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Hillbrook Dental Health Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of this service on 8 September 2015 as part of our regulatory function where a breach of legal requirements was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We followed up on our inspection of 8 September 2015 to check that the practice had implemented their plan and to confirm that they now met the legal requirements. We carried out a focused inspection on 13 October 2016 to check whether the practice had taken action to address a breach of Regulation 17(1), (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This report only covers our findings in relation to those requirements. You can read the report from our previous comprehensive inspection by selecting the 'all reports' link for Hillbrook Dental Health Centre on our website at www.cqc.org.uk.

Our findings were:

Are services well-led?

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

Key findings

- Overall we found that sufficient action had been taken to address the shortfalls identified at our previous inspection and the provider was now compliant with the regulation.

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

- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's infection control procedures and protocols giving due regard to 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.

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 well-led?

No action

This focused inspection concentrated on the key question of whether or not the practice was well-led. We found that the practice was now providing well-led care in accordance with the relevant regulations.

At our previous inspection of the practice in September 2015 we identified that governance arrangements were not sufficiently robust. We reviewed the action taken to address issues raised during this focused inspection and found that the practice was now meeting regulatory requirements.

Hillbrook Dental Health Centre

Detailed findings

Background to this inspection

We carried out an inspection of this service on 13 October 2016 to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 8 September 2015 had been implemented. We reviewed the practice against one of the five questions we ask about services: is the service well-led? This is because the service was not previously meeting some of their legal requirements under the well-led domain.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

The review was led by a CQC inspector who had access to remote advice from a specialist advisor.

During our review, we checked that the registered provider's action plan had been implemented. We reviewed a range of documents provided by the registered provider. We found that the practice was meeting their legal requirements under the well-led domain.

Are services well-led?

Our findings

Governance arrangements

Clinical Governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and promoting high standards of care, by creating an environment in which clinical excellence will flourish. Governance arrangements are part of that ongoing process.

At our previous inspection on 8 September 2015, we found that the practice did not have robust governance arrangements in place.

At our previous inspection we found that significant incidents were not routinely recorded and shared with all staff. In October 2016, we saw examples of incidents and saw evidence that learning was shared across the practice. All incidents were now discussed at staff meetings and we saw the minutes from a staff meeting held in February 2016 which confirmed this. Details of the incident were comprehensive and appropriately managed.

At our previous inspection, not all staff were aware of how to proceed in the event of a safeguarding issue. In October 2016, we saw evidence that the provider had carried in-house safeguarding training for the team. Powerpoint presentations had taken place and staff subsequently completed relevant questions in quizzes and evaluation feedback forms. These were checked and graded by senior team members. We were shown a selection of certificates which confirmed that staff had completed the appropriate training external to the practice. Staff also had easy access to the contact details for local safeguarding teams – this information was clearly displayed in the reception area.

At our previous inspection we found that not all of the dentists were routinely using a rubber dam for all stages of the root canal treatment. The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. Rubber dam kits were available in all of the treatment rooms. We discussed the use of rubber dam with staff in October 2016 and were told that some dentists were still not using rubber dam but alternative actions were taken to reduce the risks in the absence of its use.

At our previous inspection we found that the practice had satisfactory arrangements for dealing with medical emergencies; however these did not extend to domiciliary dental visits (visits made by the dentist to the patient's place of residence). We discussed this with staff and saw evidence that these visits were carried out after the practice closed or during the lunch hour when no patients were on the practice premises. The dentist would take the emergency equipment and medicines with them and return them to the practice immediately after.

At our previous inspection, we found that portable fans were used in the treatment rooms. These have the potential to spread contamination due to the rapid uncontrolled air circulation and are not recommended in dental treatment rooms. In October 2016, we checked all treatment rooms and found that the fans had been removed and were no longer used.

At our previous inspection, we found that some of the burrs in the treatment rooms were rusty. A dental burr is a type of burr (cutter) used in a dental handpiece (drill). They are used during dental procedures, usually to remove decay and shape tooth structure prior to the insertion of a filling or crown. These burrs should be discarded and checks should be in place to ensure that rusty equipment is not used when treating patients. This was discussed with the provider and they informed us this would be closely monitored in future. We visited the practice in October 2016 and found that no rusty equipment was present.

At our previous inspection, we reviewed the practice's decontamination procedures and found that the heavy duty gloves (used for manually cleaning the instruments) were not being replaced weekly as per guidance. We spoke with staff in October 2016 and they confirmed that these were now replaced on a weekly basis.

