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N Bloom & Associates - Bridlington Road

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of this practice on 24 June 2015. Breaches of legal requirements were found. The practice was visited again on 22 July 2015 to confirm that improvements were underway. After the comprehensive inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for N Bloom & Associates - Bridlington Road on our website at www.cqc.org.uk

Our findings were:

Are services safe?

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

Are services effective?

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

Are services responsive?

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

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

N Bloom & Associates - Bridlington Road is a dental practice in the Oxhey area of Watford, Hertfordshire.

The practice has three treatment rooms, a waiting area, and a multi-purpose room which houses X-ray machines and an autoclave (to sterilise dental instruments). It provides NHS and private treatment to adults and children.

The CQC inspected the practice on 24 June 2015 and again on 22 July 2015 and asked the provider to make improvements regarding safeguarding of vulnerable adults and children, infection control, safe use of X-rays, recognising and mitigating risk, supervision and training of staff, clinical audit, underperformance process and patient and staff feedback.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Our key findings were:

- The practice met the essential standards in infection control and cleanliness documented in the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05).
- All X-ray equipment had been serviced and tested in line with Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) 2000.
- The practice had policies in place to aid the smooth running of the service, these were readily available for staff to reference, and in some cases were displayed in staff areas of the practice.
- Staff recruitment procedures met the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Clinical and non- clinical audit was used to highlight areas of practice that could be improved.

There were areas where the provider could make improvements and should:

- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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?

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

The practice had implemented systems and processes for safeguarding vulnerable adults and child protection. Staff and undertaken training, and contact numbers for raising a safeguarding concern were readily available.

Health and safety risk assessments had been completed including a full practice risk assessment, a fire risk assessment and a Legionella risk assessment. (Legionella is a bacterium which can contaminate the water systems of a building).

Improvements to the decontamination process which had been undertaken after the comprehensive inspection had been maintained.

Are services effective?

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

The practice had a system in place to ensure that clinicians were kept up to date with changes in the medical history of a patient.

Clinicians followed national guidance when deciding whether to take an X-ray, but did not always record the justification and quality grade of the X-ray in the dental care records.

Are services responsive to people's needs?

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

A new complaints procedure was implemented at the practice and staff had received training in how to deal with complaints.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

The practice had a series of policies and protocols to assist in the smooth running of the practice.

Clinical audit had been undertaken to highlight areas of clinical practice which may require improvement.

The practice had implemented a programme of staff appraisals, to assess the performance and training needs of individual staff, as well as offering an opportunity for staff to raise any concerns.

N Bloom & Associates - Bridlington Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an announced focused inspection of N Bloom & Associates - Bridlington Road on 22 June 2016.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 24 June 2015 had been made. We inspected the practice against four of the five questions we ask about services: is the service safe, effective, responsive to patient's needs and well-led. This is because the service was not meeting some legal requirements.

The inspection was carried out by a CQC inspector with a dental specialist advisor.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place to report, investigate and learn from incidents and accidents, although they had not recorded a significant incident since the comprehensive inspection.

The practice manager described how a significant incident would be treated in the practice, and we were shown the template used to record an incident. This included recording the details of the investigation, what action was taken at the time and what learning could be fed back to the staff to reduce the chance of reoccurrence.

The practice had implemented a policy regarding duty of candour. This is that all investigations and outcomes be dealt with in an honest and transparent way. Practice staff had discussed the expectation of candour at a practice meeting in February 2016 as evidenced by the minutes of the staff meeting.

Reliable safety systems and processes (including safeguarding)

The practice had implemented a policy on safeguarding vulnerable adults and child protection. This was available for staff to reference in the policies folder, and in a dedicated safeguarding folder. The policy detailed the signs of abuse, as well as the process to obtain advice or raise a safeguarding concern. The practice principal was designated as safeguarding lead in the practice.

