concerns with the safeguarding lead.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments).

Rubber dam (a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patient records were accurate, complete, legible, up to date and stored securely to keep people safe and safeguard from abuse.

Medical emergencies

The practice had a medical emergencies policy which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency; everyone had received annual training in emergency resuscitation and immediate life support within the last 12 months.

The emergency resuscitation kits and oxygen were stored in the reception area and the emergency medicines were stored in the main surgery where conscious sedation takes place; all staff were aware of where to locate it. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). During conscious sedation clinics the oxygen was moved to the surgery where treatment was taking place. This enabled emergency treatment to be administered more rapidly in the event of a medical emergency.

Records showed daily and weekly checks were carried out to ensure the equipment and emergency medicines were fit for use.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration.

We reviewed a sample of staff files and found the recruitment procedure had been followed. The practice manager told us the practice carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks 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. All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

Are services safe?

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice manager carried out health and safety checks which involved inspecting the premises, equipment and ensuring maintenance and service documentation was up to date.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, a fire risk assessment and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. The practice identified how they managed hazardous substances in their health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures.

Infection control

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

The practice followed the guidance about 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)'.

Staff had received training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the surgeries and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned and colour coded equipment was used. There were hand washing facilities in each treatment room and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Patients we spoke with confirmed that staff used PPE during treatment. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfector to disinfect the used instruments, examined them visually with an illuminated magnifying glass and then sterilised them in an autoclave. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included heavy duty gloves, disposable gloves, aprons and protective eye wear.

The practice had systems in place for daily, weekly and monthly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had carried out the self- assessment audit relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This audit was completed in March 2015. This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

Records showed a risk assessment process for Legionella had been carried out in March 2015 (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice had undertaken regular in-house risk assessments for legionella. The practice undertook processes to reduce the likelihood of legionella developing

Are services safe?

which included the use of anti-microbial straws in the dental water line system, monitoring cold and hot water temperatures each month and also tests on the on the water quality to ensure that Legionella was not developing.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, autoclaves, washer disinfectors and dental chairs. The practice maintained a comprehensive list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of autoclaves and washer disinfectors. Portable appliance testing (PAT) had been completed in September 2014 (PAT confirms that electrical appliances are routinely checked for safety).

The practice also dispensed medicines including antibiotics for patients whom required it. There was an effective stock control system to ensure that all medicines were in date and also available when needed. This also applied to medicines used for conscious sedation.

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 viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) 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 available in all surgeries and within the radiation protection folder for staff to reference if needed.

Those authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training. This protected patients who required X-rays to be taken as part of their treatment.

X-ray audits were carried out every six months. This involved assessing the quality of the X-ray image. The results of the audits confirmed they were meeting the required standards which reduced the risk of patients being subjected to further unnecessary X-rays.

The practice also accepted referrals for cone beam computed tomography (CBCT) imaging. CBCT is an X-ray based imaging technique which provides high resolution visualisation of bony anatomical structures in three dimensions. Referring practitioners were evaluated prior to being allowed to refer individuals for imaging to ensure that patients were suitable for imaging and also to ensure that the practitioners were capable of reporting on the images provided.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). The practice assessed each patient individually to determine a suitable recall interval to review the treatment which had been undertaken. Patients who had received more complex treatment were recalled more frequently. All patients who had undergone extraction or implant placement were reviewed a week later to ensure adequate healing. Patients were made aware that the referring dentist was responsible for the on-going of their dental needs.

We reviewed with the dentist information recorded in four patient care records regarding the oral health assessments, treatment and advice given to patients. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer.

We reviewed with the dentist information recorded in a dental care record where conscious sedation had been used. This included a pre-sedation checklist including the patient's blood pressure and oxygen saturation. Patients had their blood pressure and oxygen saturation monitored throughout conscious sedation. After the treatment the patient was moved to a recovery room where they were monitored and given post-operative instructions with relation to conscious sedation prior to being discharged. All aspects of the treatment were in line with the Society for the Advancement of Anaesthesia in Dentistry (SAAD) guidance.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health. Patients were provided with oral hygiene advice and also referred to the hygienist for support and treatment if required.

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were health promotion leaflets available in the waiting room and surgeries to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. One of the staff members who we spoke with had recently started working at the practice and they informed us that they had completed the induction process and that it had been beneficial to becoming integrated into the working environment.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all relevant staff and we saw evidence of on-going CPD. Mandatory training included basic life support and infection prevention and control.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. The practice had systems in place to review when staff were unable to fulfil their responsibilities for heath reasons. We saw evidence of when this protocol had been applied.

Working with other services

The practice acted as a referral centre for dental implants, oral surgery, endodontics and orthodontics and CBCT imaging. Practitioners could make referrals by completing an online form or by posting a letter. When referrals were received the patient was contacted in order to arrange an initial consultation. The referral letter was stored in the patients dental care records for future reference.

Correspondence was regularly sent to the referring practitioner to keep them informed of treatment decisions which had been made and also details of advice with regards to on-going care.

Referring practitioners were also encouraged to contact the practice at any time if they had any questions or queries regarding the treatment which was being provided.

