

Mrs. Gunjan Sennik

Elder Tree Dental Practice

Inspection Report

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Essex
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Ratings

Overall rating for this service

Requirements notice



Are services safe?

No action



Are services well-led?

Requirements notice



Overall summary

We carried out an unannounced focused inspection on 6 and 15 July 2016 following concerns raised by staff and members of the public.

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the aspects of the relevant regulations which we inspected.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the aspects of the relevant regulations which we inspected.

Background

Elder Tree Dental Practice is a dental practice situated in a converted property on Canvey Island, Essex.

The practice has four treatment rooms, two waiting rooms and a reception area. Decontamination takes place within treatment a dedicated decontamination room (Decontamination is the process by which dirty and contaminated instruments are brought from the treatment room, washed, inspected, sterilised and sealed in pouches ready for use again).

The practice has a principal dentist, three associate dentists and three dental nurses.

The practice offers NHS and private general and cosmetic dental treatments to adults and children.

The opening hours of the practice are 9am to 5.30pm Monday to Thursday. Appointments are available from 9am to 1pm and 2pm to 5.15pm. The practice is open between 9am and 5pm on Fridays and appointments are available up to 4.45pm. The practice closes between 1pm and 2pm for lunch.

Summary of findings

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

Our key findings from our inspection visit on 6 July were:

- The practice did not have effective systems in place for investigating and learning from safety incidents.
- There was evidence of a cockroach infestation in the staff kitchen area and in the corridors on the first floor.
- The practice had not acted in a timely way to remove the infestation once this had been reported.
- Most areas within the practice were visibly clean and clutter free. However we found that infection control procedures were not followed consistently. The practice did not follow the national colour coding scheme for cleaning materials and equipment in dental premises to ensure that equipment used for cleaning was specific to the area that was being cleaned, and clinical waste was not stored appropriately.
- There were ineffective governance arrangements in place to assess, monitor and manage the safety and quality of services provided.
- Risks to patients and staff had not been assessed, monitored and mitigated in a timely way.
- There was a lack of clear leadership and staff did not feel supported to raise concerns.

- The practice did not act on feedback from patients and staff and use this to make improvements where these were identified.

As a result of our findings the registered provider agreed to close the practice until such time as appropriate measures were taken to remove the cockroach infestation. The practice was closed from 6 July 2016 to 12 July 2016.

Our key findings from our inspection visit on 15 July were:

- A pest control company had carried out treatment to remove the infestation.
- Insect traps were in place and staff told us that there had seen no evidence of infestation activity.
- We inspected these traps and we found no evidence of infestation activity.
- There was no risk assessment, guidance available for staff or arrangements for checking and monitoring infestation activity to demonstrate the effectiveness of the eradication measures in place.

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

- Ensure that there are appropriate systems in place for monitoring the quality and safety of the services provided. This includes listening to and acting on concerns raised by staff or people who use the service and; reviewing, monitoring and improving systems for dealing with any events which may cause unnecessary risk to people.

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 on visit on 15 July 2016 was providing safe care in accordance with the aspects of the relevant regulations which we inspected.

The practice had systems in place for reporting concerns. However this was not effective and did not include what actions would be taken when concerns were raised. Staff we spoke with told us that they knew how to raise concerns and that they were aware of their responsibilities to do so. However they did not feel confident that concerns raised would be addressed.

The practice systems for identifying and managing risks to patients and staff were not robust. The principal dentist could not demonstrate that they acted on information of concern, reviewed and investigated these to identify and take appropriate action to mitigate risks. For example timely action had not been taken when staff reported an infestation of cockroaches at the practice in May 2016. The practice had also failed to act on the recommendations made by an external pest control contractor following a visit to the practice on 1 June 2016.

Most areas within the practice looked visibly clean. However the cleaning schedules were not clear in relation to areas of the practice to be cleaned and who was responsible for doing this and cleaning within the practice was not monitored. Clinical waste was not stored safely.

When we carried out a second visit to the practice on 15 July 2016 we saw that a pest control contractor had treated the infestation. Insect traps were placed within the practice to monitor infestation activity. We inspected areas of the practice and found them to be visibly clean with no signs of infestation.

No action



Are services well-led?

We found that this practice on our visits on 6 and 15 July 2016 was not providing well-led care in accordance with the aspects of the relevant regulations which we inspected.

There was a lack of governance arrangements and leadership within the practice to ensure that appropriate systems were in place to monitor and improve the quality and safety of services.

The systems in place to monitor and assess the quality and safety of services provided were limited. No assessment of risk to staff and patients in respect of an infestation of cockroaches had been undertaken when the practice became aware of the concerns raised by staff.

There were no arrangements to ensure that policies and procedures in place to keep people safe and to improve services were monitored and followed by staff.

Requirements notice



Summary of findings

The practice did not act on feedback from staff to improve the quality of the service provided. The practice had failed to act on concerns reported by staff and

Elder Tree 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 carried out to follow up on

concerns raised by staff and members of the public and 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 unannounced, focused inspection on 6 and 15 July 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.



Are services safe?

Our findings

Monitoring health & safety and responding to risks

The practice had some systems in place to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy in place and a health and safety risk assessment was completed in February 2016; this looked at multiple areas of risk within the practice, and did not result in any action needing to be taken.

