Meridian Clinics Limited

Malcolm Patrick Association

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of this service on 15 September 2015 as part of our regulatory function where a breach of legal requirements was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We followed up on our inspection of 15 September 2015 to check that the practice had implemented their plan and to confirm that they now met the legal requirements. We carried out a focused visit on 3 November 2016 to check whether the practice had taken action to address a breach of Regulation 17(1) and (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This report only covers our findings in relation to those requirements. You can read the report from our previous comprehensive inspection by selecting the 'all reports' link for Malcolm Patrick Association on our website at www.cqc.org.uk.

Our findings were:

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Key findings

- Overall we found that sufficient action had been taken to address the shortfalls identified at our previous inspection and the provider was now compliant with the regulation.

There were areas where the provider could make improvements and should:

- Review the practice's audit protocols for infection control at regular intervals to help improve the quality of service. They should also check all audits have documented learning points and the resulting improvements can be demonstrated. The provider should also review and amend their infection control policy so that it is specific to the practice and contains information in line with guidance from Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

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?

No action

This focused inspection concentrated on the key question of whether or not the practice was well-led. We found that the practice was now providing well-led care in accordance with the relevant regulations.

At our previous inspection of the practice in September 2015 we identified that governance arrangements were not sufficiently robust. We reviewed the action taken to address issues raised during this focused inspection and found that the practice was now meeting regulatory requirements.

Malcolm Patrick Association

Detailed findings

Background to this inspection

We carried out a review of this service on 3 November 2016 to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 15 September 2015 had been implemented. We reviewed the practice against one of the five questions we ask about services: is the service well-led? This is because the service was not previously meeting some of their legal requirements under the well-led domain.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

The review was led by a CQC inspector who had access to remote advice from a specialist advisor.

During our review, we checked that the registered provider's action plan had been implemented. We reviewed a range of documents provided by the registered provider. We found that the practice was meeting their legal requirements under the well-led domain.

Are services well-led?

Our findings

Governance arrangements

Clinical Governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and promoting high standards of care, by creating an environment in which clinical excellence will flourish. Governance arrangements are part of that ongoing process. At our previous inspection on 15 September 2015, we found that the practice did not have robust governance arrangements in place.

At our previous inspection we found that the practice did not maintain clear records of adverse incidents. In November 2016, we saw examples of documented incidents and these were appropriately managed and records were comprehensive.

At our previous inspection we found that there were no systems in place to ensure that all staff members were aware and responsive to national patient safety and medicines alerts. In November 2016, we reviewed a file containing relevant safety alerts throughout 2016. These were discussed with staff members during staff meetings.

At our previous inspection we found that a rubber dam kit was not available in the treatment room and the provider was not routinely using a rubber dam for all stages of the root canal treatment. The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. In November 2016, we found that the provider was using rubber dam and would take alternative actions to reduce the risks in the absence of its use.

At our previous inspection we found that one of the emergency medicines had expired. Since then, the practice had adopted more robust processes for checking stock. Two dental nurses now checked stock and this was documented on a log sheet and on the computer system. We reviewed weekly log sheets. When the medicines were close to their expiry dates, this was also flagged on the computer system too. The emergency medicines were all in date and stored securely.

Staff were carrying out and documenting weekly checks on the automated external defibrillator (AED) and the emergency oxygen. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). The practice equipment for managing medical emergencies was now in line with current guidance as the practice now carried a portable suction device.

At our previous inspection we identified some shortfalls relating to fire safety at the practice. Since then, the practice had carried out necessary improvements. Smoke detectors were checked weekly and this was documented. We saw evidence that fire drills had taken place every six months to ensure that staff were rehearsed in evacuation procedures. We saw evidence that staff had participated in fire safety awareness training. The provider also arranged for an external contractor to carry out a fire risk assessment in February 2016. They made some recommendations to improve fire safety and we saw that the provider had implemented necessary changes. Where action had not been taken, the provider outlined this on the assessment with clear explanations.

The provider had not actively employed new staff since they took on this role. The provider had two employees and both had been at the practice for 40 years. Disclosure and Barring Service (DBS) checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Although the practice had a general risk assessment regarding the DBS checks for staff, they did not hold individual risk assessments for each staff member that did not have a DBS check. We discussed this with the provider and they assured us they would record risk assessments for each employee.

At our previous inspection we found that a Legionella risk assessment had not taken place since 2011. The contractor recommended another in 2013 but this had been previously overlooked by the provider. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The provider arranged for another risk assessment to be carried out in February 2016. All recommendations had been completed and staff regularly carried out checks of the water temperature to ensure it remained within the recommended range.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We

Are services well-led?

looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them. This was reviewed annually. This information was not readily available at our previous inspection.

At our previous inspection there was a policy about infection control which outlined procedures to help to ensure the safety of patients and staff. However, it was generic and had not been updated since 2012. Since our last visit, the policy had been reviewed and amended but it did require further modification. For example, there was a designated lead person in infection control and this information was displayed in the treatment room but not on the policy.

At our previous inspection the treatment room was clean but the work surfaces were cluttered. This was due to lack of storage space and the lack of a separate decontamination room. During our current visit, we saw that the work surfaces were clear and staff told us they had removed a lot of materials and equipment that they no longer used. The provider told us they planned to convert one of the rooms into a decontamination room but no formal plans were in place at the time of our visit.

Clinical waste was regularly collected by a registered waste carrier and we reviewed documentation to confirm this (these records were not available to view in September 2015).

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. Necessary improvements were required in this area as the practice had not completed these in line with current guidance. One audit was carried out in April 2015 but this was incomplete. Another audit was present from October 2016 but the results had not been summarised and no action plans had been compiled. Action plans should be documented subsequent to the analysis of the audit findings. Without following clear action plans, the practice cannot assure themselves that they had made improvements as a direct result of the audit findings. A third audit was present but this was undated and staff could not remember when it was completed. The provider explained that the audits had been overlooked and they would introduce a system to ensure this did not happen again.

We reviewed the dental care records at our previous inspection and found that some improvements were required when documenting details such as justification for taking X-rays and details about the patients' alcohol consumption. During our current visit, we found that the provider had implemented the necessary changes. They had also carried out an audit in dental care record keeping ensuring that their record keeping was in line with current guidance.

Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. Since our previous visit, the provider had carried out appraisals with their staff and planned to repeat these annually. Staff meetings took place regularly and the minutes of these were now available for staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date.

At our previous inspection we found that patients were able to leave verbal feedback with staff but no other methods were available to them for leaving written or anonymous feedback. Since then, the provider had introduced a suggestions box and written patient surveys.

Since our previous inspection, the provider had introduced disability, equality and diversity policies to support staff in understanding and meeting the needs of patients. They had also added a policy with details of the whistleblowing process for the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.