Dr Rajni Prasad

Rothwell Dental surgery

Inspection Report

4 Butcher Lane
Rothwell
Leeds
LS26 0DB
Tel: 0113 2822972
Website: www.rothwelldentalsurgery.co.uk

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Overall summary

We carried out an unannounced inspection on 13 November 2015 to ask the practice the following key question; Is the service safe?

Our findings were:

Are services safe?

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

Background

Rothwell Dental Surgery is situated in the Rothwell area of Leeds. It offers both NHS and private dental care services to patients of all ages. The services provided include preventative advice and treatment and routine restorative dental care.

There are two surgeries, a decontamination room, a waiting area and a reception area. The reception area, waiting area and one surgery are on the ground floor of the premises. The second surgery and the decontamination room are on the first floor of the premises.

There are three dentists (one of which is the practice owner), three trainee dental nurses and one qualified dental nurse. The dental nurses also cover reception duties on a rota basis.

The practice is open Monday, Tuesday and Thursday 9-15am to 5-00pm, Wednesday 9-15am to 6-00pm and Friday 9-15am to 3-00pm.

During the inspection we spoke with the practice owner, two dentists and two dental nurses.

Our key findings were:

- The surgeries were rather dirty and the work surfaces were cluttered.
- The decontamination and sterilisation procedures were not in line with guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- The contract for collection of clinical waste was insufficient for the amount of clinical waste produced.
- There was no child oxygen mask in the medical emergency kit.
- There was a blocked drain at the back of the premises and there was an accumulation of foul matter related to it.

We identified regulations that were not being met and the provider must**:**

- Ensure the practice's infection control procedures and protocols conform to the guidelines issued by the Department of Health - Health Technical

Summary of findings

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'.

- Ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Ensure the problem with the blocked drain at the back of the premises is remedied.

You can see full details of the regulations not being met at the end of this report.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK).
- Review the practice's policy on pre-stamping prescriptions.

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?

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

We found the surgeries to be particularly cluttered and dirty. Some of the drawers used to store instruments and materials were also cluttered and dirty.

The dental nurses did not wear adequate personal protection equipment during the decontamination process.

Staff were unsure of the daily checking process for the autoclave.

The decontamination process was not in line with HTM 01-05 guidance.

There had not been any regular checks on the ultrasonic bath including an annual service.

The practice was not undertaking quarterly water temperature tests in line with its Legionella risk assessment.

The practice's contract for the collection of clinical waste was insufficient for the amount of clinical waste they were producing. Since the inspection we have seen evidence that the contract for the collection of clinical waste has been increased.

There was a blocked drain at the back of the premises where foul matter was overflowing. Since the inspection we have been told that this issues has been addressed.

There was no child sized oxygen mask in the medical emergency kit.

The provider assured us on the day of the inspection and following our visit that they would address these issues by notifying staff of the correct procedures to follow, provide staff training, and put immediate procedures in place to manage risks.

Rothwell Dental surgery

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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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

During the inspection we spoke with the practice owner, two dentists, the qualified dental nurse and a trainee dental nurse. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we asked the following question:

- Is it safe?

This question therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Medical emergencies

The emergency resuscitation kits, oxygen and emergency medicines were stored in the decontamination room on the first floor. Staff knew where the emergency kits were kept. This was generally in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, there was no child sized oxygen mask in the emergency kit.

There was no evidence of regular checking of the emergency medicines or oxygen. All emergency medicines and oxygen were in date.

The glucagon (an emergency medicine used to treat severe hypoglycaemia (low blood sugar) in patients with diabetes who have passed out or cannot take some form of sugar by mouth) was stored in the fridge located in a room adjacent to the decontamination room. However, there was no evidence that the fridge temperature was regularly checked to ensure that it was being stored at the temperature stipulated by the manufacturer.

Infection control

There was an infection control policy and procedures to keep patients safe last reviewed in May 2014. The practice did not follow the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'.

We observed the treatment rooms including the drawers to be rather dirty. In the upstairs surgery we saw that there were bagged 3 in 1 tips (3 in 1 tips are attachments which are used to blow air or water on teeth) which had passed their sterilisation expiry dates. However, we were told that these were no longer used as they now used disposable 3 in 1 tips. In the ground floor surgery we found dental burs were stored in a small box which was dirty and some of the burs also looked dirty. We saw that the floor was stained and there were deposits of wax used in the fabrication of dentures on the floor which had not been removed. Work surfaces and drawers were also cluttered making efficient cleaning difficult. There was a daily cleaning schedule displayed in each surgery. However, from what we saw this was not being adhered to. We observed waste in the surgeries was separated into clinical and domestic waste.

