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Prescot House Dental Surgery

Inspection Report

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Overall summary

We carried out a follow up inspection on 18 October 2017 at Prescot House Dental Surgery.

On 22 March 2017 we undertook an announced comprehensive inspection of this service as part of our regulatory functions. During this inspection we found a breach of the legal requirements.

A copy of the report from our comprehensive inspection can be found by selecting the 'all reports' link for Prescot House Dental Surgery on our website at www.cqc.org.uk.

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. This report only covers our findings in relation to those requirements.

We revisited Prescot House Dental Surgery on 18 October 2017 to confirm whether they had followed their action plan, and to confirm that they now met the legal requirements in the Health and Social Care Act 2008 and associated regulations. We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We reviewed the practice against oneof the five questions we ask about services: is the service well-led?

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

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

Prescot House Dental Surgery is close to the centre of Prescot and provides dental care and treatment to adults and children on an NHS or privately funded basis.

There are steps at the front entrance to the practice with a handrail positioned alongside to assist patients with limited mobility. The provider has installed a ramp to facilitate access to the practice for wheelchair users. The practice has five treatment rooms. Car parking is available near the practice.

The dental team includes a principal dentist, four associate dentists, a dental hygienist and eight dental nurses, some of whom also carry out reception duties. The team is supported by a practice manager.

The practice is owned by a partnership and as a condition of registration must have in place a person registered with the Care Quality Commission as the registered manager. Registered managers have a legal responsibility

Summary of findings

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 Prescot House Dental Surgery is the practice manager.

The practice is open:

Monday, Tuesday, Thursday and Friday 9.00am to 5.30pm

Wednesday 9.00am to 8.00pm

Occasional Saturdays 9.00am to 1.00pm

Our key findings were:

- The practice had improved their infection control procedures.
- We found that the practice had reviewed their safeguarding and whistleblowing processes and made them specific to the practice.
- The practice had improved their procedure for dealing with complaints.
- The practice had systems in place in relation to recruitment, medical emergencies, stock control of dental materials, and training. We found these were not operating effectively and had not been improved since our initial inspection.
- We found not all risks were appropriately managed particularly in relation to the Hepatitis B immunisation status of the clinical staff.

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 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 and should:

- Review the practice's protocols in relation to the use of closed circuit television to ensure staff and patients are fully informed as to its purpose and their right to access footage.
- Review the practice's audit protocols of various aspects of the service such as radiography to help improve the quality of service. The practice should also ensure all audits have documented learning points, where relevant, and the resulting improvements can be demonstrated.

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 section at the end of this report).

After the initial inspection on 22 March 2017 the practice submitted an action plan outlining improvements which had been made and improvements which were planned, to demonstrate compliance. At the follow-up inspection on 18 October 2017 we found that not all these improvements had been made.

The practice had systems and processes in place for assessing, monitoring and improving the quality and safety of the services provided for patients. We found at our initial inspection that not all of these were operating effectively.

At the follow-up inspection we found that the provider had improved infection control procedures. Systems relating to recruitment, medical emergency medicines and the monitoring of the expiry dates of dental and medical materials and equipment were not operating effectively.

The practice had improved their complaints procedure.

We found that safeguarding and whistleblowing procedures now took into account arrangements in place at the practice.

The provider had arrangements in place to help them manage risks at the practice. We found that the risks relating to staff vaccinations had not been effectively addressed.

Requirements notice ✖

Are services well-led?

Our findings

Governance arrangements

At our comprehensive inspection on 22 March 2017 we found that the provider did not have effective systems in place to ensure that the regulated activities at Prescot House Dental Surgery were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our follow-up inspection we reviewed the provider's systems and processes for assessing, monitoring and improving the quality and safety of the services provided for patients.

We reviewed the practice's safeguarding policy and whistleblowing policy and found these now specifically reflected the practice's circumstances.

The practice's systems relating to infection control had been improved and were operating more effectively.

We found the systems in relation to recruitment were not operating effectively. The practice had recruitment procedures in place which did not reflect all the requirements of the legislation.

- The practice had recruited three members of clinical staff within the previous six weeks. We reviewed their recruitment records. The provider told us they requested new staff to provide evidence of a Disclosure and Barring Services, (DBS) check. We observed that the DBS checks for one of these staff had been carried out recently, the other was carried out four years previously, and a DBS application had been submitted two weeks ago for the third member of staff.
- The provider told us that the required pre-employment documents and certificates were checked at the interview stage and on the employee's first day. We saw that the practice did not have evidence available of qualifications for two of the recently recruited staff, and photographic identification for two of the recently recruited staff. After the inspection the provider submitted details of identification checks and qualifications for the recently recruited staff.

We found the systems in relation to medical emergencies were not operating effectively.

