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Elm Street Dental Surgery

Inspection report

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Overall summary

We undertook an inspection of Elm Street Dental Surgery on 8 March 2021. This was carried out to review the actions taken by the registered provider to improve the quality of care and to confirm that the practice now met legal requirements.

We had undertaken inspections on 24 February 2020 and November 2020 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 safe or 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 Elm Street Dental Surgery 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 review we asked:

- Is it safe?
- Is it well-led?

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Summary of findings

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Background

Elm Street Dental Surgery is in Ipswich, Suffolk and provides NHS and private dental care and treatment for adults and children. The dental team includes one dentist, one dental nurse, one trainee dental nurse and the practice manager (who was not available on the day of our inspection). The practice has two treatment rooms, only one of which is in use at the time of our inspections.

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 dentist, one dental nurse and one trainee dental nurse and looked at practice policies and procedures and other records about how the service was managed.

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspections on 24 February 2020 and again on 3 November 2020.

The provider could not demonstrate that care and treatment was provided in a safe way for people using the service.

Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations.

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspections on 24 February 2020 and again on 3 November 2020.

The provider could not demonstrate that leadership and governance systems within the practice were effective.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations.

We are considering enforcement action in relation to the regulatory breach identified and will report further when any enforcement action is concluded.

During this inspection, we found the provider had made some improvements to comply with the regulation:

- A new Perspex screen had been installed to help protect staff working at the reception desk.
- A Radiation Protection Advisor had been appointed and the practice's local rules had been updated.
- The X-ray unit had a rectangular collimator attached to help reduce exposure to patients.
- Staff were using safer sharps to help prevent the risk of injury. All clinical staff had received Hepatitis B booster jabs.
- Glucagon was being stored correctly in the fridge to ensure its safe use.
- New opening windows had been installed to increase ventilation in the practice.
- Old carpeting had been removed from the stairs and upstairs hallway.

However, the following shortfalls had not been addressed:

- We checked the practice's medical emergency equipment and noted there were no adult size face masks for self-inflating bags. Paediatric mask sizes 0-4 had been purchased accidently. The practice's weekly medical emergency equipment checks had not identified this error.
- There was no bodily fluids spillage kit available in the practice. The need for a bodily spills kit was identified in our previous inspections of February 2020 and November 2020.
- We viewed patient dental care records and noted there was no recorded evidence that a rubber dam, or alternative method, had been used to protect one person's airways during their root canal treatment. This issue was identified in previous inspections of February 2020 and November 2020.
- We were informed that the washer disinfector was now being used routinely. However, the practice's washer disinfector had not been serviced regularly to ensure its safe and effective operation. The lack of servicing of the washer disinfector was identified in our report of February 2020. The staff member questioned also did not know about any maintenance checks which should have been being completed.
- The manual cleaning of dirty instruments did not follow national guidance. There was no system in place to measure the volume of water needed for the detergent to achieve the correct concentration specified by the detergent manufacturer. Staff were unsure of the correct temperature the water needed to be, for effective manual cleaning.
- We checked how prescription pads were managed. Staff showed us they were recording the serial numbers of individual scripts issued to patients on the back of the prescription pad. We noted however, that the serial numbers were not in sequential order. This had not been identified and no action had been taken to investigate the reason for this, and if any individual scripts had been lost or stolen. This issue was identified during our inspection of November 2020.
- We viewed the practice's policy- 'The management of a sharps injury', dated November 2019. This was a document produced by the Irish Health and Safety Executive and referred to specific Irish reporting agencies and report forms, that are not relevant in England. This policy stated that the clinician was responsible for *the handling of orthodontic wires, irrigation syringe needles or any such sharp. They should not be passed to the dental nurse for disposal*. A staff member told us that the dentist handed them dirty needles to dispose of. We identified this issue in our report of November 2020.
- There was no risk assessment in place for the different types of sharp used in the practice. We identified this issue in our report of November 2020.

Are services safe?

