Inspection Report

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

The Quay Dental Practice

Natwest Bank Chambers, The Quay, Bideford,
EX39 2HW

Date of Inspection: 28 November 2013

Date of Publication: December 2013

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

Consent to care and treatment	✓ 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
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	QDP (Devon) Limited
Registered Manager	Mrs. Sarah Louise Huxtable
Overview of the service	The Quay Dental Practice provides general dentistry to private patients and to adults and children under a small NHS contract. It includes a hygiene and advisory service.
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 carried out a visit on 28 November 2013, talked with people who use the service, talked with staff and reviewed information given to us by the provider. We took advice from our specialist advisors.

What people told us and what we found

During this inspection we spoke with six people who used the service, the registered manager, four dentists and five other staff on duty. We saw all five treatment rooms and looked at documents relating to the running of the service.

People told us they had confidence in the practice. They had been given good information and advice. One person said, "I feel fully informed, but not patronised." People told us the receptionists have varied but "are all excellent now, all helpful". Each person said they were happy with the levels of confidentiality and privacy maintained in the practice - "Our privacy is not in question."

The practice is on the first floor of a listed building, where permission has not been granted for a lift or stair-lift. Several people said that the stairs caused them anxiety but they would continue coming here while they could.

We found that staff maintained good practice in explaining treatments and gaining people's informed consent. We saw that the practice was clean and hygienic. Suitable arrangements were in place to appoint staff. There were systems in place to gather feedback from people who used the service and to monitor the quality and safety of the service.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

One person told us they were given good information to enable them to make decisions. Another person said, they had been asked whether they minded being seen by the newly qualified dentist, and they had been pleased to accept. One person told us they were not worried about going to the dentist, and would have a filling without an injection, which showed they were asked before treatment began whether they wished for pain relief.

The registered manager gave us a copy of the practice's policy on consent. This stated that patients were to be treated with respect, recognising their rights and they were to be encouraged to be involved in decisions about their care. The policy included giving sufficient information so that people could give informed consent, and to cover why treatment was considered necessary, the risks and benefits of proposed treatment, what might happen if treatment was not carried out and the risks and benefits of any alternatives available.

We saw a sample of patient records. We saw that "Treatment plan was discussed." Staff told us that people were given a printout of their treatment plan, including the costs involved. We saw one example, where the cost to the person was nil. There was a space for their signature. Staff told us that after they signed, this was scanned and saved on their computer record.

A dentist told us how they asked people before they carry out a scale and polish whether they are happy for them to do that. Also, they described how they explain to people who need root canal treatment that they may choose to go to a specialist. They explained the risks, made sure the person understood before asking them to sign to give their consent to treatment.

Dentists told us what they would do if there were any doubt about a person's ability to make a decision on their own behalf. If they were not accompanied by a relative or carer they would be given a treatment plan and invited to come back. This would give them

opportunity to discuss planned treatment with a family member. Staff said they mostly knew the patients, and their families. There were chairs available for relatives to sit in the treatment room during appointments. Staff showed us that a pop-up alert on the screen alerted the dentist if there were any personal issues which might, for example, indicate the person needed support from a carer during their examination. Staff told us of a person who had refused treatment although they were in pain. They had returned with a family member to support them, and then been able to accept treatment.

All staff had benefitted from a one hour DVD which provided an introductory training session on the Mental Capacity Act 2005 and its relevance for dentistry. Senior staff had also completed an additional course provided by the Department of Health, which they told us they had found very helpful. The registered manager gave us a copy of the practice's policy on adults who lack capacity in relation to making decisions about dental treatment. This included the observation that a person may be able to consent to simple treatment but may not understand or be capable of consenting to more complicated treatment. There was information for staff on finding who would have the power to consent on their behalf.

Staff said they would contact social services if they detected any possibility of abuse which could include a family member preventing a person from accepting treatment that was in their best interest.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People told us they had confidence in their dentist, describing the practice as reliable and safe. One person said their dentist was "Very precise – the best dentist I have ever had!" People said they were recalled regularly. Each person told us they were given a form to complete about their general health and any medicines they were prescribed. One person said, "The only thing is, they tend to ask questions when there are instruments in your mouth and you can't speak." They were happy with their treatment, however, and said they had never had any reason to complain.

Patient records that we saw flagged up where there was a risk to health such as smoking or alcohol. Oral health education was given regularly as was examination of the soft tissues and screening for mouth cancer.

