Care Quality Commission

Inspection Report

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

Wellington Dental Practice

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Date of Inspection: 08 May 2014

Date of Publication: May 2014

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

Standard	Outcome
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Bahram Limited
Registered Manager	Mr Seyed Kasai
Overview of the service	Wellington Dental Practice is a medium size dental practice providing NHS and private dental treatment. The practice is located in Wellington, Somerset.
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'.

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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 unannounced 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 8 May 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

The purpose of this inspection was to find out the answers to five key questions. Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

The summary is based on our observations during the inspection; information we requested from the provider and information about patient's experience of the service. We looked at fourteen patient records, spoke with eleven patients and spoke with the provider; practice manager and all five dentists and their dental nurses who worked during our inspection. We also spoke with the two receptionists and the dental hygienist.

Is the service caring?
The people we spoke with had been using the practice for varying lengths of time from more than twenty years to new patients using the practice for the first time. Those who had used the practice for a long time told us they were very happy with the service with two people saying they retained the same dentist despite moving some distance away. New patients told us the staff were; "Friendly", "Very helpful" and "Very friendly and understanding" when they made initial contact with the practice.

After patients had been seen by the dentist they told us their treatment had been; "thorough"; "pain free" and "very good". They told us they had been involved in decision making about their treatment and had received a treatment plan which they had signed to indicate their consent to their treatment and the cost of the treatment.

Is the service responsive?
We saw from appointment lists there were emergency treatment appointments available each day. Patients who arrived for emergency treatment told us they had been able to get appointments in a timely way and at a time which suited them. We heard how recall appointments were made in consultation with the patient and heard how telephone, text or email reminders were sent out to patients.

Is the service safe?
All staff at the practice had an awareness of the need to ensure children and vulnerable adults were kept safe. Staff had received training to ensure they were aware of the signs and types of abuse and had access to information about who to report concerns to. Planning for medical emergencies was carried out and appropriate emergency medication and equipment was in place and available.

Hygiene and infection control was routinely monitored with effective systems in place to ensure the practice complied with the Department of Health's HTM 01 – 05 decontamination guidance document for dentists and dental practices.

General Dental Council (GDC) registration was checked as part of the employment process for dental practitioners, hygienists and qualified dental nurses. A disclosure and barring service certificate was also required as part of their recruitment. All staff received regular access to training and information updates arranged by the provider and other organisations to ensure they fulfilled their continuous professional development requirements.

Is the service effective?
The provider arranged for information to be available to all staff about clinical excellence in the practice. They had signed up to receive regular news letters from organisations such as the GDC and the British Dental Association (BDA). They received regular medical alerts from government agencies related to dental care and medicines. The provider had effective systems in place which had enabled them to achieve the BDA's "Good Practice" membership; an indicator of a more effective service delivery. These included effective clinical governance, routine equipment maintenance and an ongoing programme of practice improvement.

Is the service well-led?
The provider had checks and audits in place which ensured their practice was managed safely. Regular staff appraisal and performance management ensured staff were supported to deliver good quality dental care and treatment. Record keeping was monitored routinely for quality and appropriateness. The staff we spoke with spoke positively about the support they received from the provider and the wider dental team and all showed a commitment to support patient needs.

Feedback from patients indicated a positive view about the practice and the staff who treated them. Where suggestions for improvement had been made we saw the provider made adjustments to the service or the environment where they could.

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

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We looked at fourteen patient records, spoke with eleven patients who had received treatment during our inspection and spoke with the dental teams to identify how consent was gained before treatment was provided.

In all of the records we looked at where the patient had received treatment we saw written patient consent had been gained. Each patient had signed a form to agree to the course of treatment and to the cost of their treatment. Where the patient had chosen to receive NHS and private treatment the costs were clearly separated and their signatures indicated consent to both types of treatment.

When we spoke with patients about how the dentists gained their consent for treatment they told us about signing treatment plans and how the dentist gained informal verbal consent. For example one patient told us; "She always explains what needs to be done and asks me if it's OK for her to start". Another patient told us; "Before they treat my child they always check we're both happy before they even start examining him". Other patients we spoke with made similar comments. This showed both formal and informal consent had been sought before treatment commenced and that people could make informed choices.

The dentists and dental nurses told us they always checked patients were happy for them to start examining or treating them. We saw from their records they recorded verbal consent as well as the signed treatment plans. One of the dental practitioners told us how they also checked with the help of carers or support workers that the patient fully understood the treatment they required before commencing the treatment. Where patients were less able to understand more complex treatments they explained the process using dental picture cards. This helped patients to understand the treatment and helped in gaining their consent.

In all of the records we looked at and from what each patient told us we were able to evidence that consent to treatment was based on patient choice and preference. For

example one patient told us how they chose to have a tooth removed but agreed to wait until the completed a course of antibiotics; "To reduce the risk of infection". Whilst another patient chose to have a repair to their denture rather than incur the cost of a new denture. This showed patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

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

Access into the surgery was via two small steps, a ramp was available for patients who needed wheelchair access. There was dental and hygienist surgeries on the ground floor providing level access for people with reduced mobility. We saw from records and heard from patients how the dental teams supported patients' individual needs and how they responded positively to their changing circumstances.