The practice had not reviewed the health and safety policy or risk assessment in light of the concerns raised by staff and the evidence that there was an infestation problem. The principal dentist told us that they were aware of this issue but they were unaware that the infestation had spread to areas of the practice other than the staff kitchen area until 27 June 2016. However we were shown a copy of the survey carried out by the pest control company on 1 June 2016. This described the infestation activity and the recommended actions that should be taken to remove the infestation. This included cleaning of the area and removal of food sources. On 6 July when we visited we found that none of the recommended actions had been undertaken. We observed that the area around and behind the staff fridge had not been cleaned and that there was food remaining in the fridge.

Following our inspection the provider sent us confirmation that the work was being carried out. When we visited the practice on 15 July we found that a pest control company had carried out treatment to remove the infestation. Insect traps were in place and staff told us that there had been no evidence of infestation activity. We checked insect traps and areas within the practice and found no evidence of infestation. The practice had some procedures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Practices are required to keep a detailed record of all the substances at use in the practice which may pose a risk to health. During our inspection we detected a strong odour of pesticide spray / powder. Staff told us that these had been purchased by the principal dentist and were used to control the cockroach infestation. However there were no records in place in respect of these substances including risks to staff and patients.

Infection control

We observed that some areas within the practice looked visibly clean. However the area behind the fridge in the staff room was very dirty. We observed live cockroaches in this area. We also observed one dead cockroach in the staff room and small particles of what appeared to be insect faecal matter in the corridor on the first floor. The practice employed a cleaner to undertake the environmental cleaning of the practice and cleaning schedules were available. However these were not detailed and there were no records in respect of cleaning the fridge in the staff kitchen. Cleaning records we viewed made no reference to the infestation or how this was being managed.

The practice had an infection control policy in place. We were told that an infection control audit had been undertaken however this was not available at the time of our inspection. The principal dentist told us that a pest control company was due to visit the practice that afternoon to start work to remove the infestation. We were shown a document from a pest control company which consisted of a quote for proposal of works. This was dated 4 July 2016. However this did not indicate the date that the work was to be started or that this had been agreed by the practice. We discussed this with the provider and requested that they close the practice to allow the pest control treatment to be carried out with no risk to patients. They agreed and the practice was closed between 6 and 12 July.

When we visited the practice on 15 July we found that all areas we viewed were visibly clean including the kitchen area. The fridge and food had been removed.

The practice did not follow the national colour coding scheme for cleaning materials and equipment in dental premises to ensure that equipment used for cleaning was specific to the area that was being cleaned. For example, equipment used to clean clinical areas was different to equipment used to clean the kitchen. The practice could not demonstrate appropriate storage and disposal of clinical waste. We found that clinical waste was stored in an unsecured container which was situated at the rear of the property and accessible to the public.

Are services well-led?

Our findings

Governance arrangements

The principal dentist (who was the registered manager) and the practice manager took responsibility for the day to day running of the practice. The practice did not have consistent and robust governance arrangements in place to ensure the smooth running of the service. Some policies and procedures were not detailed in relation to how risks were assessed and managed.

There were ineffective systems in place for assessing and monitoring the infection control procedures within the practice. The practice health and safety risk assessment had not been reviewed in light of the cockroach infestation. The cleaning schedules were not monitored or reviewed in light of this. No checks had been carried out to ensure that the area of infestation had been cleaned in accordance with the pest control company survey recommendations.

The principal dentist had purchased insecticides to try to treat the infestation. However the effectiveness of this had not been assessed or monitored.

Leadership, openness and transparency

There was a lack of leadership and oversight at the practice. While some lead roles had been identified, such as staff leads for infection control, safety, risk assessment and equipment there were no systems in place for monitoring these areas. The principal dentist confirmed that they had not checked that policies and procedures such as those in relation to infection control and health and safety were being followed.

Staff reported that they had raised concerns and that these had not been acted on. Two members of staff told us that they did not feel supported to raise concerns. They told us that staff had felt 'blamed' for the infestation at the practice. A number of staff said that they had been told that they would have to pay for the removal and treatment of the infestation within the practice.

The practice held regular staff meetings and we saw the minutes from the most recent meetings. Staff and the principal dentist confirmed that the concerns around the infestation had been raised and discussed at the meeting in May 2016. However there was no record of any discussion within the meeting minutes.

When we revisited the practice on 15 July we found that the risk assessment had not been updated in light of the reported infestation. There was no guidance or measures for staff to use to monitor the effectiveness of the treatment carried out.

Learning and improvement

The principal dentist could not demonstrate that there was a culture of learning and improvement within the practice. They confirmed that they had not acted in a timely way when they were alert about the current concerns. We looked at a number of documents including the minutes from team meetings, risk assessments and an external survey report. We found that information had not been shared with staff, discussed or used to make improvements where these were required.

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

The practice did not have effective systems for acting on patient or staff feedback. Three members of staff told us that they had raised concerns and that they felt that these had not been taken seriously or acted on. The principal dentist confirmed that concerns had been raised but they could not demonstrate that these had been acted on.

One member of staff told us that concerns had been raised by patients in relation to the infestation within the practice. We asked the principal dentist about this. They told us that they were unaware of any concerns raised. We saw that no complaints were recorded in relation to these concerns.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider did not have effective systems in place for assessing and managing risks to patients and staff or acting on concerns where these were identified.• The provider did not always ensure that health and safety risk assessments, infection control audits and arrangements for maintaining acceptable standards of cleanliness were monitored, reviewed so that they were effective in improving the safety and quality of services provided.• The provider did not take timely action in response to known concerns or act on feedback from staff and other relevant persons to make improvements to the quality and safety of services provided. <p>Regulation 17(1) (2)</p>