Mr Barry Russell Davies

B R Davies - Mobile Dentist

Inspection Report

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Overall summary

We carried out this announced inspection on 11 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told the NHS England area team and Healthwatch that we were inspecting the service. They did not provide any information which we took into account.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

Background

B R Davies - Mobile Dentist provides NHS and private domiciliary treatment to patients within Humberside and East Yorkshire. This service is provided in either a care home setting or in a patients home. We inspected the service from their main office and also attended a home visit to asses the service provided.

Summary of findings

The dental team includes one dentist and one dental nurse.

The service is owned by an individual who is the principal dentist. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

On the day of inspection we collected five CQC comment cards filled in by patients and spoke with one other patient. This information gave us a positive view of the service.

During the inspection we spoke with the dentist and dental nurse.

The services are provided:

Monday – Friday 8:30am – 2pm.

Our key findings were:

- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The service did not have systems to help them manage risk.
- We found improvements could be made to the segregation and disposal of clinical waste in accordance with relevant regulations taking into account current guidance.
- The service had thorough staff recruitment procedures.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Governance arrangements were not in place to support the smooth running of the service; the service did not have a structured plan in place to audit quality and safety.
- The appointment system met patients' needs.
- The service asked patients for feedback about the services they provided.
- The service dealt with complaints positively and efficiently.

We identified regulations the provider was not meeting. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review and implement a system to track and monitor the use of prescriptions.
- Review the risks associated with transport of contaminated instruments outside the healthcare premises taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental services and have regard to The Health and Social Care Act 2008: 'Code of Service about the prevention and control of infections and related guidance'.
- Review the service's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review the service's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Service regarding clinical examinations and record keeping.
- Review the service's protocols and procedures for promoting the maintenance of good oral health taking into account guidelines issued by the Department of Health publication 'Delivering Better Oral Health: an evidence-based toolkit for prevention'.
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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requirements notice 

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement section at the end of this report).

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service.

The service did not have systems and processes to provide safe care and treatment.

We found there were no logs in place to monitor the use of prescription pads.

Clinical waste was not segregated appropriately.

We were told there were no risk assessments for the service including the safe use of sharps and domiciliary care.

The service did not receive MHRA alerts; and were not aware of any recent alerts which could relate to them.

There were no COSHH arrangements in place for the materials used.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles and the service completed essential recruitment checks.

The service had suitable arrangements for dealing with medical and other emergencies.

Are services effective?

No action

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

The dentist assessed patients' needs and provided domiciliary care that was usually resticted to the provision of denture care.

Patients described the treatment they received as professional, convenient and they were made to feel at ease. The dentist discussed treatment with patients so they could give informed consent. This was not always recorded in their dental care records and we found other improvements which could be made to information recorded in dental care records including the provision of preventative advice.

The service did not have clear arrangements when patients needed to be referred to other dental or health care professionals.

Summary of findings

The dentist supported the dental nurse to complete training relevant to their roles.

Are services caring?

No action

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

We received feedback about the service from six people. Patients were positive about all aspects of the service the service provided. They told us staff were kind and patient. Patients commented that they made them feel at ease, especially when they were anxious about the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

The service's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. The service provided care in their home or care home setting.

The service took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

Requirements notice

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement section at the end of this report).

The service did not have arrangements to ensure the smooth running of the service. There were no governance arrangements in place, including:

- Domiciliary care
- Clinical waste
- Infection prevention and control policies
- Health and safety polices
- Safe use of sharps
- Safeguarding adults and children policies
- Whistleblowing policy
- Equality and diversity policy.
- Mental Capacity policy

The service team kept patient dental care records which were, clearly written and stored securely.

The service did not monitor clinical and non-clinical areas of their work to help them improve and learn.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The service did not have any policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events.

The service did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). We discussed recent alerts with the dentist and they were not aware of these.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The service had a basic safeguarding policy for adults. This did not provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff received safeguarding training.

The service did not have a whistleblowing policy. The dental nurse told us they felt confident they could raise concerns without fear of recrimination in house. They were not aware of who to refer to externally.

We looked at the service's arrangements for safe dental care and treatment. There were no risk assessments for any aspect of the service including safe use of sharps and domiciliary care.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were available as described in recognised guidance. Staff told us they completed checks but these were not recorded. We found the aspirin was not dispersible, there was no portable suction and the needles were not the recommended type. We were told this would be rectified immediately.

Staff recruitment

Since registering with the Care Quality Commission the service had not needed to recruit any staff. Although the service did not have a formal staff recruitment policy in place we saw that the dental nurse had been recruited appropriately and her recruitment file contained all the recommended information.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Monitoring health & safety and responding to risks

The service did not have health and safety policies or risk assessments.

The service had current employer's liability insurance and checked each year that the staff's professional indemnity insurance was up to date.

The staff were not aware of their responsibilities under the Control of Substances Hazardous to Health (COSHH). COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. There were no safety data sheets available for materials used or risk assessments in place.

