Mr. Andrew Edney

Butterflies Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 29 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Butterflies Dental Clinic is a general dental practice situated in the town of Stony Stratford, Buckinghamshire. It provides general dental treatment to adults and children funded privately.

The practice is situated in a converted period residence and as such wheelchair access could not be assured even though the treatment areas were on the ground floor of the building.

The practice had two treatment rooms, an X-ray room, reception area/waiting room and patient toilet on the ground floor. Upstairs are the staff areas including a dedicated decontamination facility (for cleaning and sterilising dental instruments) a kitchen/staff room and an office.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received feedback from 37 patients from comment cards that we left at the premises for two weeks preceding the inspection. Patients were extremely positive about their experiences with the service.

Our key findings were:

- The practice was visibly clean and clutter free.

Summary of findings

- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- The practice met the standards set out in national guidance regarding infection control.
- A routine appointment could be secured within a few days and emergency appointments would be seen on the day they contacted the service.
- The practice had policies in place to assist in the smooth running of the service.
- The practice had medicines and equipment to treat medical emergencies. These were in date with the exception of the oxygen. This was replaced following the inspection.
- The practice was monitoring the water temperatures to ensure the risk of legionella bacteria developing was minimal. However the system did not recognise that the temperatures recorded were below the required amount. This was due to error in the method by which they were taken.
- The practice performed appropriate pre-employment checks on new staff in line with regulation; however they were not always recording references.
- The practice used national guidance in the care and treatment of patients.
- Clinical audit was used as a tool to identify areas where improvements could be made. Infection control audits were not carried out at the recommended interval of six monthly.
- Equipment was serviced and validated in line with manufacturers' guidance, with the exception of the ultrasonic cleaner which was decommissioned at the time of the inspection and the practice switched to an alternative method of cleaning.

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

- Review the use of rectangular collimator to further reduce the dose of radiation when taking intra-oral X-rays.
- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had medicines and equipment to manage medical emergencies, although the oxygen was out of date. This was replaced following the inspection. A medicine was stored appropriately in the fridge, but the temperature range of the fridge was not monitored.

Infection control standards met those outlined in national guidance.

The practice was carrying out appropriate pre-employment checks on staff; however improvements could be made to recording references.

X-rays taken on the premises were in line with regulation; however the dose of radiation to patients could be further reduced by the use of a rectangular collimator.

The practice had assessed the use of sharps in the practice and had switched to using safer sharps to reduce the risk of injury.

No action ✓

Are services effective?

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

The dentist used nationally recognised guidance in the care and treatment of patients.

A comprehensive screening of patients was carried out at check-up appointments including assessing risks associated with gum health, cancer and decay.

Staff demonstrated a good understanding of the Mental Capacity Act and Gillick competence and their relevance in establishing consent.

No action ✓

Are services caring?

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

Comments from patients were overwhelmingly positive about the care and treatment they received.

Patients were involved in the decisions around their treatment and care.

Written treatment plans were given to patients for them to be able to consider their options.

No action ✓

Are services responsive to people's needs?

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

The practice saw all emergency patients on the day they contacted the practice.

Out of hours patients were given the telephone number of the principal dentist so they could receive advice.

No action ✓

Summary of findings

Although the practice was not easily wheelchair accessible, the practice was constrained by the grade two listing of the building. They had made all adjustments possible to assist patients accessing the premises.	
Are services well-led? We found that this practice was providing well-led care in accordance with the relevant regulations. Polices were available to assist in the smooth running of the service. These had all been reviewed in the year before our visit. The practice used clinical audit as a tool to highlight areas where improvements could be made. Staff had annual appraisals where their training needs were addressed and a personal development plan drawn up to reflect it.	**No action** 

Butterflies Dental Clinic

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.

We carried out an announced, comprehensive inspection on 29 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with members of staff and patients during the inspection.

