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Abbeyside Dental Practice

Inspection Report

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Overall summary

We undertook a follow up focused inspection of Abbeyside dental practice on 9 January 2020. 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 dental practice adviser from NHS England.

We undertook a comprehensive inspection of Abbeyside dental practice on 16 July 2019 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 or 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 Abbeyside 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 (requirement notice only). We then inspect again after a reasonable interval, focusing on the area(s) where improvement was required.

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 16 July 2019.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded adequately to the regulatory breach we found at our inspection on 16 July 2019.

Background

Abbeyside dental practice is in Stoke on Trent and provides NHS and private treatment to adults and children.

Summary of findings

The entire practice is situated on the first floor and there is no level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available immediately outside the practice in their own car park.

The dental team includes one dentist, two dental nurses (who are also the practice managers), two trainee dental nurses and one receptionist. One dental nurse was on a period of extended leave at the time of our visit. The practice has two treatment rooms and a separate room for carrying out decontamination.

The practice is owned by an individual who is the principal dentist there. 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 dentist and two dental nurses (who were the practice managers). We looked at practice policies and procedures and other records about how the service is managed.

The practice is open between 9am and 5pm from Monday to Friday.

Our key findings were:

- Improvements were made in areas such as the servicing of equipment, electrical safety, staff training, fire safety, and the introduction of some policies.
- The provider had taken action to address some of the issues that we identified at our previous inspection. However, there were significant delays associated with resolving some of these issues.
- Many shortfalls remained and had not been resolved. These related to areas such as audits, evidence of immunisation status for clinical staff and recruitment processes.

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.

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

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

- Implement 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?	**No action**
Are services well-led?	**Requirements notice**

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At our previous inspection on 16 July 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 requirement notice. At the inspection on 9 January 2020 we found the practice had made the following improvements to comply with the regulation(s):

- The service for the pressure vessel had been completed in September 2019.
- The equipment used for developing X-rays had been serviced in July 2019.
- Staff were now carrying out validation tests for each autoclave cycle in line with guidance. We saw records of these which showed that these tests had been consistently completed for several months.
- We saw evidence that staff had been carrying out the recommended quarterly validation tests for the ultrasonic cleaning bath. The due dates had been added to the practice planner to ensure that this was not overlooked.
- A gas safety inspection had been carried out on 19/07/19 and it met safety requirements.
- We saw evidence that the provider and two dental nurses had completed training in the safeguarding of children and vulnerable adults to the recommended level. The practice managers told us that the dental nurse on extended leave will complete this training upon their return to work. The two trainee dental nurses had received training during their induction; however, this was not logged anywhere as it was a verbal induction.
- The dentist had updated their training in the management of medical emergencies.
- The dentist demonstrated good knowledge of the Local Safety Standards for Invasive Procedures to prevent wrong site surgery.
- Staff had contacted a fire safety officer regarding the installation of fire alarms and smoke detectors at the practice. There was no evidence that these had been fitted at the time of our visit on 9 January 2020. However, the practice manager contacted us shortly after this visit to inform us that smoke detectors, emergency lighting and fire alarms had all been installed.
- An electrical safety inspection had been carried out at the practice on 11 December 2019. The report concluded that the fixed wiring was unsatisfactory and recommended 'urgent' and 'immediate' actions. At the time of our visit on 9 January 2020, these had not yet been completed. Staff explained that the electrician had advised that the practice would need to close for two days to enable them to complete these actions. Staff did not want to disrupt the service to their patients so these actions remained incomplete. Following our inspection, the practice manager informed us that all electrical work had been completed during the week after our visit. We requested evidence of this from the practice but the practice manager explained that the paperwork was not available as it was held by the landlord of the premises.