One dentist told us of a vulnerable patient who attended for treatment. They had become accustomed to attending and liked the rituals of putting on goggles and apron. The dentist prescribed high fluoride toothpaste to help them avoid decay and reduce their need for attendance.

We found that staff were well prepared to deal with medical emergencies. Two dentists who were partners in the company were qualified as first aiders. The registered manager told us that one of them was always on duty when the practice was open. The staff on reception were newly recruited and not yet trained. They showed us how they could send an instant message to the dentist if there was a medical emergency in reception. We saw the first aid box, oxygen supply and emergency medications. We saw that guidance for staff was provided about the use of emergency medicines and we saw that they had been checked regularly by the registered manager and were all within the expiry date and fit for use. The practice had obtained a defibrillator as recommended by the Resuscitation Council UK. All staff attended annual training in basic life support including cardiopulmonary resuscitation (CPR) and use of the defibrillator. This had been brought forward because of the arrival of new staff and was booked for shortly after this inspection.

We saw that the dentists were qualified to take X-rays. We saw the 'local rules' were displayed beside each X-ray machine to show the safety measures in place, and the

names of the Radiation Protection Supervisor for the practice as well as a named person who was the Radiation Protection Advisor from a professional body. This was in accordance with the Ionising Radiation Regulations 1999.

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 and protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

The registered manager gave us a copy of the policy on infection prevention and control (IPC). One of the dentists had taken the lead, to ensure standards were maintained. The policy was suitable, covering the minimising of blood borne virus transmission, the decontamination of instruments and equipment between patients, environmental cleaning, hand hygiene, clinical waste disposal and personal protective equipment (PPE) which refers to disposable gloves, aprons, face masks and eye protection. The policy had been reviewed annually by senior staff in the practice to ensure it was up-dated in line with professional guidance.

The Department of Health published in November 2009 a document called Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). It set out in detail the processes and practices essential to prevent the transmission of infections and deliver clean safe care. This practice had not as yet achieved best practice as they had not been able to identify a separate room in which to carry out the decontamination process away from other clinical areas.

We looked at each of the five treatment rooms, as each had their own equipment where staff carried out this work. New splash backs had been installed behind the sinks and worktops to provide an easily cleanable workspace. All working surfaces that we saw were smooth and in good repair which meant they could be kept clean and hygienic. Wash hand basins were provided in each treatment room. Staff showed us the PPE they used for different tasks. All dental chairs were in good condition, except for one protective cover of a foot area of a chair, which was split. We brought this to the attention of the dentist who agreed that it needed to be replaced.

We saw that in one treatment room instruments were put through a cycle of an ultrasonic cleaner. In another surgery, staff soaked instruments in disinfectant for 15 minutes before scrubbing. All five systems used manual scrubbing and rinsing, followed by checking under a magnifying lamp. The provider may like to note that not all staff inspected items each time, as recommended by the HTM01-05, paragraph 3.49. If no dirt was seen, instruments were then put into the autoclave to be sterilised. After sterilisation, items were allowed to dry, then bagged and stamp-dated, or kept on lidded trays if they were to be

reused the same day. They were stored in dedicated cupboards in the treatment rooms.

With small adjustments made at the time of this inspection, we saw that work flows from dirty to clean were achieved in all five treatment rooms, which was required by the guidance in order to assist in the cleaning process.

The IPC systems had been audited at three monthly intervals. We saw that faults identified in September 2012 were subsequently dealt with.

Staff showed us records of the daily, weekly and three monthly tests they carried out on the machines to ensure they were clean and working effectively. The registered manager showed us the validation certificates for each autoclave. All five had been serviced and tested on 25 November 2013.

We saw that clinical waste was stored securely, and we saw the registration document for the hazardous waste, showing that it was disposed of safely.

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 by suitably qualified, skilled and experienced staff.

Reasons for our judgement

The registered manager gave us a copy of the practice's policy on recruiting staff. We saw that it had been reviewed annually by senior staff in the practice and amended to include checking candidates' registration with the General Dental Council (GCD). We also saw the public protection policy which specified staff responsibility to raise concerns if they had any doubts about a person's fitness to practice.

The policy outlined the measures in place to ensure fairness in advertising and shortlisting and guard against discrimination. The information to be requested from referees was listed, including the employee's general performance and development as well as their reason for leaving.