People's needs were assessed and care and treatment was planned and delivered in line with their individual treatment plan. The treatment plans we looked at were based on a full mouth assessment. Treatment plans showed the length of time until the patient's next visit. Medical histories and risk assessments for patients were routinely reviewed when patients came for check-up appointments or treatment.

The patients we spoke with reported they were able to get treatment when needed and at a time which suited them. Patients told us they understood their treatment plan and what will happen after their appointment because the dentist explained clearly what was required. For example one patient we spoke with told us about a broken a tooth and needed urgent treatment. They said, "I was fitted in today. The dentist was clear about the choices I had, how long the work would take and how long it would last. We discussed my treatment plan and agreed the course of treatment I needed". This showed patients were happy and able to get treatment when the needed it.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that all staff working in the practice had undertaken awareness training about vulnerable adults and children and information was provided for staff to enable them to raise concerns with the local authority. We saw children were always accompanied by an adult when seeing the dentist. Records showed treatment was based on a full mouth assessment and oral health advice and treatment was routinely available.

Patients had access to a range of treatments for routine and cosmetic dentistry. Dentists were skilled in specific areas of dental work including root canal fillings, dental implants and teeth whitening. The costs of these treatments were available in the practice and appointments were made with the relevant dentist to ensure appropriate care and

treatment. Where patients chose to have sedation for treatments such as tooth extraction the patient was referred to another service to ensure a specialist was available for patient safety as Wellington Dental Practice did not offer a sedation service.

There were arrangements in place to deal with foreseeable emergencies. In the records we looked at we saw staff were appropriately trained to deal with medical emergencies which might occur within the practice. Training including dealing with a collapsed patient. The staff we spoke with told us they had not had any major problems, only an occasional patient complaining of feeling faint. We saw there was suitable equipment available in the practice including emergency medicines, oxygen and an automated external defibrillator. All were in date, fit for use with equipment in adult and children sizes. The equipment and stock were regularly checked and recorded as fit for use. The dentist was the appointed person for first aid, whilst the nursing team also all had qualifications in first aid. This showed there were appropriate measures in place to manage emergency situations.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We looked at information available in the dental surgery and spoke with staff about the measures they had in place for ensuring patients remained safe. We reviewed the policies and procedures, which included guidance for staff. We saw staff were provided with information about abuse and whistle–blowing as well as information from the British Dental Association (BDA). We were told by the provider that training was provided to all staff in child protection and safeguarding vulnerable adults annually. We saw from training records that all dental practice staff had undertaken this type of training since the beginning of the year.

Staff told us their understanding and the process of reporting concerns through their line management. They told us they had access to the practice's policies and procedures in regard to child protection, safeguarding vulnerable adults and the Mental Capacity Act. We heard from the dentists and dental nurses how vulnerable patients such as children or patients with a learning disability were always seen by two dental team members and were accompanied by a family member, relative or carer. This ensured patients and staff remained safe during treatment.

The staff we spoke with confirmed they had training and were able to describe the signs and types of abuse. The patients we spoke with told us they had no concerns about their safety when waiting for or receiving treatment. Parents and their children told us the practice asked that they always had to be in the surgery together before treatment could commence. The provider told us about occasions where the dental team had not provided treatment until a parent could attend the surgery with their child. This showed the provider met the standards set by the General Dental Council.

We saw information on the provider's website and on the practices' dental plates that all the dentists at the surgery were currently registered with the General Dentist Council and there were current certificates of dental indemnity for each dentist at the practice. The practice manager said that all staff had undergone an enhanced check from the Disclosure and Barring Service. The dental nurses were similarly checked to ensure they were

appropriately employed to work with vulnerable people.

Where the performance of individual staff placed patients at risk we saw the provider had taken immediate and proportionate steps to ensure patient safety. Where individual staff performance continued to place patients at risk they followed their disciplinary procedure and dismissed poorly performing staff. This ensured patients were treated by competent staff in a safe environment.

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 protected from the risk of infection because appropriate guidance had been followed. 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. We looked at the six dental surgeries in the practice; the dedicated equipment decontamination room; the areas used for storage of clinical and offensive waste and the public areas of the practice. All areas appeared clean, tidy and clutter free. The patients we spoke with told us they found the practice; "Clean"; very clean" and "Spotless".

We spoke with dental nurses about their cleaning routines and infection control training they had undertaken. We saw the provider employed a cleaner to clean the practice thoroughly twice a week with the dental nurses, hygienists and reception team responsible for daily cleaning of the areas they worked in. We saw how dental nurses cleaned the surface areas of the surgeries after each patient. All practice staff had undertaken relevant training in infection control and demonstrated familiarity with the standards expected. For example they wore appropriate personal protective equipment (PPE), routinely washed or used anti- bacterial gel on their hands when re-entering the surgeries and after contact with non-surgical equipment. Staff ensured PPE was available to patients during treatment such as aprons and safety glasses and anti- bacterial gel was available in public areas around the practice.