- Staff were unable to evidence how the fallow time following an aerosol generating procedure had been calculated to ensure the treatment room was safe for re-use. They were not able to tell us how many air changes per hour there were in the treatment room, or what mitigating factors were in place to reduce the recommended time of one hour.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations.

We are considering enforcement action in relation to the regulatory breach identified and will report further when any enforcement action is concluded.

We found systems in place for the management of fire were insufficient. Fire checks had not been recorded appropriately and daily, weekly and monthly checks as recommended in the practice's fire risk assessment had not been completed. There was no evidence to show that staff had undertaken fire training and staff confirmed they had not received any. In addition to this, they stated that they had never practised using the specific fire escape ladder and exit hole on the top floor of the surgery, despite this being the only way to exit the premises in the event of a fire on the lower floors. This was identified in our previous inspections of February 2020 and November 2020.

We found systems in place around the governance and management of radiation were insufficient. The practice's radiation equipment had not been registered with the Health and Safety Executive (HSE), and there was no radiation equipment inventory. This was identified in our inspection on 3 November 2020.

We found systems in place for staff development and appraisal were insufficient. None of the staff had received a formal annual appraisal of their performance and none had personal development plans in place. This was identified in our previous inspections of February 2020 and November 2020.

We viewed the minutes of recent staff meetings which often only consisted of a couple of sentences. The minutes did not document the details of the discussions held or any action to be taken as a result of the meeting. The infection control audit dated 26 November 2020 stated that *infection control is a rolling item on staff meeting agendas*. This was not evident in the meeting minutes we viewed.

We found systems in place for assessing and monitoring the quality of service provision were insufficient. For example;

We viewed the practice's infection control audit dated 26 November 2020. There was a total of 158 questions, the large majority had been assessed as being met by the provider. However, we found it was not an accurate reflection of actual practices. For example-

- Question 22 stated that all staff had completed online- HSEI (Ireland) programmes – Good information Practice and Fundamentals of GDPR. Staff stated they had not undertaken this.
- Q46 stated that there was a laminated poster detailing the procedure to follow in the event of an inoculation injury displayed in the surgery. We checked the treatment room and no such poster was on display.
- Q 56 stated that there was a dental surgery cleaning checklist for each dental surgery. We noted there was such a list. However, staff had routinely ticked to demonstrate they had changed the developer liquid. The practice has digital X-rays in use and velopex developer liquid has not been used for years.
- Q74 stated there were instrument duck bags available for use. When we asked staff did not know what 'duck bags' were.
- Q102 stated that there was a written protocol available to staff stating steps to take if there is an autoclave cycle failure. Staff members we spoke with were unaware of such a protocol.
- Q130- stated that there was a successful trial track and trace procedure completed. Both staff members we spoke with were not aware of any such trial and did not know what the question meant.

We viewed the practice's Records Audit template dated 29 January 2021. There was no record of who completed the audit and the patient identifiers had not been recorded. There was no analysis of the result, or any resulting action plan. There was no evidence to show how frequently the audit would be conducted or the date of its second cycle. The lack of documented learning outcomes and action plans for audits was identified in our inspection report of February 2020.

Are services well-led?

We viewed the practice's radiograph audit dated 10 November 2020. The audit was limited in scope. There was no analysis of the reasons for grade 2 rated X-rays, no record of strengths or weaknesses identified as a result of the audit, and no date for a second cycle audit. The lack of documented learning outcomes and action plans for audits was identified in our inspection report of February 2020.

We viewed the practice's COVID 19 Risk Assessment, completed on 4 June 2020. It stated- *All staff have individual risk assessments undertaken*'. We asked for a copy of these staff risk assessments but were told that these had not been completed.

We found an out of date container of root canal sealant in the practice's fridge. There was no system in place to monitor the expiry date of this product, or the Glucagon medication that was also stored there, to ensure they were safe for patient use.

We asked staff to describe their responsibilities under The Duty of Candour, they were not aware of what this meant. We raised this in our inspection of November 2020.

This evidence shows that there were limited systems to assess and monitor the quality of service provision and the practice was not providing well-led care in accordance with the relevant regulations and guidance.

This section is primarily information for the provider

Enforcement actions

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