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 a system in place for reporting, investigating and learning from significant incidents, although they had not recorded an incident in the year preceding our visit. We discussed with the principal dentist what would be recorded as a significant incident and how they would investigate such an incident. The answer demonstrated that the principal dentist understood their duty of candour.

Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice had not received regular alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), although the principal dentist did check on any new alerts form time to time. Following the inspection the practice signed up to these so that they could be assured of receiving these alerts in a timely manner.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). Information on how and when to report in this way was available for staff to reference.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding safeguarding vulnerable adults and child protection. These were reviewed in 2016. The process for reporting concerns was documented with a flow chart which was available to reference in the policy folder and was also displayed in the reception and treatment areas along with the relevant contact details.

Staff we spoke with were able to describe the situations in which they would raise a concern and cold identify the safeguarding lead in the practice. Staff had received safeguarding training appropriate to their role.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in February 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that a rubber dam was being used routinely by the dentist.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from the dentist, and directed staff to occupational health or accident and emergency for further advice and treatment.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary. With the exception of Oxygen. Three Oxygen cylinders were available dated 2015, 1995 and 1993. Staff informed us that the older two cylinders were not in use and they would immediately move them and make arrangements for their appropriate disposal. The practice replaced the other cylinder and entered into a service arrangement to ensure that a similar situation could not arise in the future.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Staff had all undertaken medical emergencies training and staff we spoke with were able to detail which emergency medicine would be required for a specific emergency.

Staff recruitment

Are services safe?

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed the staff recruitment files for four members of staff and found that DBS checks had been sought for all staff, and appropriate pre-employment checks had been carried out; however the practice was not always recording references.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy (which was dated December 2015) was available for staff to reference. This included topics such as accidents, fire, personal protective equipment and autoclaves.

A health and safety risk assessment had been reviewed in 2016. This covered areas of risk in the practice, and separate risk assessment covered the reception areas and treatment rooms.

A sharps risk assessment was dated 2016 and detailed that the clinicians took responsibility for the sharps. The practice used a safer sharps needle which allowed a plastic tube to be drawn up over the needle and locked into place to prevent injury. The practice also used disposable matrix bands (a sharp dental instrument) to further reduce the risks in that regard. These measures were in line with the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

A fire policy was dated 2016. This gave details such as the designated muster point in the event of evacuation. A fire risk assessment had been carried out internally, and was specific to the premises if lacking some detail.

The practice had business continuity plans in place to ensure appropriate actions were in place should the building become unusable due to an unforeseen event.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which was reviewed on 3 October 2016. This included separate policy documents on hand hygiene, decontamination and personal protective equipment.

The practice had a dedicated decontamination facility containing an ultrasonic cleaner (which cleans dental instruments by immersing them in a solution and passing ultrasonic waves through the solution) and a washer disinfector (which is a machine not unlike a dishwasher that cleans dental instruments).

The practice were using either the ultrasonic cleaner or the washer disinfector and occasionally both. During the inspection we became aware that the ultrasonic cleaner had not been serviced or validated in line with manufacturer's instructions; the practice took it out of commission until such time as this had been carried out.

Following the inspection the practice purchased two bowls for the sink in the decontamination room. These would act as washing and rinsing sinks and would allow the staff to manually clean instruments within the facility.

Following cleaning instruments were inspected under an illuminated magnifier before being sterilised in the autoclaves. Sterile instruments were then pouched and dated with a use by date.

Tests carried out on the process were in line with the recommendations of HTM 01-05.

Are services safe?

Environmental cleaning was carried out daily by the practice staff. The equipment used conformed to the national system of colour coding cleaning equipment and was stored appropriately.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked bin prior to its removal.

All clinical staff had documented vaccinations against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. One member of staff had not responded to the vaccinations and was therefore not immune to Hepatitis B. We discussed this with the principal dentist and the member of staff concerned who assured us that although they had not completed a written risk assessment all measures were in place to mitigate the risk as far as possible.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company on 26 September 2011. This detailed that water temperatures should be checked monthly to ensure they are not in the range that would allow Legionella to develop.

