Mr. Adrian Weiss

Mr Adrian Weiss - Poplar Road

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 24 July 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

CQC inspected the practice on 10 January 2014 and asked the provider to make improvements regarding respecting and involving patients who use the service, assessing and monitoring the quality of the service and record keeping. We checked these areas as part of this comprehensive inspection and found that improvements had been made to respect patients and involve them in their treatment, and measures had been put in place to monitor the quality of the service. We noted that audits had now been put in place however improvements were still required in relation to the quality of the audits. The issues around record keeping had still not been resolved.

Mr Adrian Weiss – Poplar Road is an NHS dental practice located in the London Borough of Merton. The premises consist of one surgery, a waiting room and small reception area.

The practice provides NHS dental services to both children and adults The staff structure consists of one dentist and a dental nurse. Both staff take on the reception and administration duties. The practice is open on Fridays from 9.00am-5.30pm.

Summary of findings

We received 17 completed comment cards from patients and spoke with five patients during the inspection. The feedback we received was positive about the service. Patients told us the care and treatment they received was good and generally had positive experiences.

Our key findings were:

- There were effective processes in place to ensure patients were safeguarded from the risks of abuse.
- The practice had processes in place to reduce and minimise the risk of infection
- Clinical staff were up to date with their continuing professional development
- Patients felt involved in making decisions about their treatment and told us they received enough information to make informed decisions
- Patients' needs were not always suitably assessed and treatment was not planned and delivered in line with best practice guidance such as from the National Institute for Health and Care Excellence
- The practice was not maintaining appropriate dental care records in that dental records were not always complete.
- The practice did not have an automated external defibrillator (AED) and not all emergency medicines were present in line with British National Formulary guidance
- There was a lack of evidence of learning from clinical audits.
- Routine x-rays were not being taken in line with the selection criteria for dental radiography Faculty of General dental practitioners (UK) guidelines

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

- 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.
- Ensure that clinical audits have documented learning points and the resulting improvements can be demonstrated.

You can see full details of the regulations not being met at the end of this report.

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

- Review availability of medicines and 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.
- Ensure all staff are aware of their responsibilities under the Mental Capacity Act (MCA) 2005 as it relates to their role.
- Adopt an individual risk based approach to patient recalls having regard to National Institute for Health and Care Excellence (NICE) guidelines.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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 provider had systems in place to ensure people were safeguarded from abuse. Both staff working in the practice were trained to level two in child protection and had also completed adult safeguarding training. The safeguarding policy was up to date and staff were aware of their responsibilities. Processes were in place for staff to learn from incidents and accidents. The practice had carried out risk assessments and there were processes to ensure equipment and materials were well maintained and safe to use. Recommended medicines (except midazolam) and equipment were available to manage a medical emergency. However, the practice did not have an automated external defibrillator in line with Resuscitation Council (UK) guidance.

Are services effective?

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

The provider was assessing patients' needs and delivering care and treatment, however it was not always in line with published guidance, such as from the National Institute for Health and Care Excellence and the Department of Health (DoH). Patients told us they were given relevant information to assist them in making informed decisions about their treatment. Referrals were made and followed up appropriately.

Information was available to patients relating to health promotion and maintaining good oral health. Staff gave necessary advice to patients on oral health Both clinical members of the dental team were meeting their requirements for continuing professional development in line with General Dental Council (GDC) guidelines.

Staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005; however one member did not have a full understanding of the requirements of the Act though knew where to go to for guidance.

Are services caring?

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

We spoke with patients during this inspection and they were generally happy with the service the received. They described staff as friendly and helpful and felt that a caring service was being provided.

We observed interaction between staff and patients and the interactions were positive. Staff were polite and helpful. Provider had taken reasonable steps to ensure patient confidentiality was protected. Patients' information was held securely, both electronically and in paper records. Computers were password protected so that they could not be accessed by unauthorised persons.

Are services responsive to people's needs?

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

Patients had appropriate access to the service. Information was made available to patients through leaflets and posters in the patient waiting area. Urgent on the day appointment slots were available during opening hours and appropriate arrangements were in place for out of hours.

There were systems in place for patients to make a complaint about the service if required.

Summary of findings

Are services well-led?

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

There were policies and procedure for staff to refer to for the smooth running of the service. Practice meetings were on a regular basis and staff found them useful. Staff had access to training and development opportunities and told us they felt supported and that leadership was good. Audits were being completed regularly however learning from audits was not being used to ensure continuous improvements and to ensure the continued monitoring of quality in the service. Clinical records we reviewed were not complete, legible or accurate in all cases.

