Eurodental

Eurodental Devizes Road Swindon

Inspection Report

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Overall summary

We carried out a focused inspection of Eurodental Devizes Road Swindon on 7 November 2017.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We carried out the inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 17 March 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

At a comprehensive inspection we always ask the following five questions to get to the heart of patients' experiences of care and treatment:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

When one or more of the five questions is 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.

At the previous comprehensive inspection we found the registered provider was providing safe, effective, caring and responsive care in accordance with relevant regulations. We judged the practice was not providing well-led care in accordance with Regulation 17 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 Eurodental Devizes Road Swindon on our website www.cqc.org.uk.

We also reviewed the key question of safe as we had made recommendations for the provider relating to this key question. We noted that some improvements had been made.

Our findings were:

Are services well-led?

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

The provider had made some improvements to put right the shortfalls and deal with the regulatory breaches we found at our inspection on 17 March 2017.However there were still significant areas that had not been addressed.

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

Summary of findings

The provider had made insufficient improvements to put right the shortfalls and had not dealt fully with the regulatory breaches we found at our inspection on 17 March 2017.

We identified regulations the provider was not meeting. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure all premises and equipment used by the service provider is fit for use and properly maintained.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Full details of the regulations the provider was not meeting are at the end of this report.

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?

The provider had made some improvements to the management of the service. This included obtaining fire and health and safety risk assessments from a competent person and they had taken action to mitigate most, but not all. of the risks.

The practice team kept complete patient dental care records which were clearly written or typed but were not stored securely.

The practice had a clearly defined management structure and staff felt supported and appreciated. However clear roles and responsibilities for all the practice team had not been established.

Premises and equipment were clean but not properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had suitable arrangements for dealing with medical and other emergencies.

There were limited systems and processes in place for the monitoring of staff by way of supervision and appraisal.

Policies had been reviewed and staff made aware of them. All required recruitment checks had been obtained and a patient feedback system had been implemented.

The improvements demonstrated some progress towards the on going development of effective governance arrangements at the practice.

Requirements notice ✖

Are services well-led?

Our findings

At our inspection on 17 March 2017 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 7 November 2017 we noted the practice had made some improvements to meet the requirement notice:

- The registered manager had obtained a Fire risk assessment which had been completed in March 2017. The identified risks relating to health, safety and welfare had been mostly addressed. They showed us documentary evidence which demonstrated risks were assessed, monitored and mitigated mostly in accordance with current guidance and legislation.
- However we saw the fire exit at the rear of the building was partially blocked by the compressor. The compressor was leaking oil and was covered in a thick layer of dirt and dust providing a potential fire hazard. We also spoke with the registered manager about the positioning of the compressor as the room comprised part of the reception area and did not appear to be a suitable place for noisy machinery.
- We were shown the fire safety file. It contained records of regular checks of the fire bell and extinguishers. The registered manager did not have a servicing certificate for the fire extinguishers but they had the last date of inspection on them, March 2017. A fire drill had been completed since the last inspection but there was only a brief record which stated it had happened. There was no list of staff in attendance and no record of learning points.
- We saw the practice appeared to have emergency lighting but were told it was not connected to the system. Should there be a fire there was no other lighting for patients to navigate out of the building which had a variety of steps and levels. The registered manager told us they had been given differing advice about the need for it. It had been highlighted in the risk assessment. We have referred these fire safety concerns to Dorset and Wiltshire Fire Authority. The registered manager told us they would welcome advice from the Fire service.
- We observed no action had been taken to improve the quality of the exterior of the premises. On arrival at the practice we noted the exterior of the building was shabby and in disrepair. We saw peeling paint on the entrance door, window frames and fascia boards. Some of the windows and door appeared to have rotting wood. We ascertained from the registered manager the provider owns the building and it is not a leased property.
- The interior of the practice had been appropriately furbished however there were a number of significant trip hazards in the staff areas of the building which had not been highlighted.
- The staff areas were not well maintained and we observed ivy growing through the conservatory area which was used as a staff room and patient records storage area. We observed patient records were not stored in the filing cabinets but were piled loosely on top of these cabinets. This arrangement does not comply with the guidance about the storage of patient records.
- The registered manager showed us they had ensured all relevant policies had been reviewed and updated and had a review date. Staff spoken with told us they knew where to find the policies. We saw sign sheets to evidence staff had read the policies.
- The registered manager had ensured a lead professional for safeguarding had been identified. We saw a flow chart with all the local numbers present and an appropriate whistleblowing policy was in place. We were shown documentary evidence staff had signed to say they had read the policy. Staff spoken with demonstrated a good understanding of safeguarding and the reporting process if required.
- We reviewed four staff files and saw the registered manager had ensured they had all the required recruitment information. However for the latest recruit we saw they had commenced employment two months before a Disclosure and Barring Service check had been obtained. The registered manager was not aware of the need to manage the potential risk of such a situation and evidence this through a risk assessment.
- We observed records were not stored securely. Large numbers of archived records were sat on top of open filing cabinets in the room behind the reception and in

the conservatory. We were told the rooms were locked at night but this is arrangements does not comply with current legislation and guidance regarding the safe storage of patient records.

