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Corra Linn House Dental Practice

Inspection Report

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Overall summary

We undertook a follow up focused inspection of Corra Linn House Dental Practice on 22 October 2018. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was carried out by a CQC inspector.

We undertook a comprehensive inspection of Corra Linn House Dental Practice on 30 May 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing well led care in accordance with the relevant regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Corra Linn House Dental Practice on our website www.cqc.org.uk.

When one or more of the five questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

• Is it well-led?

Our findings were:

Are services well-led?

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

The provider had made improvements in relation to the regulatory breach we identified at our inspection on 30 May 2018.

Background

Corra Linn House Dental Practice is in Stockport and provides NHS and private treatment to adults and children.

A portable ramp is available for people who use wheelchairs and those with pushchairs. On street parking is available near the practice.

The dental team includes seven dentists, seven dental nurses (three of which are trainees), two dental hygienists, and a receptionist. The team is supported by a practice manager and deputy practice manager. The practice has six treatment rooms.

Summary of findings

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.

During the inspection we spoke with the responsible individual and the practice manager, who were not able to attend the inspection on 30 May 2018. We also spoke with the deputy manager and dental nursing staff. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Friday 8:30am to 1pm and 2pm to 5pm.

Our key findings were:

- The management and clinical governance arrangements had been reviewed and improved.
- Improvements had been made to infection control procedures. These were in line with nationally agreed guidance.
- The practice had introduced systems to help them identify and manage risk
- A system of audit was in place to review standards of clinical care.
- The practice had reviewed their processes to ensure incidents were reported and investigated appropriately.
- Risk assessments were in place for the provision of domiciliary care.
- Recruitment procedures reflected guidance. Improvements were needed to the process for obtaining Disclosure and Barring checks.

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

- Review the practice's protocols and procedures to ensure staff are up to date with their mandatory training and their continuing professional development.
- Review the availability of medicines in the practice to manage medical emergencies taking into account the guidelines issued by the British National Formulary and the General Dental Council. In particular, whether additional adrenaline is required.
- Review the practice's protocols to ensure audits of infection prevention and control are completed fully and action plans include all documented learning points.
- Review the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 well-led?

No action

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

The provider had implemented a new management structure. They were knowledgeable about issues and priorities relating to the quality and future of services. They had liaised with external providers where applicable to support them in this process.

A dental clinical governance compliance package had been implemented to help them to meet the required standards, this had been used to review and organise practice policies and other key documentation. Improvements had been made in relation to recruitment, safeguarding, incident reporting, patient safety alerts and whistleblowing.

Risk assessments had been carried out in relation to fire safety, legionella, health and safety, domiciliary care and disability access. The documented reports from these were received on the day of the inspection. We saw evidence the practice was in the process of acting upon recommendations in line with documented action plans. All urgent recommendations had been addressed. The sharps risk assessment could be improved to identify risks from all sharp items.

We saw that improvements had been made in infection control. We saw evidence that decontamination processes and procedures had been improved, and clear instructions were displayed for staff to follow. Improvements are needed to ensure the audit process can highlight any omission in the systems at the practice.

We saw evidence that decontamination processes and procedures had been improved, and clear instructions were displayed for staff to follow. Improvements were needed to ensure the infection control audit process can highlight any omission in the systems at the practice. The practice had obtained evidence of immunity for staff.

We saw evidence the practice had consulted their Radiation Protection Advisor (RPA) in relation to radiographic safety and acted on their recommendations.

There was no process to ensure that all staff completed training, including safeguarding vulnerable adults and children training. This was discussed with the practice manager who gave assurance this would be addressed.

The arrangements for responding to medical emergencies had been reviewed. Further improvements could be made to the process to ensure it was in line with nationally agreed guidance, and to establish whether additional doses of adrenaline should be made available.

Are services well-led?

Our findings

At our previous inspection on 30 May 2018 we judged it was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 22 October 2018 we found the practice had made the following improvements to comply with the regulation:

The provider had implemented a new management structure. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. They had liaised with external providers where applicable to support them in this process.

A dental clinical governance compliance package had been implemented to help them to meet the required standards, this had been used to review and organise practice policies and other key documentation. Policies were in place, up to date and appropriate to the service. The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice. For example:

- Safeguarding policies and procedures including a flowchart and information relating to the deprivation of liberty, radicalisation, financial abuse and female genital mutilation (FGM) were now available to staff.
- The process for staff to report any incidents had been improved and information relating to RIDDOR was available. No incidents had occurred since the previous inspection.
- A system was now in place for receiving and acting on patient safety alerts, and to report any adverse reactions or medical device issues through the MHRA yellow card system.
- The whistleblowing policy had been updated to include information about external organisations.
- The compliance system included a planner to remind staff when policies and risk assessments were due for review, and to highlight when the servicing of equipment was required.

An external company had carried out risk assessments in relation to fire safety, legionella, health and safety and disability access. The documented reports from these were received on the day of the inspection. We saw evidence the practice was in the process of acting upon recommendations in line with documented action plans. All urgent recommendations had been addressed. For example:

- The provision of additional fire safety signage, electrical safety testing, improvements to electrical systems and we saw a fire safety log book was maintained by the practice as recommended in the fire safety assessment. This showed fire drills, testing and servicing of smoke detectors, emergency lighting and fire extinguishers.
- They had highlighted that the fire alarm could not be clearly heard in some areas of the practice. Whistles had been placed in these areas to enable staff to raise the alarm.
- We saw evidence a member of staff was booked to attend fire marshal training.
- The boiler had been serviced and repaired in response to water temperatures that were out of the accepted temperature range and water quality testing had been carried out in line with recommendations from the legionella risk assessment.
- A legionella management plan was now in place, the lead had completed legionella awareness training.
- The dental compressors had been serviced and we saw evidence of this.
- Additional reasonable adjustments had been made to improve access for patients. These included additional grab rails and an emergency call system in the patient toilet.