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Detailed findings

Background to this inspection

The inspection took place on the 24 July 2015 and was undertaken by a CQC inspector and a dental specialist adviser.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

The methods used to carry out this inspection included speaking with the dentist and the dental nurse. We also reviewed policy documents and records. We spoke with five patients and observed interactions between staff and patients. We received 17 CQC completed comment cards

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 an accident book to record all accidents that occurred in the practice and an incident log. At the time of our inspection no accidents or incidents had been reported in the past 12 months. The dentist explained how learning from incident would be carried out and it was in line with our expectations for incident handling.

The practice had not had any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidences.

Staff were aware of their responsibility to raise and record any concerns they had in relation to incidents or near misses that occurred in the practice.

Reliable safety systems and processes (including safeguarding)

The dentist was the safeguarding lead. The practice had a safeguarding adult and child protection policy. Staff were aware of the safeguarding issues including the duty to report concerns to the local safeguarding team. Both staff had completed vulnerable adults and child protection level two training.

The practice was not following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. [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]. The dentist told us that they did not feel the need to use rubber dam. Whilst they were aware of the guidance that recommended use of rubber dam it was not the preferred option.

Medical emergencies

The provider had the majority of emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. However midazolam (used to manage an epileptic seizure) was not present. The dentist told us that it would be ordered as a matter of urgency. Medicines were stored appropriately, and all were within their expiry date. Regular checks were carried out by the dental nurse to check medicines were still within their expiry date.

Medical oxygen and other equipment to manage a medical emergency was available in the practice. However, the practice did not have access to an automated external defibrillator (AED) in line with Resuscitation Council (UK) guidance and the General Dental Council (GDC) standards for the dental team. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. The dentist explained that they did not have an AED because the practice was very small and only open once a week. They had therefore assessed that an AED was not necessary, but assured us they would review the risk assessment.

Both staff had completed training in management of medical emergencies in July 2015. Training was planned to be updated annually.

Staff recruitment

The staff team consisted of one dentist and a dental nurse. Both staff had worked in the practice for a number of years. As the staff requirement was very small there had not been any recruitment in a long time. The dentist explained how staff would be recruited to the practice. This included requiring proof of identity, proof of registration with the General Dental Council (GDC), references, history and a Disclosure and Barring services (DBS) check. Both staff working in the practice had a DBS check on file.

Monitoring health & safety and responding to risks

The practice had a health and safety policy that outlined staff responsibilities towards health and safety, accidents, fire safety and manual handling.

A premises risk assessment had been completed in April 2015. The risk assessment covered all areas of the practice including equipment, the premises, electrical hazards and manual handling. Risks had been analysed and appropriate action detailed if necessary.

Checks were carried out routinely to the fire alarm to ensure it was working.

Infection control

Staff were following the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance from the Department of Health, and there was a copy in the decontamination room for quick

Are services safe?

reference. The nurse was the infection control lead and gave us a demonstration of the decontamination process. All decontamination of instruments was carried out in a separate area of the dental surgery.

Instruments were manually washed. There was one sink for washing and a separate bowl was used for rinsing instruments in line with the guidance. Instruments were inspected under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); then sterilised in the autoclave; pouched and date stamped, so expiry was clear. We saw that correct personal protective equipment was available for staff to wear whilst carrying out the decontamination process and appropriate levels of stock were maintained.

We reviewed the records of the weekly and monthly checks carried out to sterilising equipment (autoclave) to ensure it was working effectively. The checks and tests were in line with guidance recommendations and included annual servicing.

Both staff had been immunised against blood borne viruses.

The segregation and storage of dental waste was in line with guidance.. Clinical waste was stored securely and there was a contract in place for it to be collected every two weeks.

Staff were following sharps regulation guidance and knew what first aid steps to take and how to report in the accident book. Sharps containers were correctly assembled though not labelled.

The surgery was visibly clean and tidy although it was small and storage space was limited. The surgery was too small to allow the recommended 1.5 metres space between the clean instruments and aerosol (generated from the use of dental drills) contamination, however staff were taking steps to ensure clean instruments were stored safely to prevent contamination.

Paper hand towels and hand gel was available and clinical waste bins were foot controlled. The dental nurse was responsible for cleaning all clinical surfaces including the dental chair in the surgery, in-between patients and at the beginning and end of each session of the practice.

A Legionella risk assessment had not been carried out in the practice [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. We discussed this with the dentist and were advised that they were unaware they needed to complete a full assessment as the dentist had carried out their own local assessment. The dentist agreed that they would arrange for a full legionella risk assessment to be carried out in the near future.

