Northgate Dental health Practice Partnership

Mydentist - Upper Northgate Street - Chester

Inspection Report

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Overall summary

We carried out an unannounced responsive inspection on 1 August 2016 to ensure the practice was providing safe care in respect of the regulations; we did not inspect other aspects of the service.

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations after immediate action was taken as a result of this inspection. Detailed feedback was given to the practice during and following the inspection and this resulted in the practice voluntarily taking the decision to close for a period of time to undertake remedial work. A comprehensive action plan was developed and acted upon within a short timescale to address the concerns.

Background

Mydentist - Upper Northgate Street - Chester is an NHS and private dental practice situated in the centre of Chester close to public transport links. The practice has five treatment rooms, two on the ground floor, a further three surgeries in the basement, a decontamination room, an instrument bagging room and a separate room for the Orthopantomogram (OPT) machine. There is a reception area and two waiting areas. Staff facilities were located on the first floor.

There are seven dentists, two dental hygienists, a dental hygiene therapist, a practice manager, a receptionist and six dental nurses (four of which are trainees).

The practice is open:

Monday - Thursday 09:00 - 18:00

Friday 09:00 - 17:00.

The practice manager 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 were:

Summary of findings

- Governance arrangements were in not place for the smooth running of the practice; the practice did not have a structured plan in place to audit quality and safety including infection control.
- Daily and weekly checks on the decontamination equipment were not carried out.
- The dental surgeries were cluttered and visibly dirty.
- Some dental instruments which had been sterilised still had debris on them. Dental instruments were not always bagged in line with HTM 01-05 guidance.
- A medicine in the emergency drug kit was out of date.

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 stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understood how to minimise risks associated with the use of and handling of these substances. Review the storage of products identified under (COSHH) Regulations to ensure they are stored securely.
- Review the practice's infection control procedures and protocols are suitable 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 safe?

No action

We found that this practice was providing safe care in accordance with the relevant regulations after immediate action was taken as a result of this inspection. Detailed feedback was given to the practice during and following the inspection and this resulted in the practice voluntarily taking the decision to close for a period of time to undertake remedial work. A comprehensive action plan was developed and acted upon within a short timescale to address the concerns.

The practice did not have effective systems and processes in place to ensure all care and treatment was carried out safely. There were some systems in place for infection prevention and control, clinical waste control and management of medical emergencies but they were not robust enough to protect patients. For example, the checks to ensure the medical emergency drugs and equipment were in date and fit for purpose had not been completed for over five weeks and due to this we found adrenaline pre-loaded syringes (used to control the symptoms of a severe allergic reaction) were now out of date and no process was in place to replace this.

The practice had hazardous substances which could be easily accessible to the public.

There was a decontamination room in place and no evidence was available to show any daily or weekly tests were being performed within the last five weeks; some tests had not been completed for over eight months. One autoclave had no evidence any testing had ever been completed. The decontamination room was not secure and patients could gain easy access to this room.

The store cupboards were not locked and easily accessible to patients. This was brought to the attention of the registered manager and keys were available to be used and systems were put in place to ensure they cupboards were locked after use.

The practice did not have effective decontamination processes as we found instruments and burs with dried blood and dental materials still in place after the decontamination process. We found instruments not bagged or instruments protruding from a bag.

There was no system in place to monitor when dental implant equipment or instrument kits had last been sterilised. Bags were open and not fully sealed. We found equipment in a cup and all equipment was stored in the dental surgery where this could be contaminated.

The practice had a system called platelet rich fibrin (PRF). This system required a sample of the patients' blood before the placement of a dental implant to provide a clot that helped with the healing process. If any blood clot products were not used then these were disposed of down the sink.

Staff could not show evidence of any infection prevention and control training within the past five years.

Clinical waste was not secure. We found containers with teeth and amalgam sludge easily accessible to patients.

Summary of findings

Patients' conversations could easily be overheard in the waiting room as one surgery kept their door open. Computers were not locked when left unattended with patient details easily accessible.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We carried out this inspection as a result of concerns expressed to us and focussed on those elements of the practice concerned with keeping patients safe.