We had previously highlighted concerns in relation to infection control, decontamination processes and equipment validation. We saw that improvements had been made, for example:

- We saw evidence that decontamination processes and procedures had been improved, and clear instructions were displayed for staff to follow.
- A second sink had been installed in one of the treatment rooms.
- Soft or torn furnishings had been removed and replaced with wipeable chairs.

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- Foil ablation and protein residue testing was now in place to ensure the efficacy of the ultrasonic cleaner, the records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.
- There was a process to ensure the water purifier was cleaned in line with the manufacturer's instructions.
- Sleeve covers had been provided and were in use by members of staff who were not bare below the elbow for cultural reasons.
- We saw evidence that a system was now in place to dispose of gypsum waste appropriately.

Infection control audits were carried out in August and October 2018. We noted that whilst an action plan was in place to address the findings of the audit, some of the questions had not been answered. For example, questions relating to the correct segregation of waste, waste consignment notes, anti-retraction valves in dental unit waterlines, gap analysis and action planning had not been answered. Improvements are needed to ensure the audit process can highlight any omission in the systems at the practice.

A sharps risk assessment was in place, this related to needles and matrix bands. Additional needle re-sheathing devices had been provided for staff, and instructions to carry out safe manual cleaning of instruments were in place. The risk assessment did not include the risks from all sharp items. For example, burs, scalpels, sutures and endodontic instruments. The risk assessment could be improved to identify risks from all sharp items.

We previously highlighted the lack of systems to identify if staff had obtained adequate protection against hepatitis B. The practice was in the process of obtaining results for four members of staff. One staff member had been identified as a low responder. A risk assessment was in place for them and their duties had been restricted to prevent accidental exposure. After the inspection, the provider sent us risk assessments for the staff members whose results were still not available. Clear protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were aware of the importance of reporting inoculation injuries.

We saw evidence the practice had consulted their Radiation Protection Advisor (RPA) in relation to radiographic safety. Action had been taken to fit rectangular collimation devices, review the local rules and the positioning of patients in one surgery. Additional evidence was sent immediately after the inspection that they had consulted with their RPA on recommendations to consider the dosage settings of some of the equipment. They were in the process of addressing this.

The provider carried out annual domiciliary visits at a local care home. They had implemented a documented risk assessment in relation to this. They had highlighted patients where additional reasonable adjustments needed to be made to safely provide care.

The arrangements for responding to medical emergencies had been reviewed, for example:

- The location of the emergency medical kit had been reviewed in response to concerns about the high temperature of the room they were previously stored in. They were now located in a cooler, accessible area of the practice.
- Staff had completed training in emergency resuscitation and basic life support (BLS) in June 2018.
- Staff kept records of equipment and medicines checks to make sure these were available, within their expiry date, and in working order.
- The practice had systems to ensure that staff were familiar with the contents of the emergency kit and the correct operation of the emergency medical oxygen cylinder.

We noted there was no child-sized self-inflating bag and mask. Generic defibrillator pads had been purchased, it was not clear if these were compatible with the device at the practice. Glucagon, which is required in the event of severe low blood sugar, was refrigerated but the temperature of the fridge was not monitored. We discussed this with the manager on the day of the inspection, they took immediate action to obtain the child-sized self-inflating bag and mask and the correct defibrillator pads, and we saw evidence of this. The practice manager gave assurance that the storage of Glucagon would be reviewed. We saw there was a single dose of adrenaline for adults, adolescents and children. The practice owner explained their reasons for not making additional doses of

Are services well-led?

adrenaline available. We highlighted that this decision should be documented and risk assessed, taking into consideration local information. For example, proximity to emergency services and ambulance response times.

An up to date recruitment policy was in place, we looked at the recruitment records for two new members of staff. These showed the practice followed their procedures, with the exception of a DBS check for one member of staff. We were sent evidence immediately after the inspection that an up to date DBS check was in progress. The practice manager was in the process of auditing all staff files to ensure they contained the appropriate information. Updated job descriptions and a new induction process had been introduced to support the recruitment process.

We asked how the practice ensured that all staff completed highly recommended training, including safeguarding vulnerable adults and children training. The practice manager showed us information provided to staff that suggested they completed locally available safeguarding training, and other online training, but there was no process to ensure that all staff completed this.

The practice had also made further improvements:

- Hazardous substances had documented risk assessments in place and a system had been introduced to check product expiry dates.
- The practice had reviewed information governance arrangements which complied with General Data Protection Regulation (GDPR) requirements.
- Clinical governance had been reviewed and a system to audit radiography and dental care records had been introduced. These included a review by the provider, who was the clinical lead. This was to be discussed with clinicians. Further plans were in place to audit antimicrobial prescribing. Staff had discussed sepsis, they introduced an urgent triage process, and provided sepsis awareness posters and prompts for staff in clinical areas.
- The consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age. Capacity assessment tools were available for staff.
- Regular staff meetings had been implemented to involve staff in the improvement process. The provider held individual meetings with staff to discuss any areas of concern, such as issues with record keeping and we saw evidence of these.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulations: when we inspected on 22 October 2018.