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Dairyground Dental Practice

Inspection Report

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Overall summary

We undertook a follow-up focused inspection of Dairyground Dental Practice on 26 June 2019. 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 Dairyground Dental Practice on 3 October 2018 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 and well-led care and was in breach of regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We used our enforcement powers that required the provider to take action.

We carried out a follow-up inspection on 19 March 2019 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. We found that some improvements had been made, but further work was required to ensure that care was fully safe and well-led. The provider was required to take remedial action.

You can read our reports of these previous inspections by selecting the 'all reports' link for Dairyground Dental Practice on our website www.cqc.org.uk.

As part of this inspection we asked the following questions about care and treatment provided:

• 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. 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 not providing safe care in accordance with the relevant regulations.

The provider had made some improvements in relation to the regulatory breaches we found at our inspections of 3 October 2018 and 19 March 2019. We found that systems and processes to support safe working were not embedded.

Are services well-led?

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

Summary of findings

The provider had made some improvements in relation to the regulatory breaches we found at our inspections of 3 October 2018 and 19 March 2019 but had not done all that was necessary to meet the regulatory requirements.

Background

Dairyground Dental Practice is located in Bramhall, Stockport, Greater Manchester and provides NHS and some private treatment for adults and children.

The practice is not accessible for people who use wheelchairs and those with pushchairs due its access via a flight of stairs. Car parking spaces are available outside the practice, where the waiting time is limited to 90 minutes.

The dental team includes four dentists, two dental nurses, a locum dental nurse and a part-time receptionist. A practice manager works at the practice three days each week and also carries out reception duties. The practice has two treatment rooms.

The practice is owned by an individual who is the principal dentist at a sister practice. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

During the inspection we spoke with the provider, two dentists, one dental nurse, the receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open from 8.30am to 1pm and from 2pm to 5.30pm Monday to Thursday. On Friday the practice is open from 8.30am to 1pm.

Our key findings were:

- Staff carrying out work in the decontamination room, were using appropriate personal protection equipment.
- Staff were still not examining manually cleaned instruments, before moving them to the autoclave be processed.
- We found recommendations for infection control were not embedded. We found two buckets of dirty water with mops in them, in the small decontamination room, close to the 'clean area', designated for packaging of dental instruments.
- Management of Legionella and practises to support this, were still not understood or executed, as per the practice risk assessment. The provider lacked oversight or understanding of this.
- Although all recruitment checks on permanent staff were now up to date, assurance of all checks on locum staff were not in place.
- Oversight of staff training had improved.
- Radiation protection information was in place, with local rules available to staff for reference. Evidence of servicing and safety checks on all radiation equipment was available.
- Arrangements for review of the fire risk assessment were in place. We saw evidence that work had been carried out on the electrics at the practice to ensure these met required standards.
- There was still no effective way for receipt, circulation, discussion and confirmation of understanding, of medical alerts and updates on clinical guidance.
- Communication across the practice, and between the and provider and staff, was not effective.
- Quality assurance processes required further work. Audits we were shown, did not contribute to learning and were not reviewed and analysed to drive improvement.
- A Statement of Purpose had still not been submitted to the Care Quality Commission.
- Leadership remained insufficient.

We identified regulations the provider was not meeting. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We are taking regulatory action to impose conditions on the registration of the provider.

Full details of the regulations the provider is not meeting are at the end of this report.

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

- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found that this practice was not complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

We are taking regulatory action to impose conditions on the registration of the provider.

At our previous inspections on 3 October 2018 and 19 March 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 Warning Notices. At the inspection on 26 June 2019 we found the practice had made the following improvements to comply with the regulation:

- Staff were carrying out their duties safely, specifically in relation to using appropriate personal protective equipment.
- Checks were made to ensure staff had sufficient immunity to blood borne viruses, for example, Hepatitis B.
- All required recruitment checks in respect of permanent staff were now in place.
- Information on radiation protection was available for staff using and working with radiograph equipment. Evidence of servicing and safety testing was available.
- The fire risk assessment was planned for review on 10 July 2019. Electrical work had been carried out at the practice to ensure the mains electrical system was safe and met required standards.

The provider had made sufficient improvements to put right the shortfalls we had previously identified, in all but one area, in relation to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014:

Decontamination processes were still not embedded. We saw that staff were still not examining instruments following manual cleaning, before moving them to the autoclave for processing. Staff overseeing the decontamination process failed to demonstrate an awareness and understanding of HTM01-05.

