Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Southerhay Dental Practice

20 Southernhay East, Exeter, EX1 1QL

Tel: 01392202242

Date of Inspection: 22 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Southernhay Dental Practice
Registered Manager	Mr. Ian Turner
Overview of the service	Southernhay Dental Practice is a private practice. It was established in 1923 and provides dental treatment and cosmetic dentistry for people living in Exeter and the surrounding areas. The practice is also able to offer assessments for performance mouthpieces for athletes. The surgery opens on weekdays with an emergency call out service out of hours and at weekends.
Type of service	Dental service
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 October 2013, checked how people were cared for at each stage of their treatment and care and sent a questionnaire to people who use the service. We talked with staff.

What people told us and what we found

This was Southernhay Dental Practice's first inspection since registering with the Care Quality Commission. During our inspection, we checked and were assured that people using the dental practice received their examinations in private so that their dignity was respected. People told us they were involved in their treatment planning and they were invited to give feedback about their experiences.

We met and spoke with staff and checked records. We toured the premises and were satisfied people received safe and effective treatment in a clean environment.

Prior to the visit we contacted, with their permission, some people who had attended the practice the week preceding our visit. We sent an email questionnaire to 12 people and received six responses. People expressed high levels of satisfaction with the practice. Comments included, "I have known my dentist for many years and trust him entirely." "When I have needed treatment it is always fully explained." "Staff in the surgery are always friendly and helpful."

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who used the service were given appropriate information and support regarding their care or treatment. We received comments from six people registered with the service. They told us they were satisfied with the treatment provided at the practice. They told us the dentists clearly explained their treatment to them. People also told us the dentists asked for their consent before going ahead with any treatment.

People who used the service understood the care and treatment choices available to them. They confirmed if they required more complex treatment a treatment plan was discussed with them. One person told us "treatment options have been clearly explained when the need has arisen and my own involvement in decisions has been encouraged." Patient records showed treatment plans detailed what the course of treatment was and how much they would need to pay. Information displayed in the practice detailed costs for treatments. The providers also had an informative website detailing such as services, costs, opening times. Information leaflets for patients were available at the practice.

People expressed their views and were involved in making decisions about their care and treatment. People told us that the providers gained feedback by asking them verbally at the end of their appointment if they had any comments or concerns. One person wrote "I am usually asked if everything is ok." Another person told us they were aware of questionnaires at the surgery to rate their experiences.

We saw patient questionnaires in the waiting rooms and the practice manager showed us examples of comments that had been left and where this had led to changes at the surgery. Regular audits of questionnaires were kept to demonstrate how the practice was responsive to people's views. People were able to leave anonymous replies if this was their preference. We read a random selection of patient responses. Satisfaction rates were very high and we saw that the providers had acted on people's suggestions, for example to improve décor and seating in waiting areas.

People told us their privacy was maintained whilst receiving examinations or treatment at the practice. When we visited we saw consulting room doors were kept closed when people were being examined by the dentists and hygienists on duty. People also confirmed that the staff were approachable. One person wrote "I would give them top marks for this." Another person told us that although the reception desk was not private, "Due to its very nature the reception does not lend itself to conducting discussions in private but in the event that this was deemed necessary I would have no hesitation in making such a request and have no doubt that this would be granted." During the visit the practice manager told us rooms were available and had been used if a person wished to have a private conversation with them.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People told us the dentists checked their medical history and any changes to their health before an examination. We spoke with three dentists on duty all who acknowledged the importance of ensuring they had up to date medical information about people before examining or treating them. Dentists' records we looked at demonstrated discussion of on-going treatment and oral health advice for people they had seen. For example, dietary advice and assessment of the mouth, gums and teeth and tooth brushing advice for patents accompanying small children during their examinations. To mark oral cancer awareness month in November, self-monitoring advice was displayed in waiting areas.