The dental water lines were maintained and cleaned with a purifying agent. Dental water lines were flushed in line with recommendations.

The practice had an Infection Protection Society (IPS) audit which had been completed in April 2015. They had passed with a 95% score and no major actions were required.

Equipment and medicines

The practice had appropriate maintenance and service contracts in place for equipment. This included service and maintenance for the x-ray machine, autoclave (serviced December 2014) and compressor (August 2014). We saw the certificate for portable appliance testing (PAT) that had been competed in 2012. The dentist told us it was next due at the end of the year.

Radiography (X-rays)

The dentist was the radiation protection supervisor and had completed Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER) training .There was an appointed external radiation protection adviser. There was a radiation protection file. The practice was carrying out radiography audits annually, and records for the last four years were available. Whilst the audits had been completed there was no discussion of action plans for improvements that needed to be made. We discussed this with the dentist and they agreed that they would begin to record learning and outcomes from the audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were assessed, however we did not see evidence that care and treatment was always delivered in line with current legislation such as National Institute for Health and Care Excellence (NICE) guidance. For example, there was no evidence in the dental care records we reviewed to show that recall intervals were discussed or that risk assessments were being completed for patients with high or low risk for caries, in line with guidance.

In the dental care records we reviewed, we did not see evidence of comprehensive assessments and treatment plans that were individualised for patients. This was because clinical notes did not record that a full assessment of the patient had been undertaken in line with record keeping guidelines such as those from the Faculty of General Dental Practice (FGDP). For example, soft tissue checks were not being recorded. The dentist explained that it was because they rarely saw soft tissue conditions, and he did note them if he identified it. The dentist was also not recording advice given to patients relating to oral hygiene, diet or smoking and alcohol advice.

Medical histories were obtained from patients, however in some of the records we reviewed there was no evidence that they had been updated. The dentist told us they did update them routinely, but did not always record it. Routine x-rays were not being taken in line with the selection criteria for dental radiography in line with Faculty of General Dental practitioners (UK) guidelines.

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Health promotion & prevention

There was some oral health and prevention information available to patients in the waiting area. Staff told us that oral health information was given to patients during consultations however this was not documented in patient's clinical notes and they were not aware of the Delivering better oral health toolkit. 'Delivering better oral health' is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Some of the patients we spoke with confirmed that they were given advice about maintaining better oral health including proper tooth brushing techniques and smoking cessation.

Staffing

Both staff had current registration with their professional body, the General Dental Council. Records showed they had both undertaken a good variety of training to demonstrate sufficient hours of working towards their continuing professional development (CPD) requirements to complete their five year cycle. The dentist and dental nurse took responsibility for making arrangements for their own CPD [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 every five years].

The dental nurse told us that development opportunities existed and there were always opportunities to attend training and learning events.

Working with other services

The practice worked with other professionals to ensure that patient' needs were met. We saw examples of referrals made to the hospital for wisdom teeth extractions and orthodontic referrals. The dentist wrote individual letters explaining the / reason for referral, required personal details and medical history information.

Consent to care and treatment

The provider made information available to patients relating to costs and treatment to support patients to understand their care and treatment options.

The dentist told us that consent was taken verbally from patients but confirmed that they did not always record this in patient's clinical notes. The records that we reviewed did not have consent documented.

Staff had not completed Mental Capacity Awareness training; however they demonstrated an awareness of mental capacity issues and gave examples of how they identified patients with capacity issues and the steps they would take if they suspected the patients lacked capacity to make decisions. The Mental Capacity Act 2005 (MCA) 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received 17 completed CQC comment cards. Patient feedback was very positive. Patients were complimentary about the staff, describing them as friendly and caring. They said that the dentist explained treatment options clearly and with enough information for them to make informed decisions. All the patients we spoke had been with the surgery for many years (as was the majority of the practice's patient population). They told us that staff treated them with dignity and respect and their privacy was always respected. They spoke about the caring nature of the dentist. We observed interaction between staff and patients and our observations were in line with what patients had told us.

The practice was very small. As such to ensure privacy during consultations the dentist played music to ensure conversations could not be heard by patients waiting in the waiting area. We noted during our inspection that patient consultations were not overheard when the dentist was treating patients inside the treatment room.

Patients' information was held securely, both electronically and in paper records. Computers were password protected so that they could not be accessed by unauthorised persons.

Involvement in decisions about care and treatment

Feedback from patients relating to being involved in their treatment was positive. They told us that staff asked them if they understood treatment being proposed and went over things if they were unsure.

The dentist told us that treatment options were discussed with patients so that they had a clear understanding.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was open one day a week. If patients required an urgent or non-routine appointment they were able to visit the dentist at the other location or an appointment would be made for them to attend the practice out of normal surgery hours.

Tackling inequity and promoting equality

The dentist told us that the practice's patient population was an even mix of the local population. The service took account of the needs of patients in vulnerable circumstances.

The practice was set out on the ground level and access to the building was step free with wheelchair access for all areas except for the toilet facilities. The dentist told us they did not have any patients who were wheelchair users; however if they did they would either be accommodated at the other practice or referred to a nearby service.

Access to the service

The practice was open one day a week on a Friday. Patients booked appointments by calling the practice on the day it was open. They could also contact the dentist or book an appointment by calling the provider's other location to make the booking. If a patient required an emergency appointment during opening times or outside of opening times the dentist was always willing to accommodate them. Patients could either visit the other location or the dentist would make an appointment to see them in the evening. The provider had details of the local 111 out of hour's service and dental triage service displayed in the patient waiting area and leaflets were also available for patients to take.

Concerns & complaints

The provider had a complaints policy and procedure in place. There was a compliments and complaints notice and box in the reception area for patients to share their views. Alternatively staff told us patients could write in to the practice. At the time of our visit the practice had not received any complaints in the last few years. We spoke with staff about complaints and they both explained how they would deal with complaints. The explanations were in line with their policy and included investigating the matter, providing an apology if necessary and sharing any lessons learnt.

Are services well-led?

Our findings

Governance arrangements

The provider had a range of policies and procedures in place to ensure the smooth running of the practice. This included policies and procedures for infection control, health and safety and complaints handling.

We inspected the provider in January 2015. This inspection found that he provider was not complying with regulations related to record keeping. This was because written records were not legible and clear, there were several typographical errors in patient's records and clinical records were not comprehensive. The provider was asked to take action however improvements were minor. Our inspection found that the records we reviewed still needed improvement. This was because they were not complete and legible. The dentist was not including an accurate record of decisions taken, neither were they documenting discussions with patients.

Paper records we reviewed were difficult to read and not legible. We had to ask the dentist to read them in order to understand them. When the dentist read the notes we found that records were not complete and information was missing. For example, whilst the dentist told us they carried out full assessments this was not documented in patients' notes. Discussions around soft tissue checking for cancer and smoking cessation with patients were not recorded, details relating to dietary advice or oral health advice were missing and treatment options discussed were not documented. The dentist assured us that they completed a full assessment which included all of the above; however this was not reflected in clinical notes.

The practice had completed various audits including an x-ray audit, monthly cleaning audit, compressor audit, X-ray audit and infection control audit. Whilst audits were being completed, improvements could be made to identify learning being derived from them. For example, the cleaning and compressor audits did not include a section to record any action that was required or how things were resolved. We spoke with the dentist about this and they agreed that learning from audits was not always recorded. They agreed that they would revise their audit process to ensure that they were being used as a tool to drive improvement.

Leadership, openness and transparency

Both staff spoke positively about the service. They told us that they supported each other to ensure the practice achieved the aims in their statement of purpose. Monthly meetings were held to discuss quality issues in the practice such as complaints. The staff team was small, however the dental nurse told us that the dentist led with openness and transparency.

Management lead through learning and improvement

The practice had not had any incidents for at least the past three years. However the dentist told us that he shared all learning with the dental nurse through their monthly staff meetings. For example, if something minor happened during a patient's treatment that was not to plan they would discuss learning from this and talk about how it could be avoided in the future. The staff meetings were used to discuss a range of issues relating to the practice. Both staff described how useful they found the meetings and the benefits of attending. We reviewed the minutes of the monthly meets and saw that meetings were occurring on a regular basis.

The nurse received an appraisal every year. Whilst we did not see that the appraisal was used to identify learning or development opportunities the nurse told us that opportunities existed for development and they was well supported by the dentist.

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

The practice completed patient satisfaction surveys to seek feedback from patients and involve them in service development. We reviewed 12 surveys completed over the past 12 months. Patient feedback was very positive. Areas covered by the survey included treatment options being discussed and explained and appropriate information being given. The dentist told us the survey was conducted annually and analysed on an on-going basis.

The staff team was small but both confirmed that they frequently discussed developments for the practice to drive improvements.

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 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014** **Good Governance.** **How the regulation was not being met:** **The provider did not have effective systems in place to :** **Ensure accurate and contemporaneous clinical patient records were always maintained.** **Ensure that the audits and governance systems were effective** **Regulation 17 (1) (2) (c)**