We saw records relating to the water checks and found that in the last four years that hot water had rarely reached that appropriate temperature. This had not been highlighted as a concern in that time. We discussed this with the member of staff responsible for taking the temperatures and ascertained that the method by which they were completing the task was not accurately measuring the temperature. The temperatures were measured whilst we were on the premises and met the requirements of the risk assessment form 2011.

In addition to this measure staff were sending water samples to a company for testing annually. The report form 15 June 2016 had not shown growth of Legionella.

Staff demonstrated appropriate management of the dental unit water lines to reduce the risk of Legionella growth.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in November 2016, and the following equipment had been serviced and validated within the year preceding our inspection: the compressor, both autoclaves and fire extinguishers.

The practice dispensed antibiotics. Systems were in place to log the appropriate information and labelling was in line with schedule 26 of the Human Medicines Regulations 2012.

Glucagon is an emergency medicine used to treat diabetics. In order for it to be effective until the expiry date it has to be stored at a specific temperature range. Although the practice were keeping the medicine in the fridge they were not monitoring the temperature range.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice had one intra-oral X-ray machine that was able to take an X-ray of one or a few teeth at time, and one dental panoramic tomograph (DPT) machine that takes a panoramic image of all the teeth and jaws.

Rectangular collimation limits the beam size on intra-oral machines to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. The practice had a rectangular collimator available but were not regularly using it.

Local rules were available for each X-ray unit. These are a safety requirement to have a record of those persons responsible for the X-ray machines. In addition they are required to list those persons that are trained to operate the equipment, details of the controlled zone for each machine, and contingency plans in the event of the machine malfunctioning.

The machines had been tested and serviced in accordance with regulation. The dentist had undertaken the appropriate training as set out in IRMER 2000 and by the General Dental Council.

Are services safe?

The dentist was making a quality assessment of every X-ray taken, and recording it along with a report of the X-rays findings, however they were not consistently writing a justification for taking an X-ray.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed, then checked and signed by patients at each attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology. Patients were assessed regarding their risk of gum disease, decay and cancer.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Health promotion & prevention

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

An assessment of oral hygiene was made by the dentist and the practice used the televisions in the treatment room to demonstrate oral hygiene techniques. Leaflets were available for patients on oral health promotion, smoking and diet.

We found an 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. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example the dentist recommended high fluoride toothpaste for those at risk of decay.

Patients indicated that the practice focussed on preventative care, and they received advice from the dentist on the same. A display in the waiting area showed visually the amount of sugar in popular drinks.

Staffing

The practice was staffed by one dentist, two dental hygienists, one dental nurse and two receptionists.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

If an urgent referral was made for a suspicious condition the referral would be made by fax and followed up immediately with a telephone call to ensure the fax had been received. In this way patients could be assured of the referral being actioned in a timely manner.

Patients commented positively about referrals made on their behalf.

Consent to care and treatment

The dentist described the process of gaining full, educated and valid consent to treat. This involved detailed

Are services effective?

(for example, treatment is effective)

discussions with the patients of the options available and the positives and negatives of each option. We saw that details of these discussions were documented in the patient care records.

A comprehensive treatment plan was drawn up for the patients which included colour photographs of the areas of concern for the patient to take away and consider. The clinicians made good use of visual aids to demonstrate to the patients and improve patient understanding, and an intra-oral camera to show the patient clearly the area of concern.

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. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. The practice had a policy detailing the considerations with adults who lacked the capacity to consent for themselves, this had been reviewed and signed by all staff in 2015.

Similarly staff had a good understanding of the situations where a child under the age of 16 would be able to consent for themselves. This is termed Gillick competence and relies on an assessment of the competency of the child to understand the treatment options.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments that we received from patients indicated consistently that the care and treatment they received was of a high standard. Staff were described as helpful and attentive, and the advice given by the dentist was appreciated. Some patients travelled long distances or overseas to attend dental appointments.