The inspection was carried out on 1 August 2016 and was led by a CQC Inspector and a specialist advisor.

The methods that were used to collect information at the inspection included interviewing staff, observations and reviewing documents.

During the inspection we spoke with two dentists, three dental nurses, the practice manager and the receptionist. We saw policies, procedures and other records relating to the management of the service.

Are services safe?

Our findings

Medical emergencies

The practice kept medicines and equipment for use in a medical emergency. These were in line with the 'Resuscitation Council UK' and British National Formulary guidelines. We found the adrenaline was past their expiry dates. No recent or consistent checks were in place to review the medical emergency oxygen, equipment or emergency drugs. This would ensure the emergency medicines were within the manufacturer's expiry dates. This was brought to the attention of the registered manager and all checks were now completed and reviewed by the registered manager.

Monitoring health & safety and responding to risks

The practice had undertaken a number of risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. The practice had a Health and Safety policy which included guidance on fire safety, manual handling and dealing with clinical waste.

The practice had access to information in regards to Control of Substances Hazardous to Health (COSHH) on the company's intranet. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. On the day of the inspection we found several hazardous substances could be easily accessible to the public. This was brought to the attention of the registered manager and the facilities team were made aware of the requirements and ensured all areas where these substances were stored had key pad locks in place.

Infection control

The practice had a decontamination area that was not set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. Clinical staff were not aware of the work flow in the decontamination area from the 'dirty' to the 'clean' zones. This was brought to the attention of the registered manager and the room was reviewed to ensure the flow of decontamination was in accordance to HTM 01-05.

There was a separate hand washing sink for staff and two sinks for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was not displayed on the wall to guide staff. We saw that appropriate personal protective equipment was not available in the decontamination area. No full sets of heavy duty gloves or disposable gloves were available. This was brought to the attention of the registered manager and all PPE was available and restocked accordingly.

We found instruments were not being cleaned or sterilised in line with published guidance (HTM01-05). The dental nurses were not knowledgeable about the decontamination process and could not demonstrate they followed the correct procedures and did not know enough about HTM01-05 to be able to effectively follow the guidelines.

Instruments were hand scrubbed in the surgery under a running tap, transferred to the decontamination room and placed in the washer disinfector or ultrasonic bath. The practice had an illuminated magnification device for instruments to be examined that was not used and in the wrong location. The instruments were then sterilised in an autoclave (a device for sterilising dental and medical instruments). Sterilised instruments were not always correctly packaged, sealed and dated. Instruments were transported between the surgeries and the decontamination room in lockable boxes. This was brought to the attention of the registered manager and full training took place to ensure every member of staff was aware of their responsibility. A new infection prevention and control lead was appointed to ensure continuity of all aspects of infection prevention and control.

We found numerous dental instruments with debris still visible after the decontamination process. If visible debris is not removed during the decontamination process, it will interfere with microbial inactivation and can compromise the disinfection or the sterilisation process. Some instruments were banded or had tape on them which meant the area underneath the band or tape couldn't be cleaned and decontaminated effectively. This was brought

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to the attention of the registered manager and all instruments within the practice went through a full sterilisation process to ensure all instruments were cleaned in accordance to the practice policy and HTM 01-05.

We found the practice had records to show the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. No recent records were in place to evidence the validation of the decontamination cycles of the autoclaves; this would demonstrate that all instruments have been decontamination fully at each stage. No evidence was available on the day of the inspection that protein testing or steam penetration testing was in place. This was brought to the attention of the registered manager and full training took place to ensure every member of staff was aware of their responsibility. A new Infection prevention and control lead was appointed to ensure continuity of all aspects of infection prevention and control.

On the day of the inspection we asked to see evidence that staff had completed training in regards to infection prevention and control. This information was not available and subsequently all training was completed in the following days after the inspection and evidence of this was seen. Further supporting evidence was sent to the inspector to show historical training had also been completed.

