D R Walker (Lincolnshire) Limited

D R Walker - Lincolnshire

Inspection Report

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Overall summary

We carried out an unannounced inspection on 18 July 2016 and a follow up inspection on 27 July 2016 to ask the practice the following key question; Is the service safe? We undertook the inspection acting on information of concern which we received on 15 July 2016.

Our findings were:

Are services safe?

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

Background

D R Walker – Lincolnshire is situated in Grimsby, Lincolnshire. It offers private dental care services. The services provided include preventative advice and treatment and routine restorative dental care.

There is one working surgery, a decontamination room, a waiting area and a reception area. The reception area, waiting area and the surgery are on the ground floor of the premises.

There is one dentist (the practice owner), one trainee dental nurse and a receptionist.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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 on our initial inspection were

- The autoclave had broken approximately two weeks before our visit and had been sent for repair.
- We saw evidence that patients had been treated since the autoclave had been absent.
- We were told by staff that the registered manager had told them to clean the used dental hand pieces and ultrasonic scalers with bleach.

At the follow up visit we saw that

- Immediate action had been taken to ensure that a working autoclave and an appropriate infection control policy and procedures were in place.
- The practice had been closed to patients until the infection control practices were up to the required standard.

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?

No action

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

On 18 July 2016 we saw that the autoclave (a device for sterilising dental and medical instruments) had broken approximately two to three weeks before our visit. It had been taken away by engineers to be repaired shortly after it had broken. We were told that the practice was developing an arrangement with a local practice whereby they could sterilise their instruments at this local practice. This arrangement had not been implemented yet.

We saw evidence that patients had been treated in the week before our first visit. There were inconsistencies between the number of dirty instruments and the number of patients which had been seen.

Staff told us that the registered manager had told them to use bleach to clean the used dental hand pieces and ultrasonic scalers and this had been done. This does not meet the current required standards.

Immediate action was taken to address the issue and by the time of the follow up inspection the autoclave had been returned and was in full working condition. The practice had also implemented an infection control policy and procedures which were in line with guidance issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'.

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Detailed findings

Background to this inspection

We carried out these inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections were planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection was triggered as a result of concerning information which we had received.

The unannounced inspection was carried out by a dentally qualified CQC inspector who was supported by another CQC inspector. The follow up inspection was carried out by a dentally qualified CQC inspector who also had access to remote advice from a specialist advisor.

During the inspections we spoke with the trainee dental nurse and the receptionist. The registered manager was not in the practice on the days of inspection. We spoke with the registered manager on the telephone during the inspections.

Are services safe?

Our findings

Infection control

The autoclave that the practice used had recently developed intermittent faults. Approximately two weeks before our first visit the autoclave developed a major fault and was not capable of completing a full cycle of sterilisation. The autoclave had to be taken away by an engineer to be repaired and the company had told the practice it would be back within seven working days. The autoclave had not been returned on the first day of inspection and no replacement had been arranged.

We saw evidence that prior to the autoclave breaking a daily log was kept of the first cycle of each day and the appropriate tests had been completed. These tests included the Helix test and the automatic control test. These tests indicated that the autoclave was working correctly.

Staff at the practice had contacted a local practice to see if they could use their autoclave to sterilise the used instruments. This had not been implemented yet as they were unsure as to what paperwork or audit trail needed to be completed in relation to taking instruments to other locations.

We saw that used instruments were being kept in a locked box until they could be sterilised. These instruments had been decontaminated using an ultrasonic bath and manually scrubbed but not sterilised.

On the first day of inspection the practice had been closed and all patients had been cancelled as there were not sufficient amount of sterile instruments available to treat the patients.

We saw evidence (from the day lists) of patients having received treatment on three days in the week commencing 11 July 2016. These treatments included five crown preparation appointments and five filling appointments in addition to several check-up appointments. Crown preparations and fillings usually require the use of an air rotor (fast) dental hand piece in order to carry out the procedure effectively. When we looked in the box which contained the used instruments we found three air rotor dental hand pieces and three ultrasonic scalers with the scaler tips attached. An ultrasonic scaler is an instrument with a tip for supplying high-frequency vibrations, used to remove plaque and calculus from teeth. We asked the staff about the inconsistencies between the number of patients who were seen (where an air rotor dental hand piece or ultrasonic scaler was needed) and the amount of used instruments in the box. Staff told us that the registered manager had instructed them to decontaminate these instruments by using their ultrasonic bath and manually scrubbing and then sterilise them chemically by submerging them in bleach. This process had been done and the instruments had been used again on subsequent patients. This does not meet the current required standards.

We took urgent action and asked the registered manager to provide us with evidence that a fully functional autoclave was available and an infection control policy and procedures were in place. We monitored progress by frequent contact with the practice to ensure they were acting swiftly to achieve these goals.

At the follow up inspection on 27 July 2016 we found that a new infection control policy and procedures had been drawn up. The procedures involved in decontamination had been displayed on the wall in the decontamination room for staff to reference. We observed several cycles of the autoclave and saw that it was reaching the correct temperature for the appropriate time to enable effective sterilisation of instruments. The dental nurse was able to demonstrate to us the daily procedures for checking the autoclave and these included the automatic control test and the Helix test.

We will continue to monitor the provider to ensure that these procedures are embedded in practice.