S A Groups

Highfield Clinic

Inspection Report

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Overall summary

We undertook a follow up focused inspection of Highfield Clinic on 24 February 2020. 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 led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Highfield Clinic on 2 July 2019 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 and was in breach of regulation 12 and 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 Highfield Clinic on our website www.cqc.org.uk.

As part of this inspection we asked: Remove as appropriate:

• Is it safe?

• Is it well-led?

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

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 2 July 2019.

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 breaches we found at our inspection on 2 July 2019.

Background

Highfield Clinic is in Edgbaston, Birmingham and provides private treatment to adults and children. The practice is located on the first floor of a multi-occupancy building and can only be accessed by stairs. Car parking spaces are available in the practice car park at the rear of the building.

Summary of findings

The dental team includes three dentists, three dental nurses, one dental hygiene therapist and one receptionist. The dental hygiene therapist is also the practice manager. The practice has two treatment rooms.

The practice is owned by an organisation and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Highfield Clinic is the principal dentist.

During the inspection we spoke with the principal dentist and the dental hygiene therapist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday and Wednesday from 9am to 8pm, Tuesday and Thursday from 9am to 6pm, Friday from 9am to 5pm. The practice is also open on alternate Saturdays from 9am to 1pm.

Our key findings were:

Not all medical emergency equipment was available. The practice had purchased items identified as missing during the previous inspection. Upon checking equipment at this inspection it was identified that other items were missing, these items were ordered during this inspection.

Evidence was available to demonstrate that all staff had completed training regarding safeguarding vulnerable adults and children, basic life support and infection prevention and control. Evidence was available to demonstrate that the visiting sedationist had received update training regarding sedation.

The provider assured us that patients were no longer treated in areas other than a designated dental treatment room.

We saw cleaning schedules for the practice although these had not always been signed by the person undertaking the cleaning.

Emergency lighting had been subject to routine servicing and checks.

Evidence was available to demonstrate that a five-year fixed wiring test had been completed. A gas safety certificate was available.

Appropriate dispensing information was recorded on dispensing labels.

The practice had introduced an information governance system which ensured that policies and procedures contained a date of implementation and review.

The provider had recruitment files for each staff member which demonstrated that records relating to people employed included information relating to the requirements of Schedule 3 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Risk assessments were available regarding all substances hazardous to health in use at the practice.

A practice health and safety risk assessment and fire assessment had been completed by an external professional.

The provider had obtained assurances that all clinical staff had immunity against vaccine preventable infectious diseases.

A system had been introduced for the on-going assessment, supervision and appraisal of all staff. Some improvements were required to the practice's induction processes.

A legionella risk assessment had been completed by an external professional on 21 February 2020 and the practice were awaiting a copy of the risk assessment.

Improvements had been made to the practice's policies and procedures for obtaining patient consent to care and treatment. Capacity assessment forms were available for use as required.

Improvements had been made to the practice's complaint handling procedures and an accessible system for identifying, receiving, recording, handling and responding to complaints by service users had been introduced.

Some action had been taken to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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

Summary of findings

- Take action to ensure the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
- Take action to implement any recommendations in the practice's Legionella risk assessment, taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to 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 asked the following question(s).

Are services safe?
We found that this practice was providing safe care and was complying with the relevant regulations.

No action

Are services well-led?
We found that this practice was providing well-led care and was complying with the relevant regulations.

No action

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At our previous inspection on 2 July 2019 we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 24 February 2020 we found the practice had made the following improvements to comply with the regulation(s):

Not all medical emergency equipment was available. The practice had purchased items identified as missing during the previous inspection but other items were identified as missing or stored incorrectly during this inspection. For example, the practice did not have any clear face masks for self-inflating bags (sizes 0 – 4). The oxygen face mask for an adult and for a child were not stored for single use in sealed bags which contained an expiry date. The suction catheter to be used with the emergency suction was a dental suction tip and not specifically for use with the emergency suction. A discussion was held with the practice manager and all items were purchased during the inspection. The practice had completed basic life support training in October 2019 and we were told that the emergency medical equipment was checked by the training provider at that time but no issues were identified. During discussions the principal dentist and practice manager were advised to ensure that all equipment was available in line with the recommendations of the Resuscitation Council (UK) guidelines.

Evidence was available to demonstrate that staff had completed training regarding safeguarding vulnerable adults and children. The safeguarding lead had completed training at a higher level. Evidence was provided to demonstrate that staff had completed basic life support training. Since the last inspection the practice had employed three new dental nurses and we were told that these staff had completed infection prevention and control training and evidence was available to support this in the files that we saw. The practice had a file of information regarding the visiting seditionist, this included training information regarding sedation.

The principal dentist assured us that patients no longer received treatment in areas other than a designated dental treatment room. The practice had a disability policy which recorded that patients who could not access the first-floor treatment room would be referred to the sister practice which had ground floor treatment rooms. During discussions the principal dentist and the practice manager confirmed this.

We saw copies of the cleaning schedules for the practice. Not all of these had a space for staff to sign to demonstrate who had completed the cleaning task, it would therefore be difficult to undertake an audit of this. The practice manager confirmed that documentation would be amended and staff would be asked to sign to confirm that they had completed the cleaning task. Following this inspection, we were sent copies of the amended cleaning schedules which had space for staff to sign to demonstrate action taken.