The provider had also made further improvements:

- The safeguarding policy was now comprehensive and included necessary information. It was undated but the folder itself had a date and staff told us it would be reviewed annually.
- The sharps injury protocol was displayed in the decontamination room and it included the contact details for the Occupational Health department.
- Staff had made the necessary changes to improve the tracking of the NHS prescription pads.
- Clinical waste was now stored in a locked room. Staff told us they were in the process of buying a secure clinical waste bin. Currently, the bags were tied and stored in cardboard boxes.
- Staff we spoke with were now aware of the Reporting of Injuries, Diseases and Dangerous Occurrences regulation. However, they were unable to locate a policy or written information about it within the practice.

However, we identified that further improvements were required in the following areas: -

- Although staff were completing the quarterly validation tests on the ultrasonic cleaning bath in line with guidance, they had not been regularly completing the weekly protein tests. Staff told us they thought that these tests also needed to be completed on a quarterly basis but it is weekly. Following our visit on 9 January

Are services safe?

2020, the practice manager informed us that their policy had been adjusted and that all staff had been informed that this test is to be completed weekly. They told us that this had been implemented with immediate effect.

- There were no data sheets and some risk assessments were missing for the control of substances hazardous to health. The practice manager initially told us that this will be completed by July 2020. However, they informed us several weeks after our visit that this was now approximately 90% complete. They explained that data sheets were now present for all dental materials in the practice and they had started compiling risk assessments too.
- Shortfalls remained in the practice's recruitment procedures. Several recruitment checks were missing from staff files, such as references, Disclosure and Barring Service (DBS) checks and photographic identity verification documents. Staff told us that the DBS documents had been reviewed but they were unable to access these on the day of our visit. Following our visit, the practice manager informed us that the photographic identity verification documents were now present for all staff members. However, they were still waiting for one DBS check. A recruitment policy had been compiled but it did not include any information about DBS checks.
- The immunisation status to Hepatitis B had not been confirmed for one clinical staff member. We contacted the practice after our visit and staff told us that a risk assessment had been completed as they were unable to confirm the member's immunisation status. We were told that they were awaiting confirmation of blood titre levels to confirm immunity. A second staff member had not yet completed their course of immunisations for Hepatitis B and expected to complete this in April 2020.
- The fire risk assessment had not been reviewed since 2010 although several actions had been taken to mitigate fire risk since our visit.
- We saw evidence that staff were now checking the fridge temperature daily as one emergency medicine was refrigerated. We reviewed the temperatures and found that they had exceeded the maximum temperature range recommended by the manufacturer. The fridge temperature must not exceed 8°C but we saw that temperatures of up to 19°C had been recorded. Staff were unaware of the recommended temperature range for the medicine. After our inspection, staff informed us that the medicine had been replaced and that staff were aware of the temperature range that must be maintained.

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 Requirement Notices section at the end of this report).

At our previous inspection on 16 July 2019 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 requirement notice. At the inspection on 9 January 2020 we found the practice had made some improvements:

- Staff had completed an infection control audit on 6 December 2019. This was detailed and included learning outcomes and an action plan.
- Staff had completed X-ray audits in September 2019. There was a brief analysis for these but no learning outcomes were evident.
- The medical emergency equipment and medicines were now being checked weekly which is in line with guidance. However, improvements were required relating to the details recorded on the weekly checklists as they did not list individual items of equipment.
- Staff had implemented cleaning schedules for non-clinical areas of the practice.
- Staff had made arrangements to receive and respond to patient safety alerts, recalls ad rapid response reports. We saw evidence that they had subscribed to MHRA (Medicines and Healthcare products Regulatory Agency) and the practice manager checked emails daily so that any urgent information could be shared with the rest of the dental team swiftly.
- We saw evidence that staff had implemented an effective system for recording, investigating and reviewing incidents and significant events with a view to preventing further occurrences. We reviewed three documented incidents that had taken place in the previous four weeks.
- We reviewed a selection of practice policies and found that they had review dates on them. At our previous inspection we had found undated policies and risk assessments.
- The clinical chair was free from defects in the upholstery which would have made effective cleaning difficult. There were two treatment rooms in the practice and only one was used to treat patients so staff swapped the clinical chairs. The chair with the defective upholstery was placed in the treatment room that was not used for any clinical activities. Staff informed us that this chair will be repaired if the treatment room is used in future for clinical activities.
- We reviewed the risk assessment for handling sharp instruments and found that it now included a list of specific sharp instruments.