- The practice manager informed us that the automated external defibrillator, AED, was checked daily but no records were kept of this.
- The practice had a number of medical emergency medicines and items of medical emergency equipment stored in several locations in one of the treatment rooms. Not all the staff we spoke to were clear about where the medical emergency kit was located.
- The practice manager informed us that checks were carried out on the medical emergency medicines and equipment. We saw records of these checks. Not all the items of medical emergency medicines and equipment were recorded on the checklist for staff to check, for example, the AED, some of the midazolam, and one of the adrenaline auto injectors.

We found that the processes for monitoring staff training and continuing professional development, (CPD), were not operating effectively. We observed that dental professionals' CPD and training was not routinely monitored by the practice to ensure they were meeting the requirements of their professional registration and completing recommended training.

- The provider told us that, where relevant, safeguarding, medical emergencies and life support, infection control, and radiology CPD had been checked for the three recently recruited staff. We observed that the practice did not have evidence available as to when this training had been completed, except in relation to medical emergencies and life support for one of these staff. After the inspection the provider submitted evidence that the recently recruited staff had carried out all this training.
- We saw that the practice maintained a log of training dates for the dental nurses' safeguarding training. We observed the training was to a lower level than recommended in guidelines. The provider was unsure whether training to the recommended level had been completed.
- We found that not all staff were clear on the principles and practical application of the Mental Capacity Act in relation to patient consent.
- At our initial inspection in March 2017 we found that one of the staff with a lead role for infection prevention and control had not completed relevant training in this since

Are services well-led?

2015 and no evidence of training was available for the other. We observed both these staff had arranged to attend an infection prevention and control course in February 2018.

We found that systems for monitoring of the expiry dates of dental materials were not operating effectively. The lead member of staff with responsibility for stock control was unsure what systems were in place to check the expiry dates of these items in all the treatment rooms.

The practice had arrangements in place for assessing, monitoring and mitigating risks at the practice. We found the arrangements in relation to staff Hepatitis B immunity were not operating effectively. The provider required clinical staff to have received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and to provide evidence of the effectiveness of the vaccination.

The practice had evidence of Hepatitis B immunisation for all three staff but no evidence of its effectiveness for two of these staff. We observed that no risk assessment was in place for these two staff in relation to them working in a clinical environment where their immunity status was unknown. After the inspection the provider submitted appropriate risk assessments for these two staff.

We observed that the practice now had information available about organisations patients could contact should they not wish to complain to the practice directly or if they were not satisfied with the way the practice dealt with their concerns.

The practice had installed a closed circuit television system, (CCTV), in the reception, waiting room, records room and one of the staff rooms. We saw that the practice had not displayed any notices informing patients and staff for what purpose the CCTV was in use and to make them aware of their right of access to footage which contains their images.

Leadership, openness and transparency

The principal dentist had overall responsibility for the clinical leadership of the practice. The practice manager was responsible for the management and day to day running of the service.

The practice held meetings where staff could communicate information, exchange ideas and discuss updates. Staff we spoke to told us they were aware of the practice's updated safeguarding and whistleblowing policies as these had been discussed at staff meetings and during inductions for the newly recruited staff.

Learning and improvement

The practice had limited quality assurance processes in place to encourage learning and continuous improvement, for example, by carrying out clinical and non-clinical audits. The practice carried out audits of infection prevention and control but had not carried out any other audits together. The provider assured us these would be introduced now the practice had a full complement of staff.

The provider assured us that staff appraisals would be introduced in the near future to help identify individual learning needs and monitor training.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a system in place to seek the views of patients about all areas of service delivery through the use of the NHS Friends and Family Test. We observed that the practice did not communicate the results from patient feedback to patients.

The practice gathered feedback from staff through meetings and informal discussions.

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 were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Not all the medical emergency medicines and equipment items were recorded on the practice's checklist, or checked within the recommended timescales, including the automated external defibrillator and the adrenaline auto injectors. • Not all staff were familiar with where the practice's medical emergency kit was located. • The provider did not have an effective system in place to monitor staff training, including the dentists' training, to ensure all were supported to meet the requirements of their professional regulator, where relevant. • Not all the dental nurses and dentists were clear about the principles and practical application of the Mental Capacity Act 2005 in relation to patient consent. • The provider did not have an effective system in place to monitor dental materials to ensure that they, including those in the treatment rooms, were within their expiry dates.

This section is primarily information for the provider

Requirement notices

The registered person had systems or processes in place that were operating 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

- The provider did not have effective arrangements in place to ensure the Hepatitis B vaccination and immunity status of all clinical staff was assessed, monitored and mitigated.

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 Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons **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: • The provider's recruitment procedures did not ensure that photographic identification, and a recent Disclosure and Barring Service check where appropriate, was obtained from potential employees prior to employment, in accordance with Schedule 3 to the Regulations. The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular: • The provider's recruitment procedures did not ensure evidence of qualifications, where relevant, was obtained from potential employees in accordance with Schedule 3 to the Regulations.

This section is primarily information for the provider

Requirement notices

Regulation 19 (1) and (2)

Fit and proper persons employed

How the regulation was not being met

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- The provider did not have the information required by Schedule 3 available for three recently recruited staff.

Regulation 19 (3)