Mr. Alan Ribbons

Alan Ribbons Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 31 July 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. We had also received several complaints about the practice. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

We found this practice was not providing effective care in accordance with the relevant regulations.

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Alan Ribbons Dental Surgery is based in Taverham and offers private treatment to approximately 3,000 patients. There is portable ramp access for people who use wheelchairs and those with pushchairs. The dental team is small and consists of one dentist and one dental nurse, who are a husband and wife. There is one treatment room.

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

Summary of findings

On the day of inspection, we collected 20 CQC comment cards filled in by patients and spoke with four other patients.

During the inspection we spoke with the dentist and the nurse. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The practice had suitable safeguarding processes and staff knew their responsibilities for protecting adults and children.
- Staff treated patients with dignity and respect, and we received many positive comments from patients about the caring and empathetic nature of both the dentist and nurse.
- Patients received their care and treatment from staff who enjoyed their work.
- The appointment system met patients' needs and patients found it easy to access emergency and out of hours dental care.
- Patients' dental care was not always delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- Dental care records were not maintained in line with guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Medicines were not managed or prescribed according to national guidance.
- The practice's infection control procedures did not comply with national guidance.
- The practice did not have a structured plan in place to audit quality and safety beyond an audit for infection control.

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

- Ensure care and treatment is provided in a safe way to patients
- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

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

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

- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

Requirements notice 

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

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

Premises and equipment were clean and properly maintained and the practice mostly followed national guidance for cleaning, sterilising and storing dental instruments. The practice had arrangements for dealing with medical and other emergencies, although did not have all the required equipment.

The dentist did not follow national guidance in relation to the management of sharps and the use of rubber dams. Some infection control procedures did not follow recognised national guidance.

Are services effective?

Requirements notice 

We found that this practice was not providing effective 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).

The dental care provided to patients did not always follow current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) and we found the dentist was not always aware of up to date procedures. Patient records lacked detail. We found a lack of knowledge and application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients.

Staff did not have an understanding of the Mental Capacity Act 2005, or of Gillick competence and how this might impact on treatment decisions.

Are services caring?

No action

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

We received feedback about the practice from twenty-four patients. Patients spoke highly of the of the practice's staff and had clearly built up strong relationships with them over the years. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

Staff gave us specific examples of where they had gone out their way to support patients such as giving them a lift home in bad weather and providing out of hours treatment.

Summary of findings

Are services responsive to people's needs?

No action

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

Although only open four days a week, patients told us that dentist was easy to access and always offered out of hours treatment in an emergency to meet their needs.

The practice had made some reasonable adjustments to accommodate patients with disabilities including ramp access and a downstairs treatment room. However, it did not provide a hearing loop to assist those patients with hearing aids and information was not available in any other languages or formats such as large print.

The practice's complaints procedure was not displayed where patients could view it, so it was not clear how they would know to raise their concerns.

Are services well-led?

Requirements notice 

We found 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).

We found a significant number of shortfalls in key questions we inspected, indicating that the practice was not well-led. Staff were not following current evidence based guidance in several areas including some dental treatments, medicine management, infection control and training.

Policies and procedures to govern the practice's activities had not been regularly reviewed or updated to reflect current guidance.

There were no robust systems to assess and monitor the quality of service provision.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays))

Staff knew their responsibilities if they had concerns about the safety of children and vulnerable adults and had received appropriate training for their role. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Information about local protection agencies was available in a specific safeguarding folder and in the appointment book for ease of access.

The dentist did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment and it was not clear from the notes if other methods were used to protect patients' airways. There was no formal protocol in place to prevent wrong site surgery.

The practice did not have a business continuity plan describing how it would deal with events that could disrupt the normal running.

The practice did not have a recruitment policy in place but had not employed any new staff in the previous 12 years, and there were no plans to recruit any further staff. The dentist had a DBS check and one was in the process of being obtained for the dental nurse at the time of our inspection. Staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover.

A fire risk assessment had been completed in 2017 and its recommendations to improve fire and oxygen signage, and purchase a powder extinguisher had been implemented. Records showed that firefighting equipment such as fire extinguishers and alarms were regularly tested, although fire evacuations had never been undertaken. Evidence of five yearly fixed wire testing was not available.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Records of water temperature testing were in place, although we noted that one recommendation from the risk assessment to inspect, clean and maintain the hot water storage vessel had not been completed.

The practice had some arrangements to ensure the safety of the X-ray equipment. However, we noted that the dentist was unaware of the most recent IRMER and IRR regulations. Radiograph audits had not been completed and the dentist did not grade any of the X-rays they took.

Risks to patients

We looked at the practice arrangements for safe dental care and treatment. A specific sharps risk assessment had not been undertaken and the dentist had not considered the use of safer sharps as recommended in the Sharps Regulations 2013.

Staff knew what to do in a medical emergency and had completed training in resuscitation and basic life support in June 2018. Staff did not regularly rehearse emergency medical simulations so that they had a chance to practise their skills. Most emergency equipment and medicines were available as described in recognised guidance, apart from a child's self-inflating bag and a full set of airways. These were ordered following our inspection. Staff had access to a bodily fluid spills kit and eye wash station.