There were arrangements in place to deal with foreseeable emergencies. Records showed, and the staff we spoke with confirmed they had completed first aid training on an annual basis. This training was attended by the dentists, hygienists, dental nurses and reception staff. The practice had suitable emergency medicines and resuscitation equipment. However the providers may wish to note, injectable adrenaline doses for adults or children was not differentiated neither on the adrenaline medicine packaging nor on the practice's medical emergencies protocol. We spoke with the practice manager and one of the providers who told us they would ensure this information was readily available by updating the written protocol and labelling the medicine. Emergency equipment did include suitable face masks for both adults and children. A defibrillator in the event of cardiac arrest and oxygen were available at the practice. Records were completed to show that regular checks were done to ensure the equipment and emergency medication was safe to use.

We checked the provider's radiation protection file as x-rays were taken at the practice. We also looked at x-ray equipment in use at the practice and talked with staff about x-ray use. We found there were suitable arrangements in place to ensure the safety of the equipment. We saw procedures and equipment had been assessed by an independent expert within the recommended timescales. Equipment and written procedures were maintained in good order and staff vulnerable to radiation exposure, such as pregnant

staff, were risk assessed and appropriate methods were put in place to monitor their exposure to ensure this was not excessive and harmful to the unborn child.

The reception staff told us an answer phone message detailed how to access out of hours emergency treatment. Information for emergency treatment was also available on the web site. Each day the practice was open, emergency treatment slots were made available for people with urgent dental needs. On the day of our visit we looked at the records of people who had been seen at short notice that day. We saw requests for treatment were accommodated appropriately and sufficient time was allocated to each person to thoroughly examine and treat where necessary. This meant people could access treatment when they needed it.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. For example, the providers had assessed the building with regard to people with mobility needs. The building was of Georgian construction and presented some limitations to how people's needs when severely restricted with their mobility could be met. For example patient toilets were down a flight of stairs in the basement. However the providers had made reasonable adaptations. There was level access to the building from the rear entrance and ground floor consulting rooms were available. During our visit we saw one person experiencing some difficulty walking up some stairs. As a result the person was discreetly offered a consultation on the ground floor, keeping their own dentist if they wanted, on future visits.

People's email questionnaire responses indicated they found staff at the practice approachable. One person told us there was an "extremely calm and friendly atmosphere" at the practice. Another person said if they had a complaint they considered staff approachable and "always feel free" to discuss issues with their dentist and the supporting staff.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. When we visited the practice we spoke with staff about the cleaning routines and infection control training. Practice staff had undertaken relevant training in infection control within the last year. Staff told us their competencies in the workplace in good infection control techniques were monitored and recorded through clinical supervision.

We read the practice policies and procedures for management of infection control and the providers had given responsibility for infection control to a named member of staff. The providers had copies of relevant best practice guidance in infection control and decontamination of dental instruments. We spoke with dentists and dental nurses who were aware of recent changes in legislation affecting the management of decontamination and sterilisation of dental instruments and management of sharps at the practice. Staff told us there were regular 'lunch and learn' sessions where as a staff group semi-formal meeting took place to share knowledge and discuss good practice awareness.

The providers had assessed their facilities at the practice to meet government guidance for instrument decontamination in dental practices. The providers had completed regular self-assessments in relation to published best practice guidance. The audits indicated the facilities and management of decontamination and infection control was managed well.

We examined the facilities for cleaning and decontaminating dental instruments. The practice did not have a dedicated decontamination room; cleaning and sterilisation of dental instruments took place in each consulting room. However, work had started to prepare and fit a dedicated room for this purpose as is advised in best practice guidelines. We asked the practice manager when the room was likely to be operational. We were told the likely date was during 2014.

In each consulting room for the purposes of cleaning and sterilising instruments there were clear flow routes from 'dirty' to 'clean' to minimise cross contamination risk. One of the dental nurses showed us how instruments were decontaminated and sterilised. The availability of vacuum autoclaves provided sterility of instruments for the recommended 12 months. Equipment checks were carried out during each surgery session and recorded to ensure the equipment was in good working order. However, the providers may wish to

note the lack of both readily available illuminated magnification to check for any debris or damage throughout the cleaning stages and scratch resistant stainless steel bowls when rinsing instruments meant best practice guidelines were not being met. In addition there was no information for staff in policies regarding the maximum water temperature for the effective cleaning of instruments.