A dental nurse generally worked with the dentist when they treated patients but we were told on rare occasions the dentist would provide care alone. There was no policy or risk assessment in place for this.

Infection control

The service did not have an infection prevention and control policy and procedures to keep patients safe. They used single use items. We found there were areas they could improve upon if they followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental services (HTM01-05) published by the Department of Health.

The service did not have suitable arrangements for transportation of instruments in line with HTM01-05. There were no supporting policies for the transportation of instruments outside of the main office or segregation of clinical waste

The service did not carry out infection prevention and control audits.

Equipment and medicines

Are services safe?

The service did not keep any records of NHS prescriptions as described in current guidance.There was no method to show if all prescriptions were accounted for and no way to report if any were missing. We found they were stored securely.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found improvements could be made to ensure detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. We found limited evidence to show the recording of options, risk and benefits of treatment, the recording of gum scores or any preventative advice. We found several medical history forms which were not fully completed with information about medicines or allergies as the staff said it could be difficult to gather all the information.

The dentist and nurse told us they did not always provide preventative advice to patients.

The service had a contract to provide domiciliary care for patients who were unable to access dental services. The staff were not aware guidance was available on the conduct of these services. We found there were no policies or protocols in place and there were no risk assessments to ensure staff and patient safety.

Health promotion & prevention

The staff were not aware of the Delivering Better Oral Health toolkit. We were told preventative advice was not given to patients and they did not prescribe high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them.

There was no evidence recorded within the dental care records that smoking cessation, alcohol consumption and diet was discussed with patients during appointments.

Staffing

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the service did not provide but there were no clear arrangements in place for this. These included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Consent to care and treatment

The service team understood the importance of obtaining patients' consent to treatment. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. This was not always recorded in the dental care records.

The service did not have a consent policy or any other information regarding to the Mental Capacity Act 2005. The team did not understand their responsibilities under the act when treating adults who may not be able to make informed decisions. There was no policy in place to cover best interest decisions, mental capacity assessments or how they ensured the correct person gave consent. Staff described how they involved patients' relatives or carers when appropriate but they were not always available. There was no protocol in place to ensure consent for treatment was gained for patients who may not have the capacity to make the decision themselves.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were kind and patient. We saw that staff treated patients respectfully, appropriately and were friendly towards patient over the telephone.

Staff were aware of the importance of privacy and confidentiality; staff did not leave personal information where other patients might see it.

The dental equipment was carried in colourful bags, to patients homes, to ensure dignity and respect was upheld.

Staff stored paper records securely.

Involvement in decisions about care and treatment

The service gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the service.

The service had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed.

Promoting equality

Staff told us that they provided services in patient's homes or care homes if they could no longer access dental services.

Staff told us that they telephoned all patients the day before their appointment to make sure they could arrange a time that suited them and confirm accessibility arrangements.

Access to the service

The service displayed its opening hours on their information leaflet.

We confirmed the service kept waiting times and cancellations to a minimum.

The service was committed to seeing patients experiencing pain on the same day.

Concerns & complaints

The service had a complaints policy providing guidance to staff on how to handle a complaint. The service information leaflet explained how to make a complaint. The principal dentist was responsible for dealing with these. The dental nurse told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist told us they had never received a complaint. Information was available about organisations patients could contact if not satisfied with the way the service dealt with their concerns.

We looked at comments and compliments the service received. These showed the service responded to comments appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice.

The service did not have any policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events.

The practice did not have policies, procedures or risk assessments to support the management of the service and to protect patients and staff. For example there were no governance arrangements in place including:

- Domiciliary care
- Clinical waste
- Infection prevention and control policies
- Health and safety polices
- Safe use of sharps
- Safeguarding adults and children policies
- Whistleblowing policy
- Equality and diversity policy
- Mental Capacity policy.

The practice had no information governance (IG) arrangements. Staff had not received training in IG and were not fully aware of the importance of these in protecting patients' personal information. The principal dentist had not completed the required information governance toolkit training.

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the service. They said the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us principal dentist was approachable, would listen to their concerns and act appropriately. The principal dentist discussed concerns at staff meetings and it was clear the service worked as a team and dealt with issues professionally.

We were told information would be discussed informally but there were no records to support this.

Learning and improvement

The service did not have any quality assurance processes to encourage learning and continuous improvement.

Staff told us they completed training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the service provided support and encouragement for them to do so.

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

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular there were no COSHH arrangements, reporting processes for incidents, significant events or RIDDOR. There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. There were no systems or processes that enabled the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular there were no audits being undertaken of the service. There was additional evidence of poor governance. In particular there were no policies in place for the service including; • Domiciliary care • COSHH • Clinical waste • Infection prevention and control policies • Health and safety polices

This section is primarily information for the provider

Requirement notices

- Safe use of sharps
- Safeguarding adults and children policies
- Whistleblowing policy
- Equality and diversity policy
- Mental Capacity policy.

Regulation 17(1)