Morgan Dental Practice

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Inspection Report

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Overall summary

We carried out a comprehensive inspection of Morgan Dental Practice on 28 January 2015.

Morgan Dental Practice provides general dental treatment and orthodontics. There is capacity under a limited NHS contract for general treatment for adults and children as well as an NHS orthodontic contract for children. Other patients are treated on a private fee paying basis or under a care plan.

There were three dentists including the principal dentist. A fourth dentist – the co-owner of the practice had retired from clinical dentistry. One of the dentists worked one day a week carrying out orthodontic treatment. A hygienist also worked at the practice.

Before the inspection we sent CQC comment cards to the practice for patients to complete. We received 31 completed comments cards and spoke with two patients on the day of the inspection. Overall these patients were positive about the practice and described the staff team as polite, helpful and pleasant. Patients commented that they were very pleased with their care they had received.

Our key findings were:

- The practice had systems to monitor patient safety through reporting and learning from incidents and significant events. The premises were clean and there was clear guidance available regarding infection prevention and control.
- The practice carried out assessments and planned treatment in line with current guidance. Staff received training appropriate to their roles and told us they felt well supported to carry out their work.
- Patients told us they were treated with kindness and respect by staff. Staff were knowledgeable about patient confidentiality and we observed good interaction between staff and patients during the inspection.
- The practice had recorded and acted upon complaints made in order to improve the service for patients. Patients were able to make routine and emergency appointments when needed. There were clear instructions for patients regarding out of hours care.
- There were leadership roles within the practice and staff told us they felt well supported and comfortable to raise concerns or make suggestions.

However, there were some areas of practice where the provider needs to make improvements.

The provider should:

- Keep all risk assessments under regular review
- Ensure the business continuity plan has a comprehensive process for recovering from unexpected events that threaten stability of the practice.

Summary of findings

- Carry out regular checks on all emergency equipment.
- Assure themselves that all clinical staff have a working knowledge of the Mental Capacity Act 2005 (MCA).

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?

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse and maintaining the required standards of infection prevention and control. The practice carried out and reviewed risk assessments to identify and manage risk. However, they were not regularly reviewed along with emergency equipment.

The practice followed procedures for the safe recruitment of staff and had systems in place to support them carry out their work.

Are services effective?

The dental care provided followed current guidance. Patients were given appropriate information to support them to make decisions about the treatment they received. The practice kept detailed clinical records of assessments and treatments carried out and monitored any changes in the patient's oral health.

Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration. Records showed patients were given health promotion advice appropriate to their individual needs such dietary advice.

Are services caring?

We observed that privacy and confidentiality were maintained for patients who used the service on the day of the inspection. Staff recognised the importance of explaining the assessment and options for treatment to patients. We looked at 31 CQC comment cards that patients had completed prior to the inspection. Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity.

Are services responsive to people's needs?

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. Staff were knowledgeable about the process. The practice had responded appropriately to complaints and comments had made changes. For example refurbishing the waiting room.

Are services well-led?

There were leadership roles within the practice and the leadership structure was displayed in the reception area. Staff were aware of the leadership structure and told us they felt well supported and comfortable to raise concerns or make suggestions with appropriate leads.

The practice had systems in place to seek and act upon feedback from patients who used the service. We saw evidence that they were acknowledged and where appropriate responded to.

Morgan Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC.

We carried out an announced inspection on the 28 January 2015. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information that we held about the provider and by other organisations. We informed NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we toured the premises and spoke with two dentists, two dental nurses, one reception staff member and the quality/practice manager. To assess the quality of care provided by the practice, we looked at practice policies and protocols and other records.

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

Learning and improvement from incidents

The practice had a system for recording significant events which were recorded on a pro-forma and discussed at team meetings. Staff we spoke with were aware of the procedure and we saw that they were proactive in recording incidents. We saw that 19 incidents were recorded for 2014. For example, we saw an incident recorded that only six face masks were available for the day. This was highlighted as not being enough to run the surgery for the day. Face masks were on order but were not due for delivery until the next day. We saw that the immediate action taken by staff was to source more face masks from a nearby practice and to increase the monthly order to suppliers to meet the demand for this item. We saw minutes of meeting where this was discussed. We saw another example of an incident record regarding the miscommunication of fees. We saw that this was due to be discussed at the next practice meeting scheduled in March 2015.

