Inspection Report

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

Lynbridge Dental Practice

26 West Street, Tavistock, PL19 8AN

Tel: 01822612828

Date of Inspection: 20 May 2014

Date of Publication: June 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Cleanliness and infection control	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mr. Matthew Brock
Overview of the service	Lynbridge Dental Practice provides general dentistry to private patients. A hygienist is available. Domiciliary visits by a dentist may be arranged for private patients. NHS treatment is provided for children and adults exempt from charges.
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

We carried out this inspection to check whether Lynbridge Dental Practice had taken action to meet the following essential standards:

- Cleanliness and infection control
- Assessing and monitoring the quality of service provision

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 20 May 2014, observed how people were being cared for and talked with staff.

What people told us and what we found

When we (the Care Quality Commission) inspected Lynbridge Dental Surgery on 30 September 2013 we found that people who used the service were positive about the treatment they received. However, we also found that the service was not meeting some essential standards.

At that inspection we found that improvements were needed to the decontamination process, to reduce the risks of cleaned instruments being contaminated again. We identified that infection prevention audits needed to be carried out more frequently in line with recommendations set out by the Department of Health. The practice's quality assurance processes were not robust as there were not always clear lines of accountability.

Following the inspection on 30 September 2013 we asked the provider to send us an action plan detailing how they would make the necessary improvements. The provider sent us an action plan which described the changes they would make.
We carried out an inspection on 20 May 2014 to confirm that the provider had made those improvements.

During our latest inspection on 20 May 2014 we saw that effective changes had been made to the layout of the decontamination room to ensure a clear flow of work from dirty to clean areas. More frequent audits of infection prevention and control (IPC) had been carried out every three months and these had been acted upon.

The provider had also initiated a more robust system of quality monitoring, with clear lines of accountability.

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

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. There were effective systems in place to reduce the risk and spread of infection.

Reasons for our judgement

Effective infection prevention and control plays an important part in ensuring that the service provided to people is safe. The Department of Health published an updated document in March 2013 called the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). It sets out in detail the processes and practices essential to the prevention of infections and to deliver clean, safe care.

During our inspection on 30 September 2013 we identified that some improvements were needed in infection prevention and control (IPC) at Lynbridge Dental Practice. This was because the layout of the decontamination room did not support a flow of work that moved consistently from dirty to clean. Some sterilised instruments had to be placed back into the dirty area to be bagged.

When we carried out a follow up inspection at Lynbridge Dental Practice on 20 May 2014 we found that the provider had taken effective action to remedy this. The provider told us that some structural alterations had been made shortly after our previous inspection, to enable necessary improvements to the layout of the decontamination room. We saw that a hand washing sink for staff had been relocated and was now installed at the beginning of the decontamination process, as recommended in HTM01:05. Other items such as an autoclave and a clinical waste bin had also been relocated to support a continuous workflow from dirty to clean. We spoke with a member of staff dedicated to work in the decontamination area and observed them working through a decontamination process. They told us that the new layout worked better. We saw that there was a clear diagram on display which detailed the process and the dirty to clean work flow for staff.

During our previous inspection we had found that the practice was not carrying out regular audits of infection prevention and control (IPC). During our latest inspection on 20 May 2014 we spoke with the dentist who had taken on the role of IPC lead. They told us that audits had been carried out with greater frequency and they were also introducing a new

monthly cleanliness audit, which would commence at the end of May 2013. (The practice was visibly clean during our visit.) We saw records which showed that IPC audits had been carried out in October 2013, and in January and April 2014. The practice's audit compliance score had increased from 90% to 98%. The last audit had identified that hand hygiene training required updating. We were told that this would be held at a team meeting in June 2014.

Overall we found that the provider had taken positive steps to improve the prevention and control of infection. This supported the delivery of a safe service.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had initiated and was further developing an effective system to regularly assess and monitor the quality of service that people receive

Reasons for our judgement

When we inspected at Lynbridge Dental Practice in September 2013 we received positive feedback about the service from people. However, we found that the practice was not meeting required standards in ensuring that effective systems were in place to monitor and manage risks in relation the quality of the service. For example, there were not always clear lines of responsibility in some areas. This had led to a lack of auditing in relation to ensuring safety and some necessary checks such as fire safety checks and drills had not been completed.

When we inspected at the practice on 20 May 2014 we found that improvements had been made. We saw that there was a contact list for staff which informed them which person had the lead in areas such as infection prevention and control, fire safety, and managing staff files. We spoke with all of the partners at the practice and six of the dental nurses and receptionists who worker there. We found that staff understood who was responsible for particular areas. Most staff told us that they knew exactly who to direct particular issues to and that they felt that the dentists were responsive.

At the previous inspection in September 2013 we had identified that there had not been a staff representative meeting for a year. We were told that these meetings between the dental partners and staff had previously enabled staff to feedback about the service and provide an opportunity to influence it, where appropriate. At that inspection we were told that the meetings had "petered out".

During our inspection on 20 May 2014 we saw that a staff meeting had been held on 17 February 2014 and another meeting was scheduled for 19 June 2014. Minutes of the previous meeting showed that issues about staffing, training and safety had been discussed. We asked a dental nurse whether any suggestions made by staff were acted upon. They told us about one such improvement. We were shown the electronic chute which was used to deliver instruments from first floor surgeries to the decontamination room. Instruments were placed in a capsule before being despatched. We were told that dental nurses had suggested that instruments should be bagged before being placed in the capsule to reduce the risk of spillages and that this had been implemented. This

indicated that the practice had been responsive to recent staff suggestions.

Dental nurses and reception staff said that they could approach the dentists informally to discuss issues. However, the majority of dental nurses and reception staff that we spoke also said that the increased frequency of whole practice meetings would be useful. They said that more meetings would allow staff and dentists time to focus on issues in depth rather than have brief conversations between appointments. We made the provider aware of this.

The practice had a suggestion box in the reception area for people to express their views about the quality of service and to suggest improvements. We saw that the practice had received positive feedback from people who used the service. Examples included the following: "Girls in reception incredibly helpful. Just waiting to see X (a dentist at the practice) who was highly commended for their care." We discussed with the provider individual suggestions which had been made about possible improvements to the environment and facilities. The provider's response showed that these suggestions had been fully considered.

We asked staff what could be improved at the practice. The most common comment from staff was a reduction in the number of appointments which over ran, thereby prolonging patient waiting times. We also saw a very recent feedback form from a person who used the service regarding the punctuality of their appointment. It should be noted that the provider had not yet had an opportunity to see or address that particular piece of feedback. We drew the feedback to the provider's attention and spoke with them about the issue of punctuality and late running of some appointments. They assured us that over running of some appointments would be promptly addressed with individual dentists and also discussed at the next staff meeting.

Overall we found that the provider had improved clarity about individual lead roles at the practice. We found that safety checks which had not previously completed were now being undertaken. There was a more robust and evolving system of monitoring and audits. The holding of regular staff meetings had re-commenced which could allow staff to formally share their views on the quality of the service. More effective quality assurance systems had been initiated at the practice and their development was ongoing.

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.

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