The safeguarding folder contained contact numbers to raise a safeguarding concern prominently positioned at the front of the folder. There were also forms available to recording suspected abuse, and a copy of the training presentation that staff attended. All staff had received safeguarding training, except for a recently employed receptionist and trainee dental nurse, and arrangements were in place for this training to be undertaken.

Medical emergencies

We reviewed the arrangements in place for dealing with a medical emergency in the practice. All emergency medicines were found in accordance with the guidelines from the British National Formulary, and were stored appropriately.

Emergency equipment was available in line with the guidance from the Resuscitation Council UK; with the exception of a self-inflating bag for children and an automated electronic defibrillator (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The practice had not risk assessed the absence of these pieces of equipment. Following our inspection these were immediately purchased.

Oro-pharyngeal airways which can support the airway in an unconscious or semi-conscious patient were not sterile, and again these were replaced immediately following our visit.

Staff recruitment

Following our visit in July 2015 it was noted that significant improvements were underway in the recruitment process of staff. At this visit we reviewed staff recruitment files, including files for two members of staff that had commenced employment at the practice since our last inspection.

Staff recruitment files contained evidence of registration with professional bodies, and indemnity information for dentists. In addition qualifications and training certificates were filed so that the practice manager was able to maintain oversight of the training undertaken.

We saw that appropriate checks had been carried out on the new staff members, references were sought and verbal references recorded as part of the recruitment file in line with legislation.

Disclosure and barring checks (DBS) were in place for all clinical staff (DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Risk assessments were in place where a DBS was not deemed necessary, or whilst awaiting the results of the check. The risk assessment detailed that staff without a DBS check would not be left unsupervised with a patient, and included a declaration from the staff member that they had not received any previous convictions.

A new induction process had been implemented by the practice, and this included a four week programme

Are services safe?

whereby new staff were introduced to the policies and procedures within the practice and included topics such as professional standards, handling complaints and incident reporting.

Monitoring health & safety and responding to risks

Since our previous visit the practice had implemented a process of monitoring and mitigating risks to the safety of staff, patients and visitors to the practice. A health and safety policy was in place dated 30 September 2016. This detailed the persons within the practice with responsibility in various areas of risk. In addition it highlighted various areas of concern including electrical safety, fire safety, hazards from pressure vessels and substances, and latex.

A health and safety risk assessment had been carried out in June 2015 which covered aspects of health and safety at the practice including manual handling, safe use and disposal of sharps and slips, trips and falls.

A fire risk assessment had been carried out on 1 March 2016; this detailed the fire arrangements in the practice and did not highlight any immediate areas of concern. Fire drills were carried out every three months and we saw that the fire extinguishers had been serviced.

The practice had adequate arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information about the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

We observed a dental nurse carrying out the decontamination process. Cleaning of the instruments was carried out in the treatment rooms. Appropriate personal protective equipment (PPE) (mask, gloves, aprons and eye protection) were used during this process. Instruments were manually cleaned. Staff were aware that the water temperature should be below 45 degrees Celsius for this task and told us that the water was always luke warm; however the temperature of the water was not taken. Following the visit the practice amended its procedure in this regard. Staff were aware of the appropriate detergent ratio to use for manual cleaning of instruments.

After rinsing and inspecting the instruments in the treatment rooms the instruments were transported to the multi-purpose room to sterilise in the autoclave. Appropriate tests had been carried out to ensure the continued effectiveness of the procedure.

Infection control audits had been carried out to highlight any concerns in the infection control process. Although individual actions were mostly recorded within the document, this was not always the case, and no formal action plan had been generated. Immediately following our inspection the actions were bought together in a formal plan for staff to reference and complete.

The practice had introduced systems to control the risk of Legionella. Legionella is a bacterium that can contaminate the water systems in buildings. The practice had a legionella risk assessment dated 2 October 2015. This had been carried out by a specialist contractor and detailed the actions required to reduce the risk.

We saw evidence that the practice were checking and logging water temperatures at five points around the building on a monthly basis (this ensured that hot and cold water supplies were hot enough and cold enough respectively to reduce the risk of contamination). In addition the practice were sending samples of water to check for contamination, and had a record of flushing the little used outlets.