The practice also had an accident book where incidents such as needle stick injuries were recorded. We saw evidence that they were responded to appropriately and discussed at team meetings to share learning.

Reliable safety systems and processes (including safeguarding)

The practice had up to date child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. There was a lead professional for both safeguarding children and adults and a deputy in their absence. However, the lead worked at the practice one day a week and the deputy was away on maternity leave. Although staff we spoke with were aware of what to do if they suspected abuse we discussed the appropriateness of the nominated leads with the principal dentist. The principal dentist told us that they would deal with any concerns raised in the absence of the lead.

We saw that all staff had received safeguarding training through eLearning and were confident to raise any issues or concerns. There were dedicated folders for safeguarding with information, relevant contact numbers and referral forms to raise concerns with the relevant authority. We saw evidence that safeguarding leads had received children and vulnerable adults safeguarding training at a level appropriate to their role.

The dentists in the practice used rubber dams. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site (one or more teeth) from the rest of the mouth. Use of a rubber dam is considered good practice and stops bacteria in saliva from splashing onto the tooth. This is very important for successful root canal treatment, because the bacteria in saliva can re-contaminate the tooth. Other benfits include the prevention of composites or fillings from being inhaled or ingested during removal.

Infection control

There was an infection control policy with a dedicated lead who ensured that infection control guidance was being followed. We saw that the policy was updated annually and all staff had received annual in-house training. The infection control lead was aware of the guidance around decontamination of dental instruments and was aware of the recent changes.

We looked around the premises during the inspection and found the treatment rooms appeared visibly clean and hygienic. They had sealed floors and work surfaces that could be cleaned with ease to promote good standards of infection control. We looked at the cleaning schedules for the practice and saw records to evidence these had been carried out. The treatment rooms were free from clutter, with surfaces that could be cleaned and disinfected between patients. Staff we spoke with told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection prevention and control standards.

Decontamination procedures were carried out in a dedicated decontamination room to clean and reprocess dirty instruments. A dental nurse talked us through the decontamination process. Contaminated instruments were taken in sealed boxes to the decontamination room to be decontaminated using a washer disinfector dryer. If the washer disinfector dryer was out of service an ultrasonic bath was available for emergency use. The instruments were then examined under an illuminated magnifier to ensure that they were clean, functional and in good

condition before being placed in date-stamped bags and sterilised in a vacuum autoclave. These measures ensured only sterilised instruments were available for use. Any items not suitable for sterilisation are treated as “single use” and disposed of after use on each patient. We spoke with the principal dentist who told us they had the highest membership (expert) with British Dental Association (BDA). The BDA is a national professional association for dentists. This membership offered full access to the entire range of the BDA’s services which helped them to stay updated on latest guidance.This included any changes to the infection control guidance around Health Technical Memorandum 01-05 (HTM 01-05). HTM01-05 is the Department of Health’s guidance on decontamination in primary care dental practices.

We observed Personal Protective Equipment (PPE) was available to all staff for use when decontaminating instruments. Staff and patients we spoke with confirmed that protective aprons, gloves and masks were worn as appropriate and in accordance with infection control policies when examining and/or treating patients.

A risk assessment for Legionella was carried out in 2013. The practice followed actions on the assessment by monitoring cold and hot water temperatures each month. Records showed these checks were up to date. Legionella is a bacterium that can grow in contaminated water and can be fatal. This ensured the risks of Legionella bacteria developing in water systems within the premises were identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease.

Equipment and medicines

We found evidence that essential equipment at the practice was maintained and serviced as required. Records showed that contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. This helped ensure there was no disruption in the safe delivery of care and treatment to patients.

The practice had procedures regarding the prescribing, recording, dispensing, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded and these medicines were stored safely for the protection of patients.

The practice stored medicines in the fridge as recommended by manufacturers of the medicines. The fridge temperature was not checked regularly to ensure the temperature was within the required range for the safe use of the medicine. There was no cold chain policy to guide staff so that they would know what to do if the temperature range went outside recommended levels. Staff assured us that this would now be done.

Monitoring health & safety and responding to risks

The practice had a health and safety policy that was accessible for all employees and arrangements were in place to deal with foreseeable emergencies. The practice had risk assessments in place for dealing with sharps, display screen equipment as well as risk assessments for communal areas of the building. We were told that the landlord of the building carried out a risk assessment of the building. However the practice staff did not get a copy which would alert them to any risks.

We saw that most of the risk assessments were reviewed annually by the provider. However, other risk assessments were not reviewed as regularly even though the review dates were set on an annual basis by the provider. For example, the risk assessment for the communal area in the practice had not been reviewed for over four years.

We saw that the practice had a fire safety protocol and this was displayed in the practice for the benefit of staff and patients. We saw the fire drill policy was an agenda item for the next scheduled practice meeting. The quality manager told us that staff felt this needed to be reviewed and had added this as an agenda item.

The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. Copies of the plan were held in the practice and staff knew where it was kept. The plan covered loss of water supply and some environmental events such as loss of power supply. We spoke with the provider about the need to have a robust business continuity plan as the current plan did not detail steps to ensure continuity of business in all the situations listed. For example, we saw that the plan asked staff to contact the water company in the event of loss of water. It did not provide any further guidance on the steps needed to be taken in the event water was not available long term.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. There was a range of suitable equipment

Are services safe?

including an automated external defibrillator (AED), emergency medicines and oxygen was available for dealing with medical emergencies. An AED is 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. The guidance for emergency equipment can be found in the Resuscitation Council guidelines.

The emergency oxygen and medicines were all in date and securely kept. All staff we spoke with were aware of where it was kept. The expiry dates of medicines and equipment was regularly monitored so that out of date drugs and equipment could be replaced in a timely manner. The practice followed guidelines about how to manage emergency medicines in general practice in accordance with the British National Formulary (BNF). The British National Formulary (BNF) is a pharmaceutical reference book that contains a wide spectrum of information and advice on medicines.

The practice had three Yankauer suction tips as part of the emergency medical equipment. These are used in emergency situations to aspirate (remove/suck out) fluids and secretions from the mouth/ throat of an unconscious or recovering patient to prevent inhalation of those fluids.

We noted that the practice did not have an emergency medicine recommended in the British National Formulary (BNF). We spoke with the principal dentist who had arranged to have this in stock during our inspection. After our inspection we were given assurance that the medicine was now being stocked at the practice.

We saw staff had received the required training to use emergency medical equipment and carry out cardiopulmonary resuscitation (CPR). This training was delivered by an external agency to all staff at the practice. This ensured that in the event of a medical emergency staff would be able to respond appropriately with the latest training and guidance.

Staff recruitment

The practice had a detailed checklist for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications and professional registration. We looked at three staff files and found the recruitment procedure had been followed.

We saw that all staff had undergone the Disclosure and Barring Service (DBS) checks. These checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post.

Newly employed staff had a period of induction to familiarise themselves with the way the practice ran, before being allowed to work unsupervised. This was evident in the records of a new member of staff.

Radiography (X-rays)

We checked the radiation protection file as X-rays were taken and developed at the practice. We noted local rules had been posted for each surgery set as required by the ionising radiation medical exposure regulations (IRMER). In the X-ray file we observed a radiation protection adviser (RPA) had been appointed as required by IRMER. We observed appropriate staff had received training in radiology as required by the General Dental Council (GDC) and IRMER. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. We looked at examples of X-rays taken by one of the dentist present during the inspection. This ensured that X-rays were only taken when clinically necessary by suitably qualified clinicians and the findings for each radiograph were acted upon.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

We looked at patient records which confirmed that they were presented with treatment options and consent forms which were signed by the patient. Patients we spoke with also advised that they gave both verbal and written consent to their treatment.

In situations where people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA). This is to ensure that decisions about care and treatment are made in people's best interests. We spoke with two dentists during the inspection and found that but they had a limited understanding of the MCA even though we saw leaflets were available at the practice.

Monitoring and improving outcomes for people using best practice

The practice kept up to date and detailed electronic and paper records of the care given to patients. Electronics record provided comprehensive information about the patient's current dental needs and past treatment. We reviewed the information recorded in patient records about the assessments, treatment and oral health advice given to patients. Records detailing the condition of the teeth, soft tissues lining the mouth and gums were comprehensive.

We saw evidence that the dentists used National Institute for Health and Care Excellence (NICE) guidance in relation to wisdom teeth removal and in deciding when to recall patients for examination and review.

Working with other services

The dentists told us that they carried out the majority of treatments needed by their patients but some patients requiring more difficult or complex forms of those treatments were referred to specialist clinics or hospitals. For example, difficult or complex oral surgery, orthodontics, root fillings and implants. Patients who were anxious were also sent to specialist clinics that could treat them appropriately.

We saw that the practice used a pre-designed referral form which also provided guidance for clinical staff for when to refer patients and the reasons. We saw examples of referral letters which were comprehensive and thorough with medical histories and reason for referral. Patients were given a copy of the referral letter and a further letter to confirm that the referral letter had been sent out.

Health promotion & prevention

There was a folder in the reception area with health promotion leaflets advising patients on how to look after their teeth and braces as well as other advice leaflets. There was a large screen television displaying information on dental decay and advice on the importance of a good diet. We saw free sample toothpastes were available for patients to take away. Staff we spoke with told us that patients had commented that they wanted samples of recommended toothpastes and the practice had ensured this was made available.

To support patients look to after their oral health there were many information leaflets available in the practice. These included information about good oral hygiene, healthy eating especially for children and the early detection of oral cancer. Records showed patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice.

The principal dentist we spoke with was aware of delivering better oral health in accordance with guidance published by Public Health England. Delivering better oral health guidance provides evidence based interventions and new advice on how dental health professionals can improve and maintain the oral and general health of their patients. The principal dentist showed us pages they had printed off from the guidance on management of dental caries (decay) so that they could give them out to appropriate patients.

Staffing

We saw evidence of induction for new staff to support them in the first few weeks of working at the practice. Staff told us they had easy access to a range of policies and procedures to support them in their work. The practice had systems in place to support staff to be suitably skilled to meet patients' needs. We saw evidence of regular appraisals conducted by management. Any learning identified was then incorporated in a personal development plan. For example we saw an example of an appraisal for a reception staff member where they had identified further training on handling complaints. We saw that this was an action on their development plan and they had started an online course on handling complaints.

Are services effective?

(for example, treatment is effective)

Dentists and dental nurses told us they had good access to training to maintain their professional registration. All clinical staff were required to maintain a five year period of continuous professional development as part of their registration with the General Dental Council. Records showed that professional registration was up to date for all staff and we saw evidence of ongoing continuous professional development.

Regular staff meetings were in place to support staff. It was a small practice and staff told us that they would communicate any issues amongst themselves informally. We saw minutes of formal meetings which were held at least quarterly or earlier and we saw that staff were free to add any agenda item they wanted to discuss.

Staffing levels were monitored and staff absences were planned to ensure the service was uninterrupted. We saw that a staff rota was in place up to April 2015 taking into account any staff on holiday. Staff told us that they covered each other in the event a staff member being absent due to illness or holiday. One of the staff members worked part time and they usually covered extra hours where needed. The quality manager we spoke with told us that they scheduled more staff on a Monday and Thursday as there was a higher demand for treatment on those days. The practice did not regularly use agency staff but had used them in the past. Although there were no formal arrangements with an agency we saw contact details of agencies in the reception area staff should they need agency staff.

We also noted that a staff member had left recently and another staff member was on maternity leave. Staff told us this created a shortage of staff between the hours of 8am and 9am on a Friday as there was only a dentist and a dental nurse available. The dental nurse would have to cover both the reception and work clinically. We spoke with the principal dentist about this and they told us that they had offered existing staff members extra hours but they were unable to take this on. The principal dentist told us that this was temporary until the return of the staff member from maternity leave.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at 31 CQC comment cards that patients had completed prior to the inspection and spoke with two patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity.

We observed the receptionist greeting patients on arrival and departure from the practice and observed they always treated patients with respect and professionalism. We observed reception staff members who were handling patient telephone calls were polite and professional with patients.

We observed that privacy and confidentiality were maintained for patients who used the service on the day of the inspection. Paper records were stored securely in a locked cabinet. Staff members we spoke with were aware of the importance of providing patients with privacy and told us there were always rooms available if patients wished to discuss something with them away from the reception area.

Involvement in decisions about care and treatment

The patient records examined indicated that the clinicians involved their patients in choices regarding their treatment options. Patients were also given written options regarding their treatment. The patients we talked with indicated they were fully informed regarding their treatment options and felt involved in the decisions about their care and treatment.