We looked at a sample of staff files, including those of two staff who had been recruited recently. We saw that checks had been made to ensure that people working in the practice were suitable to work with children and vulnerable adults. Disclosure and Barring Service (DBS) clearances had been applied for on behalf of the most recently recruited staff. Criminal Records Bureau (CRB) clearances had been obtained on behalf of the more established staff. We saw that employment histories had been gathered. The registered manager told us of telephone calls that had been made to obtain verbal references to ensure that people employed by the practice were safe and suitable. The provider may like to note that not all the files we saw included either written references or a record of a verbal reference as evidence of these checks, as required by Schedule 3 of the Health and Social Care Act 2008.

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Recently recruited staff told us of their induction and training they had already received. They had been given guidance about the practice's main policies, including confidentiality and child protection and knew where to find guidance. We saw that staff had been immunised against diseases which they might reasonably come into contact with at any dental practice and that there were good arrangements to ensure any boosters would be arranged within the correct timescale. They had received training, including safeguarding vulnerable adults and given information about how the practice was run, including appraisals and financial arrangements. The registered manager told us they would review the new staff's progress after four weeks.

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.

There was evidence that learning from regular audits took place and appropriate changes were implemented. Also, people who use the service were asked for their views about their care and treatment and they were acted on.

Reasons for our judgement

We saw that the practice had renewed its achievement of meeting the standard for membership of the British Dental Association (BDA) Good Practice scheme for the ninth year. This involved an outside assessment of the practice and showed their commitment to providing quality dental care.

We saw the quality assurance policy for the practice. It listed some of the methods used to assess risk and maintain the quality of the service. These included training, supervision and appraisal for all staff. Any identified risks were to be discussed immediately and actioned with issues being addressed at staff meetings and management meetings. In addition the practice manager attended a Local Practice Managers' Forum 'to gain best practice and peer suggestions.'

To work in NHS practice those qualifying at UK dental schools require a period of vocational training within an approved dental practice. This practice offered such training under the supervision of the two principal dentists, who were approved Vocational Trainers. This meant that the practice was in close communication with the local Postgraduate Dental Department and their skills and performance were under scrutiny.

We saw there was a comments box available for people to post any ideas or problems. The registered manager said she checked it twice a week and discussed any contributions with the principal dentists at the lunchtime meeting when they discussed feedback as well as any near misses or identified risks. They had carried out a survey during February 2013. We were given the results and summary. 100 hundred people had been asked to fill in surveys anonymously. Questions ranged across staff skills and approach, quality of advice, friendliness of staff, pain free treatment, timekeeping of appointments and general cleanliness. The responses were overwhelmingly positive. A small number suggested the practice could do better with explanations of treatment and timekeeping. One person commented that they found it difficult walking up the stairs. The practice provided a response acknowledging what the staff needed to work on.

Some adjustments were being introduced in response to people's requests. These included reminders being sent shortly before appointments, and the possibility of making appointments at short notice had been introduced. To avoid difficulties In making phone calls at busy times, arrangements had been made to install a second telephone line.

One of the principal dentists had undertaken training in clinical audit. We saw that a range of audits were carried out regularly to assess good practice. For example, 50 record cards were audited in December 2010 to check that people had been asked for their verbal or written consent. It was found that in nearly half of appointments when the person should have been asked for their consent this had not been requested or recorded. Because of this poor performance, the audit was repeated after discussion with all clinicians. In February 2011 the audit was carried out again and this time found 98% achievement. When repeated in February 2012 and November 2013 achievement was found to be 100%. Good practice was therefore shown to have been embedded in normal practice.

Other audits we saw included radiograph audits, audits of oral cancer screening. The registered manager told us that she recently carried out an audit of the recording of medical histories that showed 100% achievement. There had been an audit of referrals to specialists during October 2013. This recorded when the dentist had seen the patient, when the letter was written, when the follow-up consultation happened, and checked that the patient attended their appointment. This was to check whether referrals made to specialists resulted in further treatment for people.

We saw that the practice had a suitable complaints policy and procedure. People who spoke to us were not aware of it but said they had no need to make a complaint. We looked at the complaints log. We saw that one of the principal dentists wrote promptly in reply to any issue that was raised. The provider may like to note that one letter was not written clearly enough. It did not state clearly that the offer made to the person to be treated by an alternative dentist involved NHS treatment and the person thought they were being offered private treatment and did not return. All the other issues raised were resolved satisfactorily. This showed that the practice had regard to complaints and comments made by people who used the service.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk