Care Quality Commission

Fraser Montague Limited

Darfoor Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 12 November 2015 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 not providing well-led care in accordance with the relevant regulations.

Background

Darfoor Dental **i**s located in the London Borough of Westminster and provides private dental services. The people attending the practice comprises mainly of staff from local embassies and work professionals.

The staff structure of the practice comprises of a principal dentist (who is also the owner), and dental nurses.

The premises consists of one treatment room which also houses the administrative area, and a dedicated decontamination area. . The practice has access to a shared waiting area that is also used by other tenants of the building it is located in.

The principal dentist was 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.

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to complete to tell us about their experience of the practice. We received two completed cards. They provided a positive view of the services the practice provides. Patients commented that the quality of care was good.

We carried out an announced comprehensive inspection on 12 November 2015 as part of our planned inspection of all dental practices. The inspection took place over one

Summary of findings

day and was carried out by a lead inspector and a specialist adviser. We spoke with the principal dentist on the day of the inspection. There were no patients to speak with on the day of the inspection. The principal dentist told us this was because no patients had booked appointments for this day. We spoke with the dental nurse on the phone the day after the inspection visit.

Our key findings were:

- Patients were involved in their care and treatment planning.
- There was appropriate equipment for staff to undertake their duties and equipment was well maintained.
- Patients told us that staff were caring and treated them with dignity and respect.
- There were processes in place for patients to make complaints and compliments.
- Governance arrangements were in place and there was a clear vision for the smooth running of the practice.
- The practice policies needed to be individualised to the practice.
- Risks arising from lack of appropriate cleaning of used dental instruments had not been suitably identified and mitigated.
- Clinical audits were not being undertaken appropriately and were not contributing to improvements in quality of care delivery.

We identified regulations that were not being met and the provider must**:**

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure the practice's infection control procedures and protocols are reviewed giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure audit methodology is reviewed so learning points are documented and the resulting improvements can be demonstrated.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the storage of dental care records to ensure they were kept secure at all times

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 policies and protocols related to the safe running of the service; these included policies for safeguarding children and vulnerable adults from abuse and maintaining the required standards of infection prevention. We found that staff were trained and there was appropriate equipment to respond to medical emergencies. In the event of an incident or accident occurring, the practice had a system in place to document, investigate and learn from it. The practice had procedures for the safe recruitment of staff which included carrying out criminal record checks and obtaining references. However, we found that improvements were needed to be made in the practice's infection control procedures. The principal dentist said they would work with their nurse to make improvements to the procedure.

We were provided evidence by the principal dentist after the inspection that necessary steps, including risk assessments had been undertaken, and additional training for staff arranged.

Are services effective?

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

Patients were given appropriate information to support them to make decisions about the treatment they received. The practice kept records of treatments carried out. Patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

Staff were supported by the practice in maintaining their continuing professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

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

The CQC comment cards we received were very positive about the service provided by the practice. Patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to routine and emergency appointments at the practice. There was sufficient well maintained equipment to meet the dental needs of their patient population. There was a complaints policy. We saw that the practice responded to complaints in line with the complaints policy. Patients were given the opportunity to give feedback through the practice website. There were arrangements to meet the needs of people whose first language was not English.

Are services well-led?

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 Notices section at the end of this report).

There was a vision for the practice that was shared with the staff. However we found improvements needed to be made in the governance arrangements and an effective management structure. There were policies and procedures

Summary of findings

in place to monitoring various aspects of care; however we found some polices were generic and not practice specific. Patients were given the opportunity to provide feedback about the practice through the practice website but there was no formal way for them to make suggestions to improve the service. Risks arising from lack of appropriate leaning of used dental instruments had not been suitably identified and mitigated. Clinical audits were not being undertaken appropriately and were not contributing to improvements in quality of care delivery.

Darfoor Dental

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 12 November 2015. The inspection was led by a CQC inspector. They were accompanied by a specialist advisor.

The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months. We also reviewed further information on the day of the inspection.

We received 2 CQC comment cards completed by patients and spoke with the principal dentist and dental nurse. We reviewed the policies, toured the premises and examined the cleaning and decontamination of dental equipment.

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 had suitable processes around reporting and discussion of incidents. We saw there was a system in place for learning from incidents. There had been no incidents over the past 12 months but staff were able to explain how incidents were logged and how they have learnt from previous incidents.

There was a system in place for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was also a poster displayed in the practice outlining these requirements. There had been no RIDDOR incidents over the past 12 months. The principal dentist told us they would further familiarise themselves with these requirements. The dental nurse we spoke with did understand the importance of the duty of candour and the need to inform the appropriate external organisations and patients effected of any relevant incidents [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity]..

Reliable safety systems and processes (including safeguarding)

The principal dentist was the safeguarding lead and staff knew who they should go to if they had a safeguarding concern. The practice had a safeguarding policy. The policy included details of how to spot signs of abuse but did not include contact information for the local authority's safeguarding teams. The policy had last been reviewed in June 2015 and was scheduled to be reviewed again in June 2016. Staff had completed safeguarding training that was refreshed on a regular basis. They were able to explain their understanding of safeguarding issues, which was in line with what we saw in the policies. There had been no safeguarding incident that needed to be referred to the local safeguarding teams.

The practice had safety systems in place to help ensure the safety of staff and patients. This included for example having infection control protocols, procedures for using equipment safely, health and safety procedures and a Control of Substances Hazardous to Health (COSHH) file. Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example a general health and safety risk assessment and a fire safety assessment carried out in January 2015.

The dentist used a rubber dam for root canal treatments. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.]

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received basic life support training which included cardiopulmonary resuscitation (CPR) training. The practice had a medical emergency kit which included emergency medicines and equipment. The kit contained the recommended medicines. We checked the medicines that were in the kit and we found that all the medicines were within their expiry date. The emergency equipment included medical oxygen. However we found the staff did not have access to an automated external defibrillator (AED), in line with Resuscitation Council UK guidance. There had been no risk assessment completed to assess the risks of not having this equipment. [An AED is a portable electronic device that analyses the heart's rhythm and if necessary, delivers an electric shock, known as defibrillation, which helps the heart re-establish an effective rhythm].

Staff recruitment

The practice had a policy for the safe recruitment of staff. In order to reduce the risks of employing unsuitable staff the provider is required to complete a number of checks. They must obtain a full employment history, check the authenticity of qualifications, obtaining references, including one from the most recent employer, and complete an up to date Disclosure and Barring Service (DBS) checks. The principal dentist told us they would follow this policy if they had to employ new members of staff. The practice only employed one member of staff and they had been employed at the practice for over ten years which was before the dentist took over the practice.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A Health and Safety Policy was in

Are services safe?

place. The practice had a risk management process which was regularly updated and reviewed. For example, we saw risk assessments for fire, radiation, health and safety and COSHH.

The practice had a business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service. The plan covered what to do in the event of issues such as loss of electricity and equipment breakdown.

Infection control

The practice had an infection control policy that outlined the procedure for issues relating to minimising the risk and spread of infections. This included details of procedures for hand hygiene, clinical waste management and personal protective equipment. The principal dentist was the infection control lead and they gave a demonstration of the decontamination process. Instruments were cleaned using an ultra sonic bath and then placed in an autoclave, pouched and date stamped. However there was no proper zoning of the clean to dirty area to minimise the risks of cross contamination. Decontamination areas and work surfaces were cluttered. Instruments were not inspected under an illuminated magnification device for cleanliness and condition following cleaning. The principal dentist commented that the dental nurse did not like the bright light on the lamp so the magnifier had been removed. Water temperature records seen were not dated or regularly completed. There were instruments which were sterilised and bagged that had rust on the surface of the instruments and bits of what looked like impression material .One bag had moisture inside it. The principal dentist assured us these instruments would be disposed immediately.

We saw that daily, weekly and monthly checks were carried out on equipment used in the practice including the steam sterilizer, to ensure they were working effectively.

We saw evidence that staff had been vaccinated against Hepatitis B to protect patients from the risks of contracting the infection.

There was a contract in place for the safe disposal of clinical waste and sharps instruments. Clinical waste was stored in a safe and secure location away from the public, though we noted that the practice was not using the correct colour coded bags as per national guidelines. The bins were collected weekly by a clinical waste contractor. We found that infection control audits were carried out on a quarterly basis.

There were stocks of PPE (personal protective equipment) such as gloves. A legionella risk assessment had been completed in 2015 and the results were negative for bacterium [Legionella is a bacterium found in the environment which can contaminate water systems in buildings].

There was a supply of cleaning equipment which was stored appropriately. The practice had a daily cleaning checklist which gave instructions for tasks to be carried at the start and end of each session, and at the end of the day.

Equipment and medicines

We found the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments and X-ray equipment. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process where electrical appliances are routinely checked for safety. All the equipment at the practice had annual maintenance checks.

The practice had clear guidance regarding the prescribing, recording and stock control of the medicines used in the practice. The only medicines stored at the practice were those found in the medical emergency box.

Radiography (X-rays)

The principal dentist was the Radiation Protection Supervisor (RPS). An external organisation covered the role of Radiation Protection Adviser (RPA). The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in clinical areas where X-rays were used. Evidence was seen of radiation training for staff undertaking X-rays. X-rays were graded and audited as they were taken. A radiograph audit had been carried out in 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dental care records were a mix of electronic and hard copies. Patients' medical histories were kept on hard copy dental care records that were not kept at the practice; there were no details of patient's medical history for us to review on the day of the inspection.

We saw some evidence that the dentist carried out an assessment to establish individual needs and preferences in the electronic records we reviewed. This included explanation of the presenting complaint and purpose of the appointment, A clinical assessment and information about the costs of treatment and a treatment plan.

The electronic records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool was undertaken. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action.

The principal dentist told us that the records were kept at their home because there was no space at the practice to keep the records. They told us that records were transported from their home to the practice based on the patients that had booked appointments for specific days. They told us that records could be transported to the practice from their home in the event of an emergency examination being carried out on someone who had not booked.

We found no evidence that the practice kept up to date with all current guidelines and research in order to continually develop and improve their system of clinical risk management; the principal dentist told us that details of recall intervals etc would be shown in the hard copy records that were not available at the practice.

Health promotion & prevention

Appropriate advice was provided by staff to patients based on their medical histories. For example patients were given smoking cessation advice where this was appropriate. We saw they provided preventive care advice on tooth brushing and oral health instructions as well as fluoride application, alcohol use, and dietary advice.

Staffing

Staff told us they had received appropriate professional development and training and the records we saw reflected this. The practice maintained a programme of professional development to ensure that staff were up to date with the latest practices. This was to ensure that patients received high quality care as a result. Examples of staff training included core issues such as health and safety, safeguarding, medical emergencies and infection control. We saw that the practice maintained records that detailed training undertaken and highlighted training that staff needed to undertake. We also reviewed information about continuing professional development (CPD) and found that staff had undertaken the required number of CPD hours.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to a local hygienist. Dental care records we looked at contained details of the referrals made and the outcome from the referrals that were made.

Consent to care and treatment

Patients who used the service were given appropriate information and support regarding their dental care and treatment. Patients were given clear treatment options which were discussed in an easy to understand language by the principal dentist. Patients understood and consented to treatment. This was confirmed when we checked electronic dental care records and treatment plans had been emailed to patients.

Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff were aware of how they would support a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient and carers to ensure that the best interests of the patient were met. This meant where patients did not have the capacity to consent, the dentist acted in accordance with legal requirements and that vulnerable patients were treated with dignity and respect.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed two CQC comment cards. The feedback we received was positive. Staff were described as helpful and caring. Patients said staff treated them with dignity and respect during consultations.

Involvement in decisions about care and treatment

We saw that the practice had a website that included information about dental care and treatments, costs and opening times.

We spoke with the principal dentist on the day of our visit. There was a culture of promoting patient involvement in treatment planning which meant that all staff ensured patients were given clear explanations about treatment. The principal dentist told us that treatments, risks and benefits were discussed with each patient to ensure that patients understood what treatment was available so they were able to make an informed choice. The principal dentist told us they would explain the planned procedures to patients using visual aids when necessary. Patients were then able to decide which treatment option they wanted.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The principal dentist told us there was enough time to treat patients, and that patients could generally book an appointment for a time they wanted.

Tackling inequity and promoting equality

The practice had recognised some of the needs of different groups in the planning of its service. The principal dentist told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. We asked how the practice would accommodate patients whose first language was not English. The principal dentist told us they would encourage patients to bring an interpreter with them to the appointment. They told us they would use an interpretation service if required.

Access to the service

The practice displayed its opening hours on the practice website. The advertised opening times for the practice was 9.00 -5.30pm Monday to Friday. This gave patients good options for accessing the service. However, we found there were no instructions telling patients what to do in an emergency.

Concerns & complaints

The practice had effective arrangements in place for handling complaints and concerns. There was a complaints policy, and information for patients about how to complain was available in the reception area. The policy had last been reviewed in 2015 and was scheduled to be reviewed in 2016. The policy included contact details for three external organisations that patients could contact if they were not happy with the practice's response to a complaint. This included the General Dental Council. There had been no complaints in the last twelve months.

Are services well-led?

Our findings

Governance arrangements

The practice did not have good governance arrangements in place. There was a lack of practice specific policies and procedures. The policies and procedures available were generic and had not been amended to be specifically relevant to the service. For example, the infection control procedure said the dental nurse should wear and apron when carrying out the decontamination process but the dentist told us this was not something the dental nurse had ever been instructed to do and they were not aware this was part of the policy. The principal dentist told us that as they just had one member of staff they had regular informal meetings; this was confirmed when we spoke with the member of staff.

We were also told by the dentist that they would be loading the records unto to a computer over the course of the next six months and all records would then be accessible to them at the practice when this was done.

Leadership, openness and transparency

The member of staff we spoke with said they felt the owner of the practice was open and created an atmosphere where staff felt included. They told us they were comfortable about raising concerns with the principal dentists. They felt they were listened to and responded to when they did so.They described the culture encouraged candour, openness and honesty.

Learning and improvement

Staff told us they had good access to training and were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC).

The dental nurse undertook quality audits at the practice. This included audits on health and safety, cleaning and clinical records. However, we found that some of the audits were not fit for purpose. For example, an audit of the practice governance had ticked that appraisals and practice meetings were regularly carried out. The principal dentist told us this was not the case and appraisals and practice meetings did not take place. Another example was an infection control audit that had not identified any issues despite the practice not having a number of things mentioned in the audit, including for example the water disinfector. The principal dentist said the dental nurse had undertaken the audits and he did not know why issues had not been picked up during these audits. None of the audits we reviewed had improvement action plans.

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

The practice had gathered feedback from patients through their website. We saw that patients had left positive message about the practice on the site. There was however no formal method for patients to give feedback about the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not have robust systems in place to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated; 12 (1), (2) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation: Good governance How the regulation was not being met: The provider did not have effective systems in place to : • Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity • Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. • Ensure that their audit and governance systems were effective. Regulation 17 (1) (2) (a) (b) (f)