A test certificate was available to demonstrate that emergency lighting had received routine servicing in August 2019. The fire alarm had been serviced in October 2019 and fire extinguishers in May 2019. Regular checks were completed on the practice's fire alarm and staff undertook fire drills.

An electrical installation condition report was completed in September 2019 and no issues for action were identified. A gas safety certificate was available dated August 2019.

Appropriate dispensing information was recorded on dispensing labels. During discussions it was noted that a monthly check was completed on medication stock held at the practice. This was overdue but was completed during this inspection.

The provider had also made further improvements:

A legionella risk assessment had been completed prior to our last inspection of the practice.. We did not see the original action plan sent with the legionella risk assessment. A further risk assessment had been completed on 21 February 2020 and the practice were awaiting the report which would record details of any actions to be taken. Evidence was requested to demonstrate that the practice had implemented any recommendations in the practice's Legionella risk assessment, taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related

Are services safe?

guidance.' During this inspection we checked records held at the practice regarding monthly water temperature monitoring. We saw that one or two were below the recommended temperature. Following this inspection we were sent evidence to demonstrate that some staff had completed training regarding legionella. We were told that all staff were now aware of the testing requirements for the practice water system and that water temperatures on all practice water heaters had been increased to 55 degrees to ensure compliance.

These improvements showed the provider had taken action to comply with the regulation(s): when we inspected on 24 February 2020.

Are services well-led?

Our findings

We found that this practice was providing well led care and was complying with the relevant regulations.

At our previous inspection on 2 July 2019 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 24 February 2020 we found the practice had made the following improvements to comply with the regulations:

A compliance system had been purchased and was recently introduced at the practice. This supported the system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Staff were converting all previous information from old policies to the new system and getting used to the new system.

At the previous inspection recruitment records were kept off site and were not available for review. We were not able to review a random sample of records to demonstrate compliance. At this inspection it was identified that the provider had taken oversight for the recruitment of staff and recruitment records were now available on the premises. We looked at three staff recruitment records and saw that records relating to people employed included information relating to the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were told that standard recruitment templates were used and all required information was available for all staff. We saw that disclosure and barring service checks had been completed for all staff.

Risk assessments were available regarding all substances hazardous to health in use at the practice. It was not recorded who had completed the risk assessment. We were told that staff were transferring all COSHH information onto a digital format which would then be dated and signed.

The practice had employed an external professional to complete a fire risk assessment and a health and safety risk assessment. An action plan was available with issues for action identified. Evidence was available to demonstrate actions taken as required.

The provider had obtained assurances that all clinical staff had immunity against vaccine preventable infectious diseases. Titre levels or other evidence of immunity were available for all staff.

The practice manager showed documentation to demonstrate that appraisal systems had been implemented. We saw completed documentation for one staff member. Other newly employed staff were due to receive annual appraisal near the anniversary date of their employment. We discussed systems of peer review for the dentists and dental hygiene therapist at the practice. The practice manager confirmed that consideration would be given to introducing a peer review system for these staff. Following this inspection, we were told that a peer review policy had been implemented and we were sent a copy of this policy. Staff were to meet monthly to discuss clinical and non-clinical topics to improve the services the practice provides but to also improve key areas such as recording patient clinical notes and clinical audits. We were shown induction records for the three new staff employed. We saw that these had not all been fully completed. There was no documentary evidence to demonstrate that two of these staff had completed their induction training or received any probationary reviews. The practice manager was aware that this was outstanding and confirmed that completion of the induction was planned. Following this inspection, we were sent evidence to demonstrate that probationary reviews had been held as necessary with staff and documentation completed.

The practice had also made further improvements:

The practice had made improvements to the practice's policies and procedures for obtaining patient consent to care and treatment. We were told that full, informed consent was always obtained. Capacity assessment forms were available for use when capacity to consent was under question. When reviewing information to evidence consent was obtained, we identified that not all clinicians were recording basic periodontal examination (BPE) information. Following this inspection we were sent confirmation that the required staff had read the "Good Practitioners Guide to Periodontology". We were told that clinical staff members had been updated regarding the guidelines in regard to recording BPE's for both children and adults and, for example, an update on classifications of periodontal disease, diagnosis, non-surgical therapy and antimicrobials.

Are services well-led?

Changes had been made to the practice's complaint handling procedures but further improvements were required. For example, we saw that a complaint log was available to record any written or verbal complaints received at the practice. A copy of the complaint procedure was on display in the ground floor reception area. The print was small and difficult to read. There was no copy of this document in the dental practice waiting room. We were told that a copy would be made available in larger print in the reception and in the waiting room. We saw that pictorial information was available in the waiting room regarding how to make a complaint.

The provider had taken some action to ensure the service considers the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010. For example, we saw that a hearing loop had been purchased for use by patients with a hearing impairment. A selection of reading glasses and a magnifying glass were available for use by patients with a sight impairment. We were told that information could be printed in large print as required. We saw a copy of the practice's disability discrimination act audit. The information was unclear as it related to areas that were not the responsibility of the dental practice. Some information recorded on the audit was incorrect and required review.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulation(s): when we inspected on 24 February 2020.