Moons Hill Administrative Services Limited

M R Richards Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 July 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

M R Richards Dental surgery is a dental practice providing NHS and private treatment for both adults and children. The practice is situated in Shanklin, a town on the Isle of Wight.

The practice has one dental treatment room in use and a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice is based in an adapted commercial property.

The practice employs one dentist, one dental nurse who also acts as a receptionist and a practice manager who also shares reception duties.

The practice's opening hours are between 8am and 4pm on Monday, Tuesday and Thursday, 1pm and 6pm on Wednesday and 8am and 12pm on Friday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

During our inspection we reviewed 11 CQC comment cards completed by patients and obtained the views of five patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Effective leadership was provided by the practice owner.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and equipment was maintained in accordance with current guidelines
- Infection control procedures followed published guidance.
- The practice manager acted as the safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owner.
- Staff we spoke with felt well supported by the practice owner and were committed to providing a quality service to their patients.
- Information from 11 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

There were areas where the provider could make improvements and should:

- Review the availability of a hearing loop for patients who are hearing aid users.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society

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?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had appropriate arrangements in place for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was maintained in accordance with current guidelines.

The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice. The staff received professional training and development appropriate to their roles and learning needs.

Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action

Are services caring?

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

We collected 11 completed Care Quality Commission patient comment cards and obtained the views of a further five patients on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and the dentist were good at explaining the treatment that was proposed.

No action

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required.

No action

Summary of findings

The practice had in place arrangements for patients with mobility difficulties to be seen in the local special care service if they could not access the surgery due to the stairs.	
Are services well-led? We found that this practice was providing well-led care in accordance with the relevant regulations. Effective leadership was provided by the practice owner who was supported by the practice manager. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had appropriate clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the practice owner. All the staff we met said that they were happy in their work and the practice was a good place to work.	**No action** 

M R Richards Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 8 July 2016. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We spoke with three members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system for maintaining patient dental care records. We reviewed CQC comment cards completed by patients and obtained the view of patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice manager demonstrated a good awareness of RIDDOR (the reporting of injuries, diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. Records showed that the last recorded incident in the practice was 2009. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant, these alerts were shared with all members of staff by the practice manager.

Reliable safety systems and processes (including safeguarding)

We spoke with the dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a rubber protective device to cover the contaminated needle following administration of a local anaesthetic. The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the dentist how they treated the use of instruments used during root canal treatment. The dentist did not use a rubber dam to protect the airway when using root canal instruments (a rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Instead the dentist used a special safety chain that was attached to root canal files that prevented the files from being swallowed or inhaled during root canal treatment.

The practice manager was the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Staff had received training in how to use this equipment and cardio pulmonary resuscitation (CPR) in November 2015. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

Staff recruitment

The dentist and dental nurse who worked at the practice had current registrations with the General Dental Council.

The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

We looked at staff recruitment files and records confirmed staff had been recruited in accordance with the practice's recruitment policy. Staff recruitment records were ordered and stored securely.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The

practice maintained a system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control were being met. It was observed that audit of infection control processes carried out in April 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the dental treatment room, waiting area and toilet were clean. Clear zoning demarking clean from dirty areas was apparent in the treatment room. Hand washing facilities were available including liquid soap and paper towel dispensers. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of the treatment room were inspected and these were clean and ordered. We noted that appropriate routine personal protective equipment was available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2016. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination area for instrument processing. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used an automated washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were either pouched or stored without pouching in accordance with current storage guidelines until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. All recommended tests utilised as part of the validation of the automated washer disinfector were carried out in accordance with current guidelines, the results of which were recorded on appropriate data recording sheets.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored appropriately.

Are services safe?

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in June 2016. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations in March 2014. The X-ray set was due to be inspected again in March 2017. Portable appliance testing (PAT) had been carried out in August 2015. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid spillage. The practice dispensed their own medicines as part of a patients' dental treatment. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current secondary dispensing guidelines and medicines were stored according to manufacturer's instructions.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules.

An audit had been carried out to monitor the quality of the X-rays taken. Dental X-rays we saw were of a consistently good quality and correctly mounted. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified and reported on. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment. The dental care records, although containing essential features, were rather brief which we drew to the attention of the practice manager.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. The dentist explained that any children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

Other advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentist had given oral health advice to patients. However, we did find that the details were very brief. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice employed one dentist, one dental nurse who also acted as a receptionist and a practice manager who also shared reception duties. We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

All of the patients we asked told us they felt there were enough staff working at the practice. Staff we spoke with told us they felt supported by the practice owner. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. There was a structured induction programme in place for new members of staff.

Working with other services

The dentist explained how they worked with other services. They referred patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery and orthodontic providers.

Consent to care and treatment

The dentist we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient, the costs were

Are services effective?

(for example, treatment is effective)

then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

The dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists.

Conversations between patients and the dentist could not be heard from outside the treatment room which protected patients' privacy. Patients' clinical records were in paper form. The paper records were stored away from unauthorised access by members of the general public. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 11 completed CQC patient comment cards and obtained the views of five patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area. Information was also available in the reception area that detailed the costs of private treatment.

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the options open to them on the standard NHS treatment planning forms for dentistry or private treatment estimate forms.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information including the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. We observed that the appointment diary was not overbooked and that this provided capacity each day for patients with dental pain to be seen. The dentist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. In instances where patients could not negotiate the stairs, patients would be referred to the local special care dental service.

Although the practice did not have a hearing loop system, the practice explained that they were able to communicate effectively with those patients who were hard of hearing. This was effected by setting aside more time for patients who were affected in this way and adopting a caring approach. They also explained that they adopted this approach with patients who were partially sighted or blind.

Access to the service

The practice's opening hours were between 8am and 4pm on Monday, Tuesday and Thursday, 1pm and 6pm on Wednesday and 8am and 12pm on Friday.

There were arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This was provided by an out-of-hours service.

All the patients we asked were very satisfied with the opening hours and were able to get appointments when they needed them.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within three working days and a full response would be provided to the patient within 10 working days. This was seen to be followed. We saw a complaints log which listed one written complaint received over the previous year, records showed that the complaint process was still ongoing.

Are services well-led?

Our findings

Governance arrangements

The practice owner was responsible for the day-to-day running of the practice. We saw that the practice had in place a system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. For example, infection control, health and safety and radiation, and were regularly review by the practice owner. Staff were aware of where these policies were held and we saw that they were readily accessible.

Leadership, openness and transparency

The practice ethos was to provide high quality patient centred care at all times. We found staff to be hard working, caring towards the patients and committed to the work they did. Staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry, were happy with the facilities and felt well supported by the practice owner. Staff reported that they were proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system along with clinical audit. For example, we observed that the dental nurse received an annual appraisal; these appraisals were carried out by the practice manager.

We found there were examples of audits taking place at the practice. These included infection control and X-ray quality. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a complaints procedure in place, with details available for patients in the waiting area.

Results of the Family and Friends Test carried out over the previous year indicated that 100% of patients who responded were extremely likely or likely to recommend the practice to family and friends.

The dental nurse told us that the dentist was very approachable and they felt they could give their views about how things were done at the practice. They confirmed that they had practice meetings every month. The dental nurse we spoke with described the meetings as good, with the opportunity to discuss successes, changes and improvements and felt they were listened to.