The provider had assessed their facilities at the practice in relating to meeting government essential standards for decontamination in dental practices. A recent self-audit showed that essential standards could be maintained with the current environmental facilities at the practice. We saw the dental teams checked surgeries, the equipment available and updated cleaning records which were in turn checked by the clinical manager. We heard that the practice had an action plan for improving facilities. This included the expansion of the decontamination room and the development of an additional surgery area. This showed the provider had current and future plans to ensure safe management of hygiene and infection control.

We looked at all the surgeries and checked how equipment, local anaesthetics and dental composites were stored. All storage areas were clean and well managed, stock control was appropriate with all items used being in date and in correctly sealed and marked packs or containers. Surface areas were clear of unnecessary items. However packs of personal protective gloves and hand washing liquid containers were stored on surface

areas in the surgeries and could lead to cross contamination during the cleaning processes. We spoke with the provider and clinical manager about this and saw they had ordered suitable wall mounted racks during the inspection.

We examined the facilities for cleaning and decontaminating dental instruments. Instruments were cleaned and decontaminated in a small dedicated hygiene area. We looked at cleaning of instruments and found there were clear flows from 'dirty' to 'clean.' One of the dental nurses explained and demonstrated to us how instruments were decontaminated and sterilised. A separate rinsing sink was used prior to using a dental practice specification automatic washing machine.

The nurse showed us how they used an illuminated magnifier to check for any debris or damage throughout the cleaning stages. We saw the practice used standard non vacuum sterilisers as well as a vacuum sterilising machine; an ultrasonic washer was also available. Hand pieces had a separate cleaning and oiling process. Once the equipment was cleaned and dried they were placed in date stamped sealed view packs; these provided sterility of instruments for twelve months.

Equipment checks were carried out during each surgery session and recorded to ensure the equipment was in good working order. The process the nurse described and demonstrated followed the guidance recommended in the Department of Health's HTM 01 – 05 decontamination guidance document for dentists and dental practices. This meant patients could be assured that dental equipment used during examinations and treatment met current hygiene standards.

We observed how waste items were disposed of and stored. The provider had a current contract with a clinical waste contractor for regular removal of clinical waste. We saw that the differing types of waste were appropriately segregated and stored at the practice.

The patients we spoke with told us that the practice appeared clean when they visited for appointments. One person told us, "It's unquestionably clean and tidy here". Whilst another person said, "It always looks clean here and makes me ashamed to go back home!" This showed appropriate infection control procedures took place routinely and patients were happy with the environment they were treated in.

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

People's personal records including medical records were accurate and fit for purpose. In the electronic records we looked at we saw they had been maintained well and were up to date. Records highlighted risks such as allergies or current medical treatments. Electronic records were regularly backed up throughout the day to prevent records from being deleted with backup data being stored in a secure fire proof safe.

Records indicated how people liked to be reminded about appointments, for example by text messages, letters or phone calls. The patients we spoke with told us they received reminders about appointments in the way they chose. This showed that the provider took steps to ensure information about people remained current.

We saw evidence that the provider carried out record audits to check that the right information is recorded and that information was up to date. Record quality was also assessed by the clinical manager and included checks for radiograph quality; treatment plans and correct completion of daily check records. We heard how reception staff and dental nurses checked patients' personal information such as telephone numbers to ensure it was accurately recorded and updated.

Medical history forms were completed by patients at recall appointments or before emergency treatment. This information was transferred onto the electronic patient record. Patients told us they were routinely asked about changes to the health and medicines by the dentist. In all the records we looked at we saw how medical alerts were highlighted to ensure dentists were aware of any concerns. For example, where a patient was taking medication to thin their blood this was clearly indicated to alert the dentist to potential risks during treatment.

We saw that soft tissue examinations were recorded as well as risk assessments for caries, gum disease and oral cancer. A radiographic justification and report was seen on records where X-rays took place. Appointment records showed that recall appointments were based on risk assessment and need and not just for standard annual or six monthly check-ups.

Staff records and other records relevant to the management of the services were accurate

and fit for purpose. Policies were up to date and routinely reviewed and information for staff was regularly disseminated during minuted staff meetings or through informal lunch time learning opportunities.

Records were kept securely and could be located promptly when needed. Prescription pads were held securely and were not pre-signed. Where paper records were needed we saw that patient paper records were stored in a secure area of the practice to protect confidentiality. The electronic patient records on the providers' computer system were password protected to ensure information was held securely. Computer screens used by staff faced away from the public to prevent breaches of confidentiality. Where this was not possible in one practice the screen only showed the current patients details. We spoke with the dentist and they explained that where the dental nurses took instruction from them, they checked and completed electronic records after seeing individual patients. This ensured that records were up to date and reflected the treatment provided.

Records were kept for the appropriate period of time and then destroyed securely. The practice manager was able to describe their systems for storing patient records for current and archived records. We saw that archived records were stored in a secure staff only area of the practice. The provider had a process of identifying when records could be destroyed and had arrangements with a certified company to destroy records at appropriate time periods. This showed the provider had appropriate systems for the safe management of records.

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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