The practice had a contract for the collection of clinical waste. This was for six bags of clinical waste each month. The waste collection was at the end of each month. On the day we visited, we saw the clinical waste bins used to store clinical waste were full. We were told that excess clinical waste was stored in the cellar until the clinical waste bins were collected. It was evident that the contract for the collection of clinical waste was insufficient for the amount of clinical waste which was being produced. We saw three closed sharps bins stored in a small room adjacent to the decontamination room. The dates which these sharps bins had been closed were August 2015 and October 2015. The third sharps bin did not have a closed date recorded. We saw evidence after the inspection that the contract for the collection of clinical waste had been increased from six bags each month to 12 bags a month with fortnightly collections.

Decontamination procedures were carried out in a dedicated decontamination room. However, we saw that the decontamination room was also used to make hot drinks as there was a kettle, a box of tea bags and a jar of coffee in the clean area. We were told after the inspection that all of these had been removed from the decontamination room.

An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection. However, we saw that used instruments were not kept moist prior to being sterilised. Evidence in HTM 01-05 indicates that keeping instruments moist after use and prior to decontamination improves protein removal and overall decontamination outcomes.

One of the dental nurses showed us the process for the decontamination and sterilisation of used instruments. They manually scrubbed dirty instruments, used an ultrasonic bath and then sterilised the instruments in an autoclave.

We saw that appropriate personal protective equipment was not being worn. Heavy duty gloves, an apron, a visor and eye protection were not worn during the manual

scrubbing procedure. There were separate sinks for the scrubbing and rinsing of dirty instruments. However, we saw that the scrubbing and rinsing sinks were not filled with fresh solution for each batch of dirty instruments. We saw that the solution in the scrubbing sink was visibly dirty before the first decontamination process of the day. This indicated to us that the solution had not been changed from the day before. There was also no check on the temperature of the solution prior to manual scrubbing. HTM 01-05 states that the temperature of the solution should be checked to ensure that it does not exceed 45'C as any temperature exceeding this will coagulate protein and inhibit its removal. A wire brush was used for the manual scrubbing of the dirty instruments. HTM 01-05 states that wire brushes should not be used for manual scrubbing as they cause surface abrasion on instruments which may reduce the overall decontamination outcome and increase the risk of a needlestick injury. Manual scrubbing was also not undertaken under water. HTM 01-05 states that manual scrubbing should be conducted underwater to reduce the risk of an aerosol forming. There was no illuminated magnifying glass available for examining instruments prior to sterilisation in the autoclave. HTM 01-05 states that instruments should be inspected for any visible soiling such as blood or dental materials prior to the sterilisation procedure. The instruments were then sterilised in an autoclave. We saw evidence that test strips were used for each sterilisation cycle and these were kept in a folder in each of the surgeries. We noted that not all instruments were stored or packaged in line with HTM 01-05 guidance.

There was a sheet displayed in the decontamination room for the daily quality testing of the autoclaves. This included visually checking the autoclaves and changing the water. All the boxes had been ticked on the sheet indicating that all of the tests had been completed. However, when we asked staff what the daily automatic control test actually involved they were unable to tell us. This indicated to us that this test was not performed. HTM 01-05 states that the automatic control test should be conducted on a daily basis and checks that the autoclave holds a temperature required for effective sterilisation for the correct amount of time. We also did not see any evidence that the ultrasonic bath had been regularly tested. They had not undertaken a weekly protein residue test or a quarterly activity test. HTM 01-05 states that these tests should be performed to ensure that the ultrasonic bath remains fit for use.

We saw evidence that they had conducted the self-assessment audit relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). However, this audit had not been dated so we could not be sure when this audit had been completed.

Records showed a risk assessment process for Legionella had been carried out in May 2015 (Legionella is a term for particular bacteria which can contaminate water systems in buildings). As a result of the risk assessment they undertook processes to reduce the likelihood of Legionella developing which included running the water lines in the treatment rooms at the beginning of each session and between patients and the use of a water conditioning agent in the dental unit waterlines. We saw that the risk assessment also suggested that the practice should record temperatures of water every three months. However, we saw that this had not been done.

After the inspection we were told that the registered provider had organised training for all staff with regards to infection control.

At the rear of the building we noted that there was a blocked drain. There was foul matter accumulating around the blocked drain and there was an unpleasant odour associated with it. After the inspection we were told that this issue had been rectified and that the drain was not the sole responsibility of the dental practice.

Equipment and medicines

During the inspection we noted that prescriptions were pre-stamped and we were told that they were kept in the surgeries when the practice was closed. Prescriptions should not be pre-stamped to reduce the risk of misuse if they are stolen. They should also be securely stored when the practice is closed.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **There were limited and inappropriate systems in place and staff lacked knowledge and understanding of how to assess the risk of, prevent detect and control the spread of infections, including those that are health care related.** **Regulation 12(1)(2)(h)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises and equipment used by the service provider was not clean.** **Regulation 15(1)(2)(a).**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider failed to adequately assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities.** **Regulation 17(1)(2)(b).**