Patients were informed of the range of treatments available and their cost in information leaflets and on notices in the reception area and waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice population was such that most patients spoke English. An interpreting service was available but the dentist told us that they had never needed to use it. The practice could also arrange a British Sign Language (BSL) translator if needed.

We saw emergency appointments were available based on the number of dentists working on the day. Staff we spoke with told us that emergency appointments varied according to the time of the year with extra appointments available during the Christmas period. We saw records where patients had been seen in an emergency.

Tackling inequity and promoting equality

The practice was located on the first floor of a building and was therefore not accessible to any patients who used a wheelchair. We saw that the practice had conducted a Disability Discrimination Act (DDA) assessment and was aware of the limitations. DDA works to protect people with disabilities by encouraging service providers to make reasonable adjustments. We saw that the risk assessment recommended that patients were to be referred to the nearest suitable practice. We did note that the DDA assessment needed to be updated as it was last assessed in September 2009. This is because the assessment stated that they would do home visits to patients who were unable to attend the practice. However the practice no longer offered this service. The DDA act has been repealed and replaced by the Equality Act 2010.

The practice was open in the evening between 6pm and 8pm once a week for the benefit of patients who could not attend the practice during regular opening hours. The practice was also open to patients early once a week from 8am. We were told that this was only for private patients.

Access to the service

The practice was located on the first floor of a building and was not accessible for patients who had difficulties with mobility or used a wheelchair. Patients who used a wheel chair were referred to other appropriate services if the practice was unable to treat them. Staff members we spoke with were aware of other services they could refer patients to.

For patients who had difficulty with their sight, the practice was able to offer large print leaflets of services available and both private and NHS costs of treatment. We saw that the website informed patients of the opening hours of the practice and also that early morning and late evening appointments were available for private patients.

Concerns & complaints

The practice had a complaints procedure which explained to patients the procedure to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact. Staff members we spoke with were aware of the process for handling complaints. Patients we spoke with told us that they had no reasons to complain but would feel comfortable to speak with a staff member. Indeed we saw evidence where patients had raised concerns with staff. We saw that staff encouraged patients to make written complaints and also recorded this on incident forms for discussions and learning during practice meetings. Comments cards we reviewed were also positive about the service.

We saw that the practice had received one written complaint in the last year. This was investigated and responded to appropriately. We also saw that staff recorded three verbal complaints on the incident reporting pro-forma. We saw that they were investigated for learning, discussed at practice meetings and changes were made to practice where appropriate.

Are services well-led?

Our findings

Leadership, openness and transparency

There was a clear leadership structure within the practice and a flowchart was displayed in the reception area so that patients were aware of this. Staff we spoke with understood their roles and knew which management staff to approach if they had any issues.

The practice had a clear vision to deliver a consistent service based on available evidence and this was communicated to patients via the website and information in the reception area.

There were arrangements for sharing information across the practice including practice meetings. These were documented for those staff unable to attend. We saw that staff were able to add agenda items that they wanted to discuss.

Governance arrangements

The practice had a flowchart of the leadership structure with lead roles they were responsible for. We looked at policies which confirmed that appropriate leads were mentioned in policies.

The practice carried out audits to ensure their procedures and protocols were being carried out and were effective. These included audits of infection control and X rays. Lead roles in infection control, radiography and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

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

The practice had a comments box in the reception area. We saw the practice regularly reviewed comments and responded to them. We saw the practice had started to give away free toothpaste as patients had commented they wanted free dental products to try. Staff members we spoke with told us the reception area had recently been painted and decorated. This was because patients had recommended they wanted the reception area to be refurbished. We saw that the practice informed patients of the comments they had received and the action they had taken through the information screen in the practice. This showed the practice was listening to patients' feedback and responding where appropriate.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff had professional development plans which identified learning and development needs.

We were shown examples of minuted regular staff meetings which demonstrated an effective medium for cascading training and information to practice staff. Staff members were able to add agenda items so that any issues could be highlighted, discussed and improvements made where necessary.

Undertaking clinical audits encouraged dental practitioners to self-examine different aspects of their clinical practice. They help to implement improvements where the need is identified and re-examine, from time to time, those areas, which have been audited to ensure that a high quality of service is being maintained or further improved. We saw some audits were carried out to help improve practice. They included infection prevention audits and radiography. We spoke with the principal dentist for the need to carry out other audits including record keeping audits.