Staff were undertaking checks of the equipment and medicines each month: national guidance states these should be undertaken weekly.

The provider had risk assessments to minimise risk that can be caused from substances that are hazardous to health (COSHH), although there were no risk assessments or safety data sheets for the cleaning products used in the practice.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments which were not in line with national guidance.

- Staff were not familiar with HTM01-05 Decontamination in primary dental care practices guidance.
- Staff were not aware of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. No annual statement had been completed.
- The box to transport dirty instruments did not have a lockable, leak proof lid.
- Staff were unaware or national guidance in relation to the reprocessing of dirty instruments.

Are services safe?

- Regularly used items such as mirrors, probes, plastic instruments, handpieces and loaded matrix bands were stored loose on trays in drawers or in pots on the work surface. They were not reprocessed at the end of the day if unused.
- The practice's ultrasonic bath had never been serviced.
- Results of the autoclave's daily TST tests were not logged and kept
- Staff conducted infection prevention and control audits, but not as frequently as recommended by guidance. They had not identified the issues that we found on inspection.

Safe and appropriate use of medicines

There was not a suitable stock control system to ensure that medicines did not pass their expiry date and we found out of date aspirin and salbutamol in the practice's emergency medicines kit. We noted that Glucagon was stored out of the fridge but its expiry date had not been reduced to account for this.

We found that the dentist's prescribing protocols were not in line with NICE guidance. For example, the dentist routinely prescribed penicillin 250 mg four times a day for a period of seven days. Current guidance recommends 500 mg, three times a day for five days. Antimicrobial audits had not been conducted to ensure the dentist was following current prescribing guidelines. The dentist told us he usually referred to a British National Formulary (BNF- a reference book that contains information and advice on prescribing) dated 2010 for prescribing guidance, and then only referred to the up to date BNF Application if that did not cover it.

Lessons learned and improvements –

The practice had a significant events' policy, although this had not been reviewed and referenced organisations that no longer existed. There was no other guidance for staff on how to manage other types of events**.** Staff told us there had not been any unusual incidents at the practice in a period of 12 years. We found that staff had a limited understanding of what might constitute an untoward event.

The practice had not signed up to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Staff were unaware of recent alerts affecting dental practice. Following our inspection, the practice informed us they were now receiving the alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received 20 comments cards that had been completed by patients prior to our inspection. The comments received reflected that patients were satisfied with their treatment and the staff who provided it.

Our discussion with the dentist and review of dental care records demonstrated that some dental assessments and treatments were not carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. For example, the dentist was unaware of, and therefore not implementing, guidance in relation to basic periodontal examinations. He did not routinely undertake pocket charting and patients had never been referred to a dental hygienist or specialist for support in managing their gum disease. We found that appropriate clinical pathways were not followed for patients requiring complex endodontic treatment.

Patients' dental records we viewed lacked detail and did not meet standards set by the Faculty of General Dental Practice regarding clinical examinations and record keeping. This meant that there were no detailed and comprehensive records for patients of their, clinical examination, diagnosis, and treatment completed.

Helping patients to live healthier lives

We found limited staff understanding and application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. Dental care records we reviewed did not demonstrate that the dentist gave oral health advice to patients.

The practice did not participate in national oral health campaigns. There was no information available for patients in the waiting area about oral health and staff were unaware of local smoking cessation services. Alcohol consumption was not discussed with patients and was not included on the practice's medical history form so that their risk of oral cancer could be identified.

Consent to care and treatment

Patients were provided with plans that outlined their treatment and its cost.

The practice's consent policy was very basic did not include information about the Mental Capacity Act 2005. We found staff had a limited understanding of this act and its requirements. Staff were also unaware of Gillick competence, by which a child under the age of 16 years of age can give consent for themselves.

Effective staffing

The practice had only been staffed by the principal dentist and the nurse in the previous 12 years. Agency and locum staff had never been used and no new staff had been recruited.

Staff had completed the continuing professional development required for their registration with the General Dental Council. The nurse told us she had just completed her five-year continuous professional development cycle and was about to start a new one.

Co-ordinating care and treatment

The dentist told us referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide such as implants and orthodontics. The practice also had systems and processes for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Are services caring?

Our findings

Kindness, respect and compassion

We received positive comments from patients about the caring nature of the practice's staff. Staff gave us examples of where they had assisted patients such as giving them lifts home in bad weather and seeing them out of hours. One patient told us that the dentist had agreed to see them, even though he was on holiday and had opened the surgery especially for them. Two patients told us the dentist had helped overcome their fear of treatment. Both the nurse and the dentist were described as kind, caring and professional. It was clear from our observations that staff had built up very strong relationships with patients over the years, and patients spoke highly of them. One patient told us that the dentist (and his father who was a dentist before him) had treated four generations of their family.

We observed many warm and positive interactions between staff and patients throughout our inspection.

Privacy and dignity

All consultations were carried out in the privacy of treatment rooms and we noted that the door was closed during procedures to protect patients' privacy. Patients' notes were stored in lockable filing cabinets.