We witnessed patients being spoken to in a polite and courteous manner, and patients indicated that staff were skilled at putting nervous patients and children at ease.

We discussed and witnessed how patients' information was kept private. The computer at the reception desk was situated behind a high level counter and angled away so that it could not be overlooked by a patients stood at the desk.

Written paper records were kept securely and filed in a timely manner so that could not be overlooked.

These measures were underpinned by the practice's information governance and data protection policies.

Involvement in decisions about care and treatment

Following examination and discussion with the clinician patients were all given a copy of a treatment plan to consider. This included the costs of treatment.

Patients commented that they felt listened to; options for treatment were clearly explained to them and followed up with a written treatment plan detailing the options and costs involved.

A copy of the private price list was on display in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

At the time of the inspection the practice were taking on new private patients. We examined appointments scheduling and found that there was enough time allocated for assessment and discussion of the patients' needs.

For the comfort of patients the practice offered wireless internet connection in the waiting room. The waiting area also had a television and magazines available for patients and a range of children's books.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs. This was underpinned by the practice's equality and diversity policy.

The building that the practice was situated within was grade two listed, and as such it was difficult for the principal dentist to get the necessary permissions to alter the building. The practice had portable ramps available to assist wheelchair users around the building, but not all wheelchairs could fit through the internal doorways. Staff were careful to explain to all prospective patients to the practice who required wheelchair access what the limitations of the premises were.

The practice had completed a disability decimation act audit in 2014 which had highlighted the need to temporary ramps to access the building with a wheelchair.

Staff we spoke with described how they met the needs of patients with individual needs. Staff assisted patients with restricted mobility and both the front door from the street and the rear door from the car park had automatic buzzers so the attention of staff would be drawn to someone at either door.

Staff had not experienced having patients who were not fully able to understand in English, however they had access to interpreters should such an eventuality arise.

Access to the service

The practice was open from 8.30 am to 5 pm on Monday, Tuesday, Thursday and Friday.

Patients who contacted the practice with an emergency would be seen on the same day, and the appointments scheduling was such that there was consideration of this.

Out of hours patients were directed by the answerphone to contact the dentist directly on a mobile phone. In this way patients of the practice could get advice from their dentist, who would also arrange to see them if necessary.

Concerns & complaints

The practice had a complaints policy in place which was displayed in the waiting area. As well as directing patients on how to raise a complaint within the service it also gave contact details for external agencies that a complaint could be escalated to. The policy was reviewed in 2016.

The practice had not received a complaint in the year before our visit. We spoke with the principal dentist who was the assigned lead for complaints and they described the process by which any investigation would be open and honest and fed back to the patient in question.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice, and had been assigned lead roles in various areas of the governance. We noted clear lines of responsibility and accountability across the practice team.

The practice had policies and procedures in place to support the management of the service, and these were available for staff to reference in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, data protection and whistleblowing. All policies had been reviewed in the previous year.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

A whistleblowing policy was available which guided staff in how to raise concerns about a colleague's actions or behaviours. It detailed the practice's expectations of candour in this regard, and staff we spoke with were able to describe the actions they would take and give examples of the sorts of behaviours they would respond to.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

Staff received annual appraisals, and personal development plans were drawn up to aid their career progression and highlight any training needs.

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out in October 2016 and notes were seen throughout the document highlighted where improvements were made. Previous to this an infection control audit was completed in November 2014. We asked the practitioner regarding the interval between audits and they assured us that going forward audits would be carried out six monthly as per guidance.

An annual record keeping audit was completed, most recently in November 2016. The action plan highlighted areas to improve.

An audit of X-ray quality was completed annually most recently in November 2016. This had generated an action plan to further improve the quality.

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

The practice obtained feedback from patients from several pathways. Patient satisfaction surveys were carried out and staff welcomed comments from patients.

Staff were happy to raise and comments and feedback with the principal dentist who welcomed this either formally through the appraisal system or informally in this close knit team.