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St Albans Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of this practice on 21 January 2016. A breach of legal requirement was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to Good Governance.

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. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Albans Dental Centre on our website at www.cqc.org.uk

Our findings were:

Are services well-led?

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

Background

St Albans Dental Centre is a general dental practice which is part of the Southern Dental corporate close to St Albans city centre in Hertfordshire. The practice offers predominantly NHS and some private dental treatment to adults and children.

The premises are located on the ground and first floor and consist of four treatment rooms, a reception area, a waiting room and a designated decontamination room.

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:

- The practice had a fire risk assessment completed shortly after the comprehensive inspection. At the time of the follow up inspection the listed recommendations had not all been implemented or addressed.
- An infection control audit had been completed, but only once in the year preceding the follow up inspection. National guidance recommends infection control audits are carried out six monthly. Certain questions had been answered incorrectly.
- Radiography audits (designed to audit the quality of X-rays taken) had been completed on one out of four clinicians, and in that one case had not generated an action plan for improvement at the time of the inspection.
- Records of complaints made to the practice were incomplete, and were not always passed to head office as per the practice policy.

Summary of findings

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

- Ensure an accessible system is established for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

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?

We found that this practice was not providing well-led 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 and Enforcement section at the end of this report).

Clinical audit had not been used effectively to highlight areas of clinical practice where improvement could be made. For example; infection control audits had not been completed six monthly and certain questions had been answered incorrectly. Audits of X-ray quality had only been completed for one dentist in the year preceding the inspection.

Steps had been taken to manage risk in the premises. For example; a second hand rail had been added to the staircase, and a fire risk assessment had been completed. Some of the recommended actions raised by the fire risk assessment had been completed, but not all.

Complaints received to the practice were kept on a log at head office. We observed that the complaints log from head office did not correlate with the complaints kept on file at the practice. A complaint record we were shown was incomplete.

Enforcement action 

St Albans Dental Centre

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.

We undertook an announced focused inspection of St Albans Dental Centre on 15 April 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 21 January 2016 had been made. We inspected the practice against one of the five questions we ask about services: is the service Well - Led. This is because the service was not meeting some legal requirements.

The inspection was led by a CQC inspector who was accompanied by a dental specialist advisor.

Are services well-led?

Our findings

Governance arrangements

Concerns were raised following the comprehensive inspection that the practice manager was managing three sites and was therefore not available at all times. Following the comprehensive inspection an assistant manager was appointed at the practice. Discussions with the practice manager indicated that the role of the assistant manager was to assist in the day to day running of the practice and was not responsible for any governance procedures or oversight.

The practice had completed risk assessments in the year preceding our follow up visit. A health and safety risk assessment had been completed on 29 June 2016 and covered topics including the autoclaves and compressors. In addition a health and safety self- assessment audit had been completed in January 2017. This had not generated an action plan.

A fire risk assessment had been completed by an external contractor on 26 January 2016 following the comprehensive inspection. This included a list of actions that were recommended to be completed within three months of the report. None of these had been recorded in the risk assessment as having been completed; however we were able to see that some of these had been implemented, where others had still not been addressed.

Examples of recommendations that had been completed included maintenance of the fixed electrical systems (which was completed in September 2016), and assembly points not detailed on fire action notices (notices we saw displayed had this information included).

Examples of recommendations that had not been addressed at the time of our follow up visit included; training of staff, no fire alarm system and no maintenance record for the emergency lighting system. Following the inspection we recived evidence that the practice were continuing to implement the recommendations of the risk assessment.

The practice had a policy on complaints, this had been reviewed in November 2016 and indicated that all complaints made to the practice were tracked and reported on a monthly basis so that head office retained oversight of the complaint activity for the practice. During our comprehensive inspection in January 2016 flaws in this system were recognised resulting in the information being held at head office not correlating with the information held in the practice. This was fed back to the practice manager and documented in the report of that visit.

During our follow up visit we were shown the complaints log held at head office, and the complaints folder held at the practice. We found evidence of a complaint that had been made to the practice which had not been reported to head office. We saw an acknowledgement letter that this complaint had been received, but the complaint letter and documentation of any action taken was missing. We asked the practice manager about this and they confirmed that the complaint had been dealt with, but couldn't account for the documentation being missing, and the fact that it had not been reported to head office.

Learning and improvement

Concerns were raised following our comprehensive inspection in January 2016 that the use of clinical audit by the practice to highlight areas of clinical practice which require improvement was largely ineffective. Following the inspection an action plan was sent to the CQC which highlighted how the provider intended to become compliant with regulation.

In respect of clinical audits; the action plan submitted by the provider indicated that infection control audits would be completed every six months (in line with national guidance) and clinical audits of X-ray quality and record keeping would also be completed for each dentist every six months.

We were shown one infection control audit that had been completed in the year preceding our inspection. This was dated 29 November 2016 and it had not generated an action plan for improvements. We compared this with the infection control audit that had been completed on 20 January 2016, just before our comprehensive inspection. The inspection report of the comprehensive visit indicated that certain questions in the audit had been answered incorrectly.

The audit from November 2016 answered those same questions incorrectly. These pertained to areas in the practice that were difficult to clean due to damage. We were able to see that these areas of damage had not been attended to and had not been identified by the infection

Are services well-led?

control audit. Therefore we could not be assured that effective systems were in place to assess, monitor and improve the infection control protocols and procedures at the practice.

Our comprehensive inspection in January 2016 highlighted that systems in place to audit the quality of X-rays taken at the practice were ineffective. Following our report the action plan submitted by the provider indicated that a new audit process would be completed for each clinician every six months and this would encompass record keeping as well as quality of X-rays.

During our follow up visit we asked to see these audits. We were shown a completed audit for one clinician. This was dated 14 March 2017. This was comprehensive and was carried out by a clinical manager in the group. We were told that the next stage to this was for the dentist to review the report and formulate their own action plan for improvement and then a re-audit would be carried out in three months; however these stages had not been completed at the time of our inspection.

A second clinician had undergone this audit process on 14 March 2017. In respect of the X-ray sections, these were largely populated with the acronym "NED" meaning not enough data. We reviewed the practice X-ray logs and saw that the clinician in question regularly took X-rays. The practice manager and compliance manager could not account for this.

The other two clinicians had not undergone the audit process, and no further audits in X-ray quality had been completed in the year preceding our visit. We could not therefore be assured that effective systems were in place to assess, monitor and improve the quality of X-rays taken at the practice.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The practice had not established an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. This included: · The provider was not able to effectively monitor complaints over time, looking for trends and areas of risk that may be addressed. · The provider had not maintained a record of all complaints, outcomes and actions taken in response to complaints. **Regulation 16 (2)**

This section is primarily information for the provider

Enforcement actions

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 How the regulation was not being met: The registered person did not have effective systems in place to ensure that the regulated activities at St Albans Dental Centre were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included: · There were not effective systems to assess, monitor and improve the quality and safety of the services provided. For example in infection control and radiography audits. **Regulation 17(1)**