Anitha Bangaru & Sergei Sonwabo Mda

Springs Dental Studio

Inspection Report

146 Yarm Road
Darlington
DL1 1XE
Tel: 01325 284808
Website: www.springsdental.co.uk

Date of inspection visit: 8 December 2017
Date of publication: 08/02/2018

Overall summary

We carried out this unannounced inspection on 8 December under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told the NHS England area team and Healthwatch that we were inspecting the practice. We did not receive any information of concern from them.

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

• Is it safe?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services well-led?

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

Background

Springs Dental Studio is in Darlington and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and pushchairs. Car parking spaces, including for patients with disabled badges, are available near the practice.

The dental team includes two practice owners, two dentists, four dental nurses, two dental hygienists and a receptionist.

The practice has three surgeries. Two on the ground floor and one on the first floor, a decontamination room for sterilising dental instruments, a staff room/kitchen and a general office.

The practice is owned by a partnership 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 Springs Dental Studio was one of the partners.

During the inspection we spoke with a dentist, two dental nurses, a dental hygienist, a receptionist and one of the practice owners. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Summary of findings

Monday, Tuesday, Wednesday and Friday 9am -5:30pm

Thursday 9am – 5pm

Saturdays for private patients 9am -12pm.

Our key findings were:

- The practice was generally clean and well maintained.
- The practice had infection control procedures which did not reflect published guidance.
- Staff knew how to deal with emergencies. The practice did not have all of the appropriate medicines and life-saving equipment available. We found some equipment had expired and not been disposed of.
- The practice had some systems to help them manage risk.
- The practice staff were not fully aware of their responsibility with regards reporting and sharing information of concern, including safeguarding.
- The practice did not have thorough staff recruitment procedures.
- The practice was not registered to receive medical device alerts from Medicines and Healthcare Products Regulatory Authority (MHRA).
- The practice did not have effective leadership.

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.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.

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?

No action

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

There was a system in place to report, record and analyse significant events and incidents. We were told of two events which could have been recorded as significant events. These had not been reported.

The practice was not registered to receive alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Immediate action was taken to address this.

Staff received training in safeguarding and there was safeguarding polices which were not up to date. Staff were not fully aware of their responsibilities with regards reporting and sharing information of concern.

The practice's risk management processes were not robust. We identified areas where risks to staff and patients safety had not been identified.

The practice had fire safety management systems in place. We found the emergency exit was partially blocked and a combustible COSHH item was stored by the exit.

The disposal process and security of clinical waste and items identified under Control of Substances Hazardous to Health (COSHH) were not always adhered to.

We found clinical waste which had not been segregated appropriately within the dental surgeries.

The recruitment process was not always consistent.

Management of medical emergencies and medical emergency equipment was not robust. Processes in place to check emergency medicines and equipment was not in line with recommended guidance.

The practice had infection control procedures in place which reflected out of date guidance. Staff did not follow the infection prevention and control policy with regards to the storage of instruments.

The practice had carried out a sharps risk assessment for needles but it did not include the steps taken to minimise the risk from other sharp instruments and devices including matrix bands and scales. We found the risk assessment was not always adhered to.

Are services well-led?

Requirements notice

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 section at the end of this report).

Summary of findings

The practice had minimal governance arrangements to ensure the smooth running of the service. Policies and procedures were not regularly reviewed and there was no evidence staff read and understood them.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. We found the X-ray audit had not been completed for over 12 months and was not clinician specific. The Infection prevention and control audit had no action plans or learning outcomes in place.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate and respond to accidents, incidents and significant events. We were told of two events which could have been recorded as significant events. These had not been reported.

The practice did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) within the past 12 months. We were told this would be addressed and a review of any alerts from the past 12 months would be reviewed.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that most staff received safeguarding training. Two members of staff training was out of date and there was no evidence to show if one other member of staff had completed training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. Information of concern was shared during the inspection and the registered manager took urgent action to report a safeguarding concern to the correct external agency who took immediate action.

The practice had a whistleblowing policy.

We looked at the practice's arrangements for safe dental care and treatment. There was a basic sharps risk assessment in place for the handling of needles but it did not include the risk from other sharp dental items such as matrix bands or scalpels. The risk assessment was not always enforced by the dentists.

The dentist told us they did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. Safety chains were used to help protect the patient's airways.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year.

Not all emergency equipment and medicines were available as described in recognised guidance. We found the medical oxygen cylinder was not the correct size to ensure sufficient medical oxygen could be given in the event of a medical emergency. A secondary dose of adrenaline was not available in the event of an allergic reaction and there were no needles and syringes available to administer the adrenaline.

We found all of the airways were not in bags and there were no dates to show if they had expired. Several expired drugs had not been removed from the medical emergency kit and new AED pads had not been fitted to the AED as staff did not know how to do this. As a result the AED pads in use had expired in 2015.

The checks of the equipment were completed monthly and not weekly as recommended by guidance. Emergency equipment and drugs were stored in a location which may cause a delay in the event of a medical emergency.