- The standard of note keeping in this very busy NHS practice appeared to be satisfactory with evidence of appropriate diagnosis and treatment planning, and patient involvement in the consent process. We observed the practice was using a mixture of computer based and hand written records which had the potential for some patient information to be unavailable to the treating dentist. The registered manager told us they did not have any timeframe for ensuring a single effective system would be operated.
- Records held in relation to the provision of the regulated activities were not robust. They were not always dated and signed with the full signature of the person completing them, for accountability purposes.
- We observed the registered manager had ensured there were effective systems in place to monitor the expiry date of drugs for use in medical emergencies and ensure maintenance of the Automated External Defibrillator and oxygen systems.
- The head nurse demonstrated they had implemented a system to ensure the temperatures of the fridge were regularly recorded to ensure safe storage of dental materials. Records seen were completed.
- The registered manager had ensured a review of the infection prevention and decontamination processes. They had implemented an up to date infection prevention and decontamination policy. They had also written an annual statement of infection control which contained the required information. The policy had not been signed although a review date had been added.
- We observed the decontamination process and saw the practice carried out some of the decontamination processes in surgery (manual cleaning and ultrasonic bathing). The instruments were then carried in closed boxes to three separate “clean areas” containing the autoclaves. We recognised this was in part due to the layout of the building. While the system seen met the essential requirements of HTM01-05 the lead nurse and registered manager were unaware of any plans to move to “best practice”.
- We observed the doors to the “clean areas” were left open and were on corridors patients accessed to reach waiting rooms. In one room we saw an open topped clinical waste bin which was easily accessible. We also observed in one of the clean areas there was a thick layer of dust on the handles of the cupboards. We asked the lead nurse who was responsible for ensuring the cleanliness of the rooms and they were unsure as to whom that responsibility had been delegated.
- In one of the “clean areas” we saw an autoclave was not in use and were told it was broken and was not going to be repaired. The registered manager and provider had not taken any action to remove the broken equipment. We observed other items of equipment in the practice that were broken or identified as not in use. The registered manager and lead nurse had not followed up with the provider the need to take action to remove the equipment from the practice.
- For example we saw an x-ray developer situated in the kitchen area which we were told was broken. It did not have a notice attached to it stating it was broken. It was not clear either if it had been drained of the developing fluid. The registered manager and lead nurse did not know if it was to be repaired or removed and neither did the radiation protection supervisor.
- We also saw an x-ray machine in the hygienist’s surgery which had a sign attached to it stating “do not use”. The registered manager did not know and had no available evidence to demonstrate this unsafe equipment had been decommissioned to prevent unintended use. From the documentary evidence shown to us this x-ray machine had not undergone a recent critical evaluation examination to check the safety of it.
- The registered manager had taken action to ensure a quality audit of X rays was undertaken. However the practice staff spoken with where unaware of how to quality assess a digital x-ray and this was not being completed. We were shown copies of local rules in each surgery which had been amended since the last inspection. They did not contain all the required information; for example they did not contain equipment specific information.
- The radiation protection file (“X-ray file”) we were shown lacked a copy of the local rules and a lot of the basic information required to satisfy IRMER, such as:

Are services well-led?

- personnel records,
- up to date equipment inventories
- Policies as required by current legislation.
- The Radiation Protection Supervisor (RPS) for the practice was aware of their role as RPS and knew the location of the X-Ray folder. However they demonstrated they had no idea the folder had been changed form an "orange file" to one which was now grey. This demonstrated they had no idea if it was being updated or that it was lacking in content. We asked if they had audited and checked the file to ensure it was complete and were told this had not been done.
- We saw the registered manager had a limited system of appraisal and personal development plans (PDP) in place. Records seen demonstrated some staff had received an appraisal but there were gaps in the documentation to some of the areas for appraisal which had not been completed by either the appraise or appraiser. Information recorded was minimal and did not reflect good leadership and governance.
- Personal Development Plans had not been developed. For trainee dental nurses there were no records to demonstrate how they were being supervised and supported in the practice during their training. We were shown evidence they were registered on a course and feedback from the course tutor about their work. In discussion with one trainee nurse they told us they felt supported in the practice and had been given time to study. The practice did not regularly observe trainees in practice or discuss the practical application of learning.
- We observed there was no clear system for monitoring staff training and ensuring they undertook training as required to maintain their skills and knowledge. We saw evidence of staff certificates to demonstrate some of the CPD requirements were being met. Induction checklists were in place and had been mostly completed. The overall form had not been signed or dated for accountability purposes and a key area of induction regarding fire safety and other hazards in the practice had not been identified and signed off.

These improvements showed the provider had taken some action to address the shortfalls we found when we inspected on 17 March 2017. The provider remains in breach of Regulation 17.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to ensure that the regulated activities at Eurodental Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** • The systems in place for assessing, monitoring and mitigating risk were limited. Actions to mitigate identified risks had not been fully implemented. • The systems in place were not operated effectively to assess monitor and improve the quality and safety of the services provided. • Systems and processes in place for the monitoring of staff by way of induction and appraisal were not operated effectively and the training records were incomplete and not monitored. • There was no clear communication system with the staff team for sharing information from audits. • The practice had limited systems that were not operated effectively for staff supervision, appraisal and professional development to enable them to carry out their duties. • All trainee staff were registered on a course. There was no supervision of trainees in practice. • The provider did not have an effectively operated system for monitoring staff training to ensure all continuing professional development was completed to ensure clinicians were able to meet the registration requirements of their profession. **Regulation 17.1**