The provider had also made further improvements: -

- We spoke with the provider and they were now aware of the Duty of Candour regulation.
- We saw evidence of a structured induction programme that would be used when new staff are to be recruited at the practice. No new staff had been recruited since our previous inspection so there was no evidence of completed induction programmes.
- Staff's personal development records were available at the practice. We reviewed a selection of records and were assured that clinical staff completed the continuing professional development required for their registration with the General Dental Council.
- We spoke with staff about Closed Circuit Television (CCTV) at the practice. At our previous inspection, staff informed us that the landlord had installed CCTV to improve security for patients and staff. We were told that one camera was positioned to film the rear car park. However, during this inspection, staff told us that the camera had never been active. Staff were aware that CCTV signage would need to be displayed if CCTV became active.

We noted that the provider had failed to take action to address the following: -

- Staff training, learning and development needs had not been formally reviewed and an effective process for the ongoing assessment and supervision of all staff had not yet been implemented. Staff showed us the templates that they would use to capture this information through a formal appraisal. They planned to commence these in April 2020. In the meantime, we saw that staff had completed training in core areas such as infection control and safeguarding children and vulnerable adults.
- No antibiotic prescribing audits had been carried out.
- Dental record keeping audits were being completed at least annually at the practice. We reviewed audits from

Are services well-led?

March 2019 and November 2019. Action plans were compiled and learning outcomes were identified. However, actions were not implemented as further audits showed that specific areas had not improved. Overall, we noted that some improvements in the record keeping were required.

- A disability access audit had not been completed.
- There were significant delays in completing some actions that were listed on the requirement notice in July 2019. We raised concerns regarding fire safety and no action had been taken until December 2019 which was five months after our visit. The electrical safety inspection had not been scheduled until December 2019. This inspection highlighted that some urgent and immediate action was required but this was not completed until five weeks later.
- Staff were completing validation tests on the ultrasonic cleaning bath on a quarterly basis as they were not aware that these tests should be carried out weekly.
- Some data sheets and risk assessments were missing for the control of substances hazardous to health.
- Staff were unable to locate a policy about the Reporting of Injuries, Diseases and Dangerous Occurrences regulation.
- Shortfalls remained in the practice's recruitment procedures.
- The immunisation status had not been confirmed for one clinical staff member.
- Staff knowledge about the temperature parameters for the refrigeration of one emergency medicine required improvement.
- The fire risk assessment had not been reviewed since 2010.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 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 improve the quality and safety of the services being provided. In particular: · Audits were being carried out but they did not all have documented learning points. The resulting improvements could not be consistently demonstrated. 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:

This section is primarily information for the provider

Requirement notices

· Significant delays were encountered when resolving actions that were highlighted at the previous inspection. These related to fire and electrical safety.

· Validation tests for the ultrasonic cleaning bath were not in line with guidance.

· The data sheets and risk assessments were incomplete for the control of substances hazardous to health.

· There was no evidence of immunity to the Hepatitis B virus for one staff member.

· The processes for checking the medicines for medical emergencies were not effective as medicines were stored at the incorrect temperature.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

· The practice did not hold all essential recruitment checks for staff. The provider failed to ensure that essential pre-recruitment checks such as valid DBS checks and photographic identity verification documents were in place.

There was additional evidence of poor governance. In particular:

· Staff training, learning and development needs were not reviewed at appropriate intervals and there was no effective process for the ongoing assessment and supervision of all staff employed.

· A disability access audit had not been completed.

This section is primarily information for the provider

Requirement notices

Regulation 17(1)