The glucagon was stored in a fridge but this was not temperature monitored. When we looked in the fridge it was dirty and contained food items, some of which were frozen.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We found this was not always followed when recruiting new staff. We looked at all staff recruitment files.

We found five of the clinical staff's medical indemnity certificates held by the practice were out of date and there was no method in place to check if staff were covered appropriately. We asked the staff who were working to provide evidence they were covered. This was actioned immediately and all staff provided supporting evidence to show they were in date.

Several staff GDC certificates were not in date and the registered manager could not ensure all staff were currently registered.

Are services safe?

DBS checks were not always completed at point of employment for staff. No risk assessment was in place to mitigate any risk this could pose.

One of the partners who would work at the practice occasionally did not have evidence of indemnity.

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were up to date and reviewed to help manage potential risk. These covered general workplace and specific dental topics. The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentists and dental therapists when they treated patients.

The practice had fire safety management systems in place. We found the emergency exit was partially blocked and a combustible COSHH item was stored by the exit.

Infection control

The practice had an infection prevention and control policy which referred to out of date guidance. They did not always follow guidance in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

We found staff had several systems which were inconsistent for reprocessing and storage of instruments with in the practice. We found significant numbers of instruments which were not bagged and were stored in damp containers. Numerous instrument were stored in bags which were not dated and bags which did have a date had exceeded their expiry date and had not been reprocessed.

We found the light and magnification was not routinely used and this was plugged in to an unsecured socket which could pose a risk to staff.

The disposal process, security of clinical waste and items identified under Control of Substances Hazardous to Health (COSHH) were not always adhered to. We found clinical waste was not always segregated effectively. We found amalgam capsules in the clinical waste bin during the inspection.

Staff completed infection prevention and control training.

The practice had arrangements for transporting instruments, we found some of the containers were not sturdy and were difficult to clean effectively.

There was inconsistent evidence all staff were appropriately immunised against Hepatitis B. For example, several members of staff could not provide evidence they had been fully immunised against hepatitis B. This was brought to the attention of the registered manger to action.

The practice carried out infection prevention and control audits twice a year. There was no action plans or learning outcomes in place.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The staff did not fully understand the daily requirements to purge the dental unit waterlines and hot and cold temperature records were not completed monthly as recommended by the risk assessment.

Equipment and medicines

We saw servicing documentation for the equipment used. Staff carried out checks in line with the manufacturers' recommendations.

There was no log in place to ensure prescriptions were recorded effectively and we found several pre stamped prescriptions.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

Clinical staff completed continuous professional development in respect of dental radiography, not all certificates for clinical staff were available during the inspection.

Are services well-led?

Our findings

Governance arrangements

The registered manager had overall responsibility for the management and clinical leadership of the practice. Staff knew the management arrangements and their roles and responsibilities.

The practice limited had governance arrangements in place. The policies and risk assessments we looked at, most had no evidence to show they had been reviewed and there was had no evidence staff had read and understood them. Some policies provided minimal information, were generic and had not been adapted to ensure they referred to up to date guidance. For example, infection prevention and control and staff recruitment.

Leadership, openness and transparency

Staff were not fully aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the registered manager encouraged them to raise any issues. We were told staff did not always feel confident they could do this.

The practice held meetings where staff could raise any concerns and discuss clinical and non-clinical updates. Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had some quality assurance processes to encourage learning and continuous improvement. The practice had not completed an X-ray audit since September 2016. The last audit was not clinician specific and there was no action plans or learning outcomes in place.

The practice carried out infection prevention and control audits twice a year. During the inspection we identified areas of improvement and this had not been incorporated in the latest audit. There was no action plans or learning outcomes in place.

The registered manager showed a commitment to learning. There was not a robust system to ensure staff were up to date with their training and development. The General Dental Council requires clinical staff to complete continuous professional development.

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 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met** • The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The registered person had not considered all reasonably practicable measures to reduce the risks associated with the safe use of sharps and fire management. The registered provider had not reported incidents, significant events when they had occurred. • There was no system in place to protect patients from harm in the event of using equipment or materials which had been recalled or identified not to use by the MHRA. • There was no effective process in place to mitigate the risk of cross infection • The registered person had a system in place to check emergency medicines and equipment to ensure the medicines and equipment were within their expiry dates and in working order but the checks failed to identify that a secondary dose of adrenaline was not available and the medical oxygen cylinder was not of sufficient size to administer the correct amount of oxygen. The AED pads had not been fitted and checks were logged to say the equipment was ready for use.

This section is primarily information for the provider

Requirement notices

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

- Reportable safeguarding concerns had not been identified and actioned.
- The registered person carried out infection control and prevention audits but these did not reflect the processes use on the practice and had not identified areas for improvement. No action plan or learning points were included.
- The X-ray audit had not been completed within the past 12 months was not clinician specific and did not have actions or learning outcomes in place.

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular • A full employment history was not sought for one member of staff. • A DBS check was not always completed on condition of employment. • References were not always gained.

This section is primarily information for the provider

Requirement notices

- The registered provider failed to ensure recruitment procedures were established and operated effectively in line with schedule 3.

Regulation 19 (1)