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# Dairyground Dental Practice

## Inspection Report

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## Overall summary

We undertook a follow-up inspection of Dairyground Dental Practice on 19 March 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 4 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. You can read our report of that inspection by selecting the 'all reports' link for Dairyground Dental Practice on our website www.cqc.org.uk.

As part of this inspection we asked:

- 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 is 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 several improvements in relation to the regulatory breaches we found at our inspection on 4 October 2018 but these did not fully address the shortfalls identified.

**Are services well-led?**

We found this practice was not providing well-led care in accordance with the relevant regulations. The provider had made some improvements in relation to the regulatory breaches we found at our inspection on 4 October 2018 but these did not fully address the shortfalls identified.

**Background**

Dairyground Dental Practice is in the village of Bramhall, close to Stockport, Greater Manchester, and provides NHS and some private treatment for adults and children.

# Summary of findings

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, one employed dental nurse, 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 one dentist, two dental nurses, 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 8.30 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:**

- The practice was visibly clean.
- There were some improvements in infection control procedures, but further work was required to ensure staff followed recognised guidance.
- There was a lack of oversight of work in the decontamination room; staff were not working in-line with recognised guidance.
- There was still no radiation protection file in place for staff to refer to. We found that recommended rectangular collimators were still not in use. The last service check on equipment, which is carried out every three years, had expired in 2017.
- Staff demonstrated that they understood their responsibilities for safeguarding vulnerable adults and children. All staff had received training to the required level and information on local area contacts was available to staff.
- We found records in relation to staff and recruitment were still incomplete.
- No changes had been made since our last inspection, in relation to protecting privacy of patients in particular, in relation to the mail received at the practice.
- Practice leadership had not improved. Staff were not fully supported when trying to bring about improvements required.
- There was no focus on improvement, for example, through audit.
- Improvements made in relation to information governance were insufficient.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure that only fit and proper persons are employed.

**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's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.
- Review staff awareness of the requirements of the Mental Capacity Act 2005 and Gillick competence, and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the fire safety risk assessment and ensure that any actions required are complete and ongoing fire safety management is effective.
- Review the practice's protocols for medicines management including the prescribing of antibiotics to ensure this is in line with current guidance.

# 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** 

We found that this practice was not providing safe 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 found the practice had made the following improvements to comply with the regulations:

- A new hot water immersion heater had been installed, providing staff with running hot water.
- The practice appeared clean. Parts of the building, for example, the decontamination room and front door had been repainted.
- Cleaning schedules for environmental cleaning were available for staff to follow.
- A new autoclave had been purchased and was in use in the decontamination room.
- Clinical waste was being stored appropriately.

The provider had not fully met the terms of the Warning Notices issued in respect of safe care and treatment and recruitment of fit and proper persons. Further improvements were required.

- The practice did not have effective systems and processes to provide safe care and treatment.
- Evidence of required recruitment checks on staff was still not in place. For two clinicians there was still no evidence of immunity to Hepatitis B. For locum staff, copies of essential recruitment checks were not held.
- There was still no radiation protection file in place for staff to refer to.
- For radiography equipment, there was no evidence of a three yearly technical check by a competent person.
- Although fire extinguishers and smoke detectors were checked and serviced, there was no evidence of review of the fire risk assessment, which we drew to the attention of the provider at our last inspection.
- Staff were not using appropriate personal protective equipment when carrying out decontamination work. Work carried out in the decontamination room did not reflect recognised guidance.

**Are services well-led?**

**Enforcement action** 

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).

Some improvements had been made.

# Summary of findings

- Record keeping in respect of patients was good; we saw that alerts were being used to highlight any vulnerable patients or those that may require longer appointments due to their circumstances or medical conditions.
- A whistleblowing policy was in place. Other policies had been updated, for example, in relation to safeguarding of children and vulnerable adults. Staff had access to up-to-date contact details for local safeguarding teams.
- Management and storage of NHS prescription pads had improved.
- There was a risk assessment in place to support the dental hygienist who worked alone.
- Oversight of environmental cleaning duties had improved, and staff had access to cleaning products and appropriate information in relation to Control of Substances Hazardous to Health (COSHH).

The provider had not fully met the terms of the Warning Notice issued in respect of well-led care and treatment. Further improvements were required.