Surgeries, including the surgery where dental implants were provided had cluttered work surfaces which were difficult to clean effectively between patients. This was brought to the attention of the registered manager and action was taken to remove unnecessary equipment and decontaminate all other equipment in line with the practice policy and HTM 01-05.

Fans were located in the surgeries and in the decontamination room; these were visibly dirty and are not recommended for use as they can cause recontamination of instruments and equipment as detailed in chapter 6, HTM 01-05. This was brought to the attention of the registered manager and all fans were removed from areas where by recontamination could occur.

In all surgeries, we saw the re-use of single use items such as steel, latch-grip burs and endodontic files. We showed the practice manager the packaging from the items to show the single use sign. Some dental materials were found to be out of date along with some composite compules also being re-used and the composite gun was unbagged and pre-loaded with a used composite compule. Local anaesthetics were out of the blister packs. Numerous pre-filled irrigation syringes were also seen in surgery drawers, there was nothing to indicate what was in the syringe or when it had been prepared. This was brought to the attention of the registered manager and all material use was reviewed and discussed to prevent this happening in the future.

Within the staff areas, the food fridges also contained dental materials and empty food packaging was noted. These areas were visibly dirty and easily accessible to patients. All staff only areas were accessible to patients and areas that should have been locked were not.

The cleaner's equipment was minimal and did not comply with recommendations outlined by the National Patient Safety Agency. The equipment that was available was stored in the interim clinical waste area of the practice and represented a danger of cross infection due to inadequate storage. This was brought to the attention of the registered manager and all equipment was moved to an area where by the equipment could be stored appropriately.

There were no paper hand towels available in the decontamination area. A poster describing proper hand washing techniques was displayed above some of the sinks and these were not the designated hand washing sink.

We saw the sharps bins were being not always used correctly and located appropriately in the surgery. The sharps containers did not have any record of when or who assembled the sharps container and some were on the surgery floor. Clinical waste was not stored securely for collection; we found extracted teeth containers and waste amalgam containers easily accessible to patients. This was brought to the attention of the registered manager and all sharps containers were reviewed and placed at eye level.

The surgery used for the placement of dental implants was visibly cluttered. There was no system in place to monitor when the equipment or instrument kits had last been sterilised. Bags containing sterilised instruments were not always adequately sealed. We found equipment not stored effectively or free from possible contamination. Some equipment was found unbagged and in a cup and all equipment was stored in the dental surgery where it could

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be contaminated. This was brought to the attention of the registered manager and action was taken to remove unnecessary equipment and sterilise all other equipment in line with the practice policy and HTM 01-05.

The practice used a system called platelet rich fibrin (PRF). This system required a sample of the patients' blood before the placement of a dental implant to help clot formation which assists the healing process. If any blood clot product was not used then this was disposed of down the sink. HTM07-01 states very small pieces of unrecognisable tissue from minor procedures (for example wound cleansing) should be disposed of in the clinical waste bags.

The PRF system had no policies, protocols or risk assessments in place to ensure the equipment was maintained and used appropriately. This was brought to the attention of the registered manager and clinical director and they decided to voluntary remove the use of the machine through the organisation until further information had been gathered and policies and protocols put in place.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressors. We saw evidence of installation written schedules for the autoclave and the compressor.

Portable appliance testing (PAT) had been completed in July 2014 (PAT confirms that portable electrical appliances are routinely checked for safety). No further visual annual checks had been completed.

Local anaesthetics were not stored securely as the store cupboard was left unlocked and the door left open. This was accessible to patients. This was brought to the attention of the registered manager to ensure these were locked in the future.

Prescription pads were left on the side in surgeries whether they were in use or not. Some surgeries were easily accessible to patients and this posed a risk. This was brought to the attention of the registered manager and all prescription pads were removed from surgeries and placed within the practice safe.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated one of the X-ray machines was newly installed and evidence of an acceptance test certificate was available. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure the equipment was operated safely and by qualified staff only. Each report for the X-ray equipment had actions to address including action to be taken for patient dose and equipment performance. On the day of the inspection we saw no evidence these actions had been addressed and this was raised with the registered manager.