Having completed a course of treatment patients were referred back to their own dentist for on-going care.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. This involved organising a separate appointment to discuss in detail treatment options including risks, benefits and fees involved. This appointment was undertaken in a dedicated room and there was access to models, X-ray images and information leaflets detailing what can be expected during treatment. Patients were given time to decide upon the most appropriate treatment for them.

After deciding upon a treatment plan, the patient was provided with a copy of the treatment plan which included information about the risk and benefits of the treatment. Prior to actually undertaking the treatment the patient was asked to take a short test to assess their understanding of the treatment. This is a robust way of ensuring that patients fully understand the proposed treatment which is essential in obtaining valid consent. Staff were aware that consent could be removed at any point.

Staff were aware of the importance of the role family members and carers might have in supporting the patient to understand and make decisions, however confidentiality was paramount and was never compromised.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at 14 CQC comment cards patients had completed prior to the inspection and spoke with three patients who used the service. Patients were positive about their experience and they commented that they were treated with care, respect and dignity. They said staff supported them and were quick to respond to any distress or discomfort during treatment.

We observed interactions between patients and staff on the day of inspection and it was obvious that treating patients with respect and dignity was important for the practice. We were told that if a patient wished to speak in private an empty room was always available to speak with them.

All patients were called the day after any surgery to check whether they were experiencing any complications. If the patients were having any problems then they were either given advice over the phone or offered an appointment to see the dentist to address any issues which they may be experiencing.

All patients were also seen at the practice two to three weeks after treatment to ensure that they were happy with outcome and not experiencing any post-operative problems.

Involvement in decisions about care and treatment

The practice involved patients in detailed discussions to enable them to make informed choices. These discussions took place at a separate appointment from the initial consultation and in a non-clinical room. These discussions involved the use of models of the patient's teeth, X-rays and visual aids. Patients were made fully aware of risks, benefits and costs associated with the different treatment options.

Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Staff had received training in the Mental Capacity Act (MCA) 2005.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

When patients booked their initial consultation they were sent an information leaflet outlining the way the practice worked. This included advice about payment, information about the appointment system, arrangements for emergency treatment out of hours and a copy of the complaints procedure.

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen within 24 hours if not the same day. On the day of inspection we saw a patient who was experiencing pain who was given an appointment that day.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity and disability policies to support staff in understanding and meeting the needs of patients. The practice had undertaken a disability discrimination survey and had made adjustments to the building to ensure it was accessible to patients who had disabilities. This included an audio loop system for patients with a hearing impairment, disabled toilet facilities, disabled parking, a ramp to access the building and step free access to all surgeries.

Access to the service

The practice displayed its opening hours in the premises, on the practice website, in the practice leaflet and in the information leaflet sent to patients prior to their initial consultation. Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Appointments were available in the evening and at weekends for those who could not attend during normal opening hours.

Where treatment was urgent patients would be seen within 24 hours or sooner if possible. If patients required emergency treatment out of hours they were advised to phone the practice where there were details of current contact numbers for attention.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The practice manager was responsible for dealing with any complaint about the service. Staff were aware of this arrangement and the importance of reporting complaints to the practice manager to ensure complaints were dealt with in a timely manner.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints made by patients. We found there was an effective system in place which helped ensure a timely response. Information for patients about how to raise a concern was available in the waiting room, on the practice website and in the information leaflet sent to patients prior to their initial consultation. There was further contact details available for complainants who were not satisfied with the outcome of the response from the practice. We reviewed a complaint which had been received in the past 12 months and this had been dealt with in a timely manner. It was evident from these records that the practice had been open and transparent with the patient.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service.

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example fire and infection control. There was an effective approach for identifying where quality and/or safety were being compromised and steps taken in response to issues. These included audits of infection control, patient records and X-ray quality. The practice also conducted regular audits on the success of implants and the healing after extractions. All patients who had undertaken these procedures were included in the audit. This enabled the practice to identify patient risk factors which may affect success rates. Any trends in risk factors would be investigated and action could be taken to address such risk factors in the future.

There were a range of policies and procedures in use at the practice. The practice held monthly staff meetings where issues such as infection control, safeguarding, MHRA alerts and patient feedback were discussed. All monthly meeting were minuted to ensure that any staff who could not attend could be kept informed of any issues raised. The practice also had daily team talks to ensure all equipment or materials were ready for upcoming treatments.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. This was evident when we looked at the complaint which they had received in the last 12 months and the response which they had provided.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner. All staff were aware of who to raise any issue with and told us that the practice manager was approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos.

Learning and improvement

Staff told us they had good access to training and were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). This included emergency resuscitation and immediate life support, infection control and safeguarding children and vulnerable adults.

The practice audited several areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as clinical records, X-rays, infection control, a fee estimate audit and an implant success rate audit. We looked at the audits and saw that the practice was performing well.

The practice held monthly staff meeting where significant events, ways to make the practice more effective and audit results were discussed and learning was disseminated. All staff had annual appraisals where learning needs and aspirations were discussed.

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

Patients and staff told us that they felt engaged and involved at the practice both informally and formally. Staff told us their views were sought and listened to. The practice had systems in place to involve, seek and act upon feedback from people using the service. This included sending each patient who had completed a course of treatment a detailed satisfaction survey. These were then checked by the practice manager who logged any negative feedback which they disseminated to the practice and acted upon if necessary. Feedback from the patient satisfaction survey was all very positive.