Involving people in decisions about care and treatment

Patients were provided with plans that outlined their treatment and its cost. They also confirmed the dentist listened to them and gave them clear information about their treatment. The dental nurse told us the dentist regularly used dental models, an intra oral camera and diagrams to help patients better understand their treatment. However, dental records we reviewed did not always show what treatment options had been discussed with patients, or described the consent process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The waiting room contained interesting magazines for patients to read and books for children to keep them occupied whilst waiting.

Patients described high levels of satisfaction with the responsive service provided by the practice, especially if they required urgent treatment out of hours. The dental nurse told us she regularly allowed longer appointment time for 'chatty' patients.

The practice had made some adjustments for patients with disabilities. There was a disabled parking spot, portable ramp access to the building and a ground floor treatment room. We noted there was no portable hearing loop to assist those who wore hearing aids. Staff were not aware of Accessible Information Standards and the requirements under the Equality Act. They were not aware of local translation services and information about the practice was not produced in any other formats or languages.

Timely access to services

The practice opened Monday to Thursday only, but patients were able to contact the dentist outside these times. Twenty minutes were held aside each morning and each afternoon for any patient needing an emergency appointment. When the dentist and the nurse went on holiday, a local practice provided emergency treatment on their behalf.

The dental nurse told us that there was about a six week wait for any non-urgent treatment.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales and other agencies that could be contacted. However, there was no information in the waiting room available to patients about how they could raise their concerns and no practice information leaflet which detailed the procedure.

The dental nurse told us there had been one complaint in the previous 12 years. We were not able to assess how the practice handled this complaint, as no separate record of it had been made and

there was no evidence to show how learning from it had been implemented to improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist and nurse were husband and wife who shared responsibility for the management of the practice: patients spoke highly of them both.

Vision and strategy

The practice did not have any specific vision or strategy in place, other than to continue offering services to its current patients. At the time of the inspection the practice was not accepting any new patients.

Culture

The practice was small and friendly, and had built up a very loyal and established patient base over the years.

The practice did have a duty of candour policy in place, although we found staff had a limited knowledge of its requirements.

Governance and management

The practice did not have robust governance procedures in place. We found that staff worked in relative isolation, and had not kept up to date with current dental practices and guidelines. Some of the dentist's clinical practices were outdated and not in line with current standards and evidence based guidance. The dentist was not aware of the General Dental Council's Standards for the Dental Team.

Many of the practice's policies had not been reviewed in a number of years and contained references to legislation and organisations that no longer existed. Checks on the practice's emergency medicines and equipment had not been effective in identifying out of date medicines and missing medical emergency equipment.

Other than a yearly infection control audit, no other audits were undertaken to assess whether the practice met national guidelines in respect of record keeping, radiography and antibiotic prescribing.

Engagement with patients, the public and external partners.

The practice had used patient surveys to gather feedback about its service. We viewed nine responses which indicated that patients were happy with the service provided. The dentist told us that one patient's suggestion to place an interesting poster on the ceiling above the dental chair had been implemented.

Continuous improvement and innovation

There was no system in pace for either the nurse or dentist to receive appraisal or any sort of peer review. The dentist was unaware of recent guidance from the GDC in relation to personal development plans.

The dentist was not a member of any local professional body, but told us the practice had recently signed up to be a member of the British Dental Association.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 – Person-centred care.** **The care and treatment of service users must -a) be appropriate** **b) meet their needs, and** **c) reflect their preferences** **· The provider did not follow nationally recognised evidence-based guidance for dental treatment.** **· The provider did not provide preventative oral health care and advice to patients.** **· Alcohol consumption and smoking was not routinely discussed with patients and was not included on the medical history form.** **· The dentist did not provide fluoride applications in line with guidance.** • Staff did not have a clear understanding of the Mental Capacity Act 2005, or of Gillick competence and how this might impact on treatment decisions. **Regulation 9 (1)**

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 **Regulation 12- Safe Care and Treatment.**

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users

How the regulation was not being met

- The dentist did not follow national guidance in relation to sharps' management.
- The dentist did not use rubber dams to protect patients' airways.
- The practice's infection control procedures did not meet national guidance.
- There was no protocol in place to prevent wrong site surgery.
- There was no five yearly fixed wire test certificate available.
- Not all recommendations from the legionella risk assessment had been completed.
- Some emergency medicines were out of date and the stock control system had not identified this.
- Medicine prescribing protocols were not in line with national guidance.
- The provider had not signed up to receive national patient safety and medicines alerts.

- Regulation 12 (1)

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 (1) Good Governance** The registered person did not have effective systems in place to ensure that the regulated activities at Alan Ribbons dental practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 In particular:

This section is primarily information for the provider

Requirement notices

· Audits of dental care records, antibiotic prescribing and radiography were not completed. Emergency medicines and equipment checks were ineffective in identifying shortfalls.

· The practice's policies and procedures were not reviewed or kept up to date.

· The practice's complaints procedure was not made easily available to patients.

Regulation 17 (1)