We found that systems and processes to support safe working were not embedded. We identified the following areas of concern:

- We found recommendations for infection control were not embedded. We found two buckets of dirty water with mops standing in them, in the small decontamination room, close to the 'clean area', designated for clean dental instruments.
- We saw dental instruments for cleaning, left on the side of the sink in the decontamination room, which had become dry, rather than being kept damp or moist, in accordance with guidance.
- Management of Legionella and practises to support this, were still not understood or executed, as per the practice risk assessment. We found hot water temperatures had consistently been recorded at 47 and 48 degrees centigrade, rather than the minimum 50 degrees centigrade, as set out in the practice Legionella risk assessment. These readings were for the months of April, May and June 2019. This had not been acted on by the practice manager. The provider had no oversight of this.
- When asked about this, although the risk assessment for the management of Legionella was available in the practice, staff lacked understanding as to why it was important for water temperatures to be within the range set out in the risk assessment.
- When we checked the hot water cylinder that had been installed, it appeared that the old thermostat had not been replaced, and this had been linked to the new hot water cylinder. We reviewed the instruction manual that accompanied the hot water cylinder. Within the first few pages of the booklet, this set out clearly the temperature range for hot water delivery, and referred specifically, to NHS clinical settings. From discussions we had with the provider and staff, it was apparent that this booklet had not been read.
- During the inspection, we tested the temperature of the hot water, after running the tap for more than two minutes. The temperature was 35 degrees centigrade.
- Two of the permanent clinical staff confirmed that they were not receiving or being informed of, any clinical updates or safety alerts. We asked about one recent update, which staff were not aware of.
- We were shown a quality compliance system that staff had been signed up to. The dental nurse had an application for this on her own mobile phone. This delivered updates on training available for staff. It did

Are services safe?

not receive alerts from the Medicines and Health Products Regulatory Agency (MHRA), or updates on clinical guidance from National Institute of Health and Care Excellence (NICE).

- Safety alerts were not being received into the practice and shared to ensure all products and equipment is safe for use.
- Previously, we had found assurance of checks on locum staff required improvement. On the day of this inspection, there was a locum dental nurse working at the practice. We found checks had been carried out, but this did not include the professional indemnity of the locum. This was sent to the practice on request, whilst we were there.

Are services well-led?

Our findings

We found that this practice was not providing well-led care and was not complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

We are taking regulatory action to impose conditions on the registration of the provider.

At our previous inspections on 3 October 2018 and 19 March 2019 we judged the practice 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 Warning Notices. At the inspection on 26 June 2019 we found the practice had made the following improvements to comply with the regulation:

- Servicing of, and safety checks for all radiography equipment were in place.
- Local rules were in place, with a named Radiation Protection Advisor. The name of the Radiation Protection Supervisor needed adding to the rules.
- A radiation protection file was in place and staff could access this for reference.
- There was improved oversight of staff training and staff professional development.

The provider had not made sufficient improvements. We found the following areas of concern:

- Communication across the practice was not effective; protocols for the maintenance of infection prevention and control were not embedded and lacked effective oversight.
- Leadership was ineffective. There was no clinical leadership or oversight of the dentists.
- Understanding of and acting on risk, remained insufficient.
- There was insufficient evidence of steps to bring about quality improvement. Audits provided were not sufficient. They were not clinician specific and there was no analysis of radiographs taken.
- We saw that audit of antibiotic prescribing was a list of patients prescribed to, by whom, and the date of prescription. Staff did not have a protocol in place for the prescribing of antibiotics to refer to. There was no review of these prescriptions, against guidelines, to drive improvement.
- There was a lack of oversight by the provider, of work in the practice.
- There were no practice meetings held on a regular basis; we were told the last practice meeting had been in January 2019. The result of the last CQC follow-up inspection had not been shared amongst staff and copies of the report and enforcement actions had not been discussed with staff.
- The practice had still not submitted a Statement of Purpose to CQC as a requirement of their registration.
- A Statement of Purpose was available on the day of inspection, but staff were not aware of its purpose. It said the provider carried out domiciliary visits to patients. We asked about these, the circumstances of the visits and how they were conducted. We were told no risk assessments were in place; the provider told us they did not assess the need to take emergency equipment and emergency medicines. There was no protocol in place to follow for domiciliary visits, or information on whether a dental nurse would support the provider in carrying out these visits.

The provider had made insufficient improvements to put right the shortfalls identified and had not responded to the regulatory breaches we found at our previous inspections of 3 October 2018 and 19 March 2019.