- Management, governance and oversight of processes in the practice remain insufficient. This included:
- oversight of decontamination processes;
- the management of audits and recording of learning points and actions required. Antibiotic prescribing appeared to be higher than expected for a practice of this size.
- The management of safety and risk.
- Maintenance of recruitment records and confirmation that essential recruitment checks were completed.
- Incoming post was still being left on the floor of the entrance to the building, at the foot of the stairs. There was no security of post arriving at the practice.
- Communication of essential processes and management of these.
- No statement of purpose submitted to CQC as required

# Are services safe?

## Our findings

At our previous inspection on 4 October 2018 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 a Requirement Notice and a two Warning Notices.

At the inspection on 19 March 2019 we found the practice had made the following improvements to comply with the regulations:

- A new hot water immersion heater had been installed, providing staff with running hot water.
- The practice appeared clean. Parts of the building, for example, the decontamination room and front door had been repainted.
- Cleaning schedules for environmental cleaning were available for staff to follow.
- A new autoclave had been purchased and was in use in the decontamination room.
- Clinical waste was being stored appropriately.

However, we found other areas identified as requiring attention at our last inspection, had not been addressed.

The practice did not have effective systems and processes to provide safe care and treatment.

Although a new immersion heater provided running hot water, no hot water testing had been introduced to ensure water was stored at the required temperature, as required in support of the Legionella risk assessment.

When we reviewed cleaning at the practice, we saw that cleaning schedules for environmental cleaning were available for staff to follow. The practice appeared cleaner than at our last inspection. Staff had received training on the cleaning products in use.

There was no reliable system in place for the safe receipt of post to the practice, including patient related correspondence. This was reported following our last inspection. On the day we inspected, we found a padded envelope containing scalers used in dental treatment, left on the floor of the hallway. Staff confirmed that post and deliveries were not brought into the practice and there was no plan to fit a secure letter box.

Some improvement had been made in the record keeping in respect of staff and recruitment, however, evidence of all required checks on staff was still not in place. For example, in the case of one staff member, the evidence of indemnity held was out of date (expired November 2018). Evidence of registration with the General Dental Council (GDC) for this staff member was also out of date. There was no evidence of immunity to Hepatitis B. There was no risk assessment in place in respect of this. For staff member A, there was no evidence of up to date registration with the GDC and no evidence of immunity to Hepatitis B. Again, there was no risk assessment in place in respect of this. The documentation for both these staff members was referred to in our Warning Notice, issued following our inspection of October 2018.

For locum staff, copies of essential recruitment checks were not held. When these were requested from the locum agency, all required documents were not available.

At our inspection of October 2018, we recorded that staff did not have radiation protection information available to refer to, for example, a radiation protection file. This was still the case at our follow-up inspection on 19 March 2019. At our inspection in October 2018, we recorded that staff told us they could not evidence of technical servicing and testing of radiation equipment; the last testing certificate expired in 2017. These certificates were still unavailable for the purposes of this inspection. There was no evidence of these checks by a competent person.

We observed staff cleaning dental instruments in the decontamination room. We noted that appropriate personal protection equipment was not being used, for example, apron and safety glasses. Instruments were hand scrubbed under running cold water, rather than in a basin of water at the appropriate temperature for use with a cleaning product. These were not inspected using a magnifying glass, post washing, before being placed in the autoclave. We noted that the staff member did not wash their hands following this work. Hand washing gel was available but placed on a shelf away from the sink.

When we observed the autoclave, it appeared to be leaking, even though it was new. The worksurface the autoclave was placed on was wet and equipment stored below the workbench was wet.

Staff did not demonstrate awareness of, and compliance with, recognised guidance for work in a decontamination room, and infection control in a clinical setting. For example, there was a log book for testing of the autoclave.

# Are services safe?

Validation checks on the autoclave were not carried out consistently. Not all instruments that had been bagged, had been date stamped. We saw new matrix bands stored adjacent to the dirty area of the decontamination room, and these were uncovered. There was a lack of oversight of work and checks in the decontamination room. We were told that when the practice manager was not in, these checks were often missed.

The fire risk assessment had not been reviewed since September 2013, which we reported at our last inspection.

These improvements fell short of those required to fully meet the terms of the Warning Notice issued.

# Are services well-led?

## Our findings

At our previous inspection on 4 October 2018 we judged the provider 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 Notice. At the follow-up inspection on 19 March 2019 we found the practice had made some improvements but that these were insufficient to meet the terms of the Warning Notice issued.

- Record keeping in respect of patients was good; we saw that alerts to highlight any vulnerable patients or those that may require longer appointments due to their circumstances or medical conditions, were being used appropriately by staff.
- A whistleblowing policy was in place. Other policies had been updated, for example, in relation to safeguarding of children and vulnerable adults. Staff had access to up-to-date contact details for local safeguarding teams.
- Management and storage of NHS prescription pads had improved.
- There was a risk assessment in place to support the dental hygienist who worked alone.
- Oversight of environmental cleaning duties had improved, and staff had access to cleaning products and appropriate information in relation to Control of Substances Hazardous to Health (COSHH).