We saw staff members had supplies of gloves, masks and eye protection. We also saw consulting rooms had eye protection supplied for patients. Staff had facilities to wash their hands in dedicated 'clean' sinks which demonstrated good practice in preventing the spread of infection. Staff told us the importance of good hand hygiene was included in their infection control training sessions.

We observed how waste items were disposed of and stored. The provider had an on-going contract with a clinical waste contractor. We saw that the differing types of waste were appropriately segregated and stored at the practice. Waste was labelled correctly with the name of the originator.

We looked at the consulting rooms where patients were examined and treated. The rooms and equipment appeared clean. The nurses explained they had cleaning duties between patients and at the end of treatment sessions. However, the cleaning schedule did not include the cleaning of water filters for distilling water for use in the autoclaves. The providers may wish to note we saw that water filters in use, stored in the staff room, were in need to cleaning as they had accumulated dust build-up. The practice manager acknowledged this and told us they would add cleaning of water filters to the written schedule to ensure the equipment remained suitably clean. Each person we contacted to comment on the practice said the practice appeared clean when they visited.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at the providers' recruitment and selection processes. Of the 22 staff working in the practice we looked at the recruitment files for three staff members who had been employed since the practice registered with the Commission in 2012. The providers may wish to note we found there was a lack of consistency within recruitment methods, which meant there was difficulty in rationalising a benchmark when assessing candidates for posts. For example, some applicants had completed a standard application form, others had submitted CVs. The lack of completed standard application form from all candidates could hinder a consistent benchmark being applied when assessing candidates.

At least one reference was obtained for successful applicants. We discussed with the practice manager the prudence of requesting information from more than one referee to corroborate views that the applicant was suitable for the post advertised. This would make the recruitment process more robust. Some references commented upon work performance and character, but not all provided this amount of detail. The practice did not have a standardised reference request form prompting the referee to comment on aspects of the applicant's work conduct or personal characteristics, such as the applicant's suitability to work with vulnerable groups. We discussed this with the practice manager who told us they would amend their employment protocol and take ownership of questions referees would be requested to respond to. This would strengthen employment processes to ensure each candidate was of good character, physical and mentally fit for that work and suitability skilled and experienced for the post.

Appropriate background checks were undertaken for newly appointed staff. Records of evidence of professional qualifications, current registration with professional body and personal indemnity insurance were maintained. Photographic proof of newly employed staff was obtained to verify their identity and disclosure and barring checks had been undertaken and received. These checks showed each employee was permitted to work with vulnerable people. However, the providers may wish to note two of the three barring checks were received after staff members started work. This meant the providers did not know if the person was on a barred list before they started their employment, which presented a risk to the public. Staff at the practice told us dental professionals never worked alone with patients. This was confirmed by people in our email questionnaire who told us dentists or hygienists always worked with a dedicated dental nurse. People told us

they felt safe at the practice.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

Records were kept securely and could be located promptly when needed. We looked at a number of records that the service maintained. We saw these records were stored securely. Patients' treatment records were stored in a lockable facility in a staff only area.

Electronic records were password protected, which meant only staff with authorisation could access confidential records. The electronic records were firewall protected to prevent them being accessed inappropriately. Computer screens used by reception staff faced away from the public to prevent breaches of confidentiality.

People could be reassured their records remained confidential. Provider information made people aware of confidentiality of their records and their rights of access to their personal records. Staff we spoke with understood the need for patient confidentiality; their knowledge was underpinned by the provider's policy documents.

We spot checked two paper and five electronic patient records, chosen at random. They had all been completed contemporaneously and were up to date. Records highlighted important and relevant risks such as allergies or current medical treatments.

However, the paper patient treatment records we viewed contained brief information about the patient examination and treatment and, for example, medical history checks and patient consent to treatment had not been recorded. We spoke with dental nursing staff who worked with the dentist that maintained paper patient records. The nurses confirmed the dentist verbally checked people's medical histories and asked for consent before examining and treating people. We spoke with the practice manager who told us they would raise the issue of record keeping with the individual concerned.

Other records relevant to the management of the services were accurate and fit for purpose. We looked at patient survey results, equipment servicing records, cleaning schedules and policy/procedure documents. We found these records were well ordered and clear.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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