At our previous inspection, we found that not all of the boxes that hold sharp instruments that required disposal were stored appropriately. These boxes should be positioned above floor level and out of the reach of children. In October 2016, we checked the treatment rooms and found that these boxes were inappropriately stored on the ground in two out of three treatment rooms. We spoke to several staff members (including the provider) who appeared surprised as they told us that the boxes were no longer stored on the ground level. The provider investigated this after our visit and told us that one box was an additional one and should've should have been stored

Are services well-led?

outside the treatment room as it was ready to be collected by the clinical waste disposal company. The other box was temporarily moved by one staff member who entered the treatment room to carry out administrative work. No patients had entered the treatment room during this period.

At our previous inspection, we found that there was a small defect in the upholstery of the dental chair which would make effective cleaning difficult. We received evidence soon after the inspection which confirmed that it had been repaired. During our inspection in October 2016, we found that a different chair had defective upholstery. We spoke with the provider about this and they explained they had identified this and had contacted their upholsterer but they were not available at the time. The provider had told staff to not use this chair in the interim and we did see evidence of an additional chair in that treatment room. Since our second visit, the provider has sent us evidence that this chair has also been repaired.

At our previous inspection we found that audits were regularly carried out but the results were not analysed or reported upon. Without any outcomes or analysis, staff could not have assured themselves that were fulfilling the requirements of published guidance. In October 2016, we reviewed audits in infection control and radiography (X-rays) and found that they had been analysed appropriately with actions. However, we found that the most recent infection control audit was seven months ago - the Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. The practice manager was aware of the delay and had a satisfactory explanation for it. The previous audit demonstrated 98% compliance in infection control and the practice planned to carry out the next audit shortly.

At our previous inspection we saw that the practice's recruitment policy stated that references would be sought for staff prior to their recruitment as part of ensuring the safe recruitment of staff. We reviewed recruitment records in September 2015 and found that no evidence that references had been requested or obtained. We were told that three staff members had been recruited between our two visits. We reviewed all three records and found that two written references had been obtained for each of the two new staff members. The third member did not have any references in their file. The provider contacted us after our visits and explained that the references were stored on the computer system and not in the individual's file. However, the practice manager was not aware of this so we were unable to confirm this on the day of our visit. The provider informed us they would copy all references in future and store them in the individual's file to prevent this from recurring.

At our previous inspection we found the practice lacked a robust system to monitor the professional registration and dental indemnity of its clinical staff members. We reviewed staff records in October 2016 and found that all relevant members had the necessary paperwork present in the practice to confirm membership.

Legionella is a term for particular bacteria which can contaminate water systems in buildings and practices are required to complete several actions to minimise the risk of this developing. At our previous inspection, not all of the practice staff were following the guidelines on running the water lines in the treatment rooms to prevent Legionella. Since that inspection, we saw evidence that the provider had carried out in-house training for their staff. Evaluation forms were also completed. We spoke with several staff members about this in October 2016 and one staff member was still uncertain about the guidance. This was discussed with the provider. They had carried out further training and quizzes but realised that more was required to ensure that all staff were confident about the current guidance. They told us that they would speak to their staff again and all duties and responsibilities of staff would be reiterated at each staff meeting.

At our previous inspection, we found that the prescription pad in one treatment room was not stored in a secure location when the room was not in use. Following the inspection, we were told that the pads were always located in a secure location when the treatment room was unattended. In October 2016, we found that a prescription pad had been left on the counter in a treatment room that was left unattended. We discussed this with the provider after the inspection. They had spoken to the relevant staff members about this and discovered that they had finished the clinical session late and had forgotten to store the prescription pad in an appropriate location. We were told that this was an isolated incident and further measures will be taken to ensure that it did not happen again. The provider told us they would display a clear notice in each treatment room which would serve as a reminder to all staff about this.

Are services well-led?

At our previous inspection, we found that not all staff were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues. In October 2016, we saw evidence that in-house training was provided and staff were requested to complete quizzes to demonstrate their knowledge. There was also information about this clearly displayed in the staff room.

At our previous inspection, we found that staff were not recording capacity assessments for patients who lacked the capacity to consent. This is a requirement under the Mental Capacity Act 2005. In October 2016, we saw evidence of blank capacity assessment forms and were told that these were used for all relevant patients. We reviewed dental care records and found that the dentists were recording whether the patient had or lacked the capacity to consent.

We spoke with staff about the duty of candour regulation but not all were familiar with its principles. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment. The provider was aware and described it to us. They explained that the staff were familiar with the policy but some were not aware of its name. The provider told us that they planned to discuss this at the next practice meeting. They also decided to produce a new practice policy that would include this information for staff to access.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was following the recommended guidance in adults but not routinely in children. We spoke with the provider about this and they said that this had been discussed with the dentists. The provider told us they would include the BPE to the template in the dental care records which would serve as a reminder to the staff during a dental examination. The provider told us that this would also be added to the next audit so that any shortfalls could be easily identified.