Some areas identified at our last inspection had not been fully addressed.

The provider did not have established systems or processes which operate effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient governance and oversight in place to ensure that all tasks were being carried out to the required standard. The practice was not carrying out audits, for example, in radiography. There was no meaningful antibiotic audit in place. Paperwork we were shown listed the date, name of patient and dose of antibiotic prescribed but lacked learning points or review to ensure that each case of prescribing followed current recognised guidance and was appropriate. Infection control audits in place remained ineffective, in that they failed to identify lack of adherence to recognised guidance in the cleaning of instruments, and management of processes within a decontamination room.

The provider had not addressed the absence of radiation protection information for staff to refer to. There was no radiation protection file in place. There was no effective system in place to ensure that evidence of staff checks was held in practice records, and that these were updated, for example, when a clinicians indemnity policy had expired, and evidence of renewal of this and their on-going professional registration. Oversight of the continuous professional development (CPD) of clinicians and of highly recommended training for all staff, was poor. For example, the practice could not show us evidence of training of staff in the Mental Capacity Act for two of the clinicians. When asked questions on consent and the Mental Capacity Act, staff struggled to answer these correctly. There was evidence of required IR(ME)R training for one dentist and one hygienist only; evidence of up-to-date training on radiography was not available for one of the dentists. The practice could not demonstrate they maintained oversight of clinicians CPD.

Communication at the practice was not effective. The last practice meeting had been held in January 2019. This covered an element of staff training, including training on the Control Of Substances Hazardous to Health (COSHH). There was no frequency of meetings, or meeting agenda framework which allowed for discussion of any safety alerts, for example from the Medicines and Healthcare Products Regulatory Agency, (MHRA), or updates to National Institute of Health and Care Excellence (NICE) guidance, or any other clinical updates that need to be shared and discussed. When we asked staff, they told us engagement with the provider was minimal. Staff were not fully supported to deliver their duties.

There was still no Statement of Purpose submitted from the provider.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met:<br>The practice did not have effective systems and processes in place to provide safe care and treatment. In particular:<br>• Staff were not carrying out their duties in a safe way or doing all that was reasonably practicable to minimise risk.<br>• When we observed staff carrying out decontamination work, we saw this was done without the use of personal protective equipment, even though these items were available. The staff member we observed did not wash their hands when they finished this work.<br>• Staff performing duties in the decontamination room did not carry out this work in accordance with recognised guidance. Staff observed failed to demonstrate an awareness and understanding of HTM01-05.<br>• There was inconsistent evidence of checks made to confirm the immunity status for Hepatitis B, for three permanent staff members and for two recently employed temporary staff. There was no risk assessment in place in respect of this.<br>Regulation 12(1)(2) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 HSCA (RA) Regulations 2014.<br>Good governance. |

This section is primarily information for the provider

# Enforcement actions

There were insufficient systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There was insufficient oversight and governance of work carried out in the decontamination process. Validation checks, for the autoclave at the start of each session were not carried out consistently.
- The registered person failed to ensure staff who completed infection control audits at the practice, had an understanding of guidance relevant for the running of a decontamination room, for example, Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05), published by the Department of Health. Infection prevention and control audits carried out were ineffective as they failed to highlight the issues we found during this follow-up inspection of the practice.
- Our observation of staff performing decontamination duties on the day of inspection confirmed their lack of understanding of recognised guidance.
- The registered person failed to ensure three yearly checks on radiography equipment were completed.

- There was no radiation protection file available to staff using X-ray equipment, or documents available with information on the safe use of this equipment.
- The registered person had failed to carry out audits of radiography.
- The registered person failed to ensure there was an effective system to monitor that staff were up to date with, and had received, appropriate training and development in line with the General Dental Council.
- The registered person has failed to submit a Statement of Purpose to the Care Quality Commission.

Regulation 17(1)

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>• Recruitment procedures were not established or operated effectively. The information specified in Schedule 3 was not available for each person employed.<br>• There was insufficient assurance provided that all required recruitment checks had been completed for locum nurses who worked at the practice in from January to March 2019.<br>• The registered person did not have effective systems in place to ensure all staff had appropriate medical indemnity cover and that evidence of checks on current professional registrations were held.<br>Regulation 19(2)(3) |