Cleaning checklists were still being used effectively at the practice to ensure environmental cleaning was carried out regularly.

We saw minutes of staff meetings which highlighted infection control topics that had been discussed to keep staff up to date and review procedures within the practice. These included discussion on safe use and disposal of sharps, correct and appropriate use of PPE and appropriate disposal of clinical waste.

Radiography (X-rays)

Are services safe?

When we inspected the practice in June 2015 the practice voluntarily agreed to stop taking X-rays as they did not meet the requirements of the Ionising Radiation Regulation 1999 (IRR 99), and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000).

When we visited again a month later significant improvements had been made. We inspected this area again to ensure that standards were still being met.

The practice had a radiation protection file which detailed the radiation protection advisor and radiation protection supervisor for the practice. All appropriate testing and servicing had been undertaken on the X-ray machines. Staff taking X-rays had all undertaken training in line with the requirements of IR(ME)R 2000.

Staff were not always justifying the reason for taking an X-ray in the dental care records, and were not grading all the X-rays for quality, although a portion were graded as part of the audit process. We received assurances from the practice and communications with their associates detailing that this would always be recorded going forward.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke to the staff about the system they have in place to ensure that they are kept informed of changes to a patient's medical history. The practice had implemented a system in which a patient was asked to fill out a new medical history form annually, and at appointments in between the medical history was checked verbally, and noted in the dental care records.

We verified this on dental care records shown to us by the dentist, although in one case a patient was not asked to fill in a new form when they re-attended after 15 months, however there was a record that their medical history had been verbally checked in this instance.

The practice took X-rays in line with the Faculty of General Dental Practice's guidelines on the frequency of taking X-rays.

Staffing

Systems had been put into place to ensure that staff were adequately trained and supervised. Staff recruitment files contained evidence of qualifications, and an induction process had been implemented for new staff.

A trainee dental nurse had been employed at the practice since our last visit. They were registered at college and were receiving regular mentoring visits from the college assessor, in addition the practice manager was holding monthly meetings with the trainee to support them in their training.

A practice wide training schedule had been implemented to ensure that all staff were up to date with mandatory training as described by the General Dental Council.

Consent to care and treatment

Staff had undertaken training on the Mental Capacity Act 2005, and it's relevance in treating patients who lack the capacity to consent for themselves. Staff we spoke with had a good understanding of the process of a best interest's decision. Information was available for staff in the safeguarding folder.

The staff had a good understanding of the situations were a child (under the age of 16) could legally consent for themselves. This is referred to as Gillick competence.

Staff had undertaken training in the Mental Capacity Act and Gillick competence as part of practice training on law and ethics.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Concerns & complaints

The practice implemented a new process of dealing with patient complaints after our comprehensive inspection of the practice in June 2015. The practice manager was able to talk through the process that would be undertaken in the event of a complaint, and the practice had appointed a complaints manager, as well as allocating a staff member to take responsibility in the complaints manager's absence.

The practice had not received a compliant since our last visit, so we were unable to see the process in action, however the policies and procedures in place indicated a robust investigation and feedback within appropriate timescales, and a commitment to candour.

The complaints policy was displayed on the wall, and indicated the contact numbers of authorities to escalate a complaint to if a patient were dissatisfied with the response from the practice.

A staff meeting in May 2016 reinforced the complaints policy to all staff, so that the practice could be assured of the staff response to a complaint being in line with the policy.

Are services well-led?

Our findings

Governance arrangements

Following our comprehensive inspection the practice made significant changes to the governance arrangements within the practice.

The practice had a series of relevant and up to date policies which were available for staff to reference in a dedicated folder. This included policies on consent, complaints handling, confidentiality, clinical governance, infection control, health and safety and underperformance.

Staff meetings were arranged every four to six weeks, and we saw minutes from these staff meetings having taken place since our last visit. Topics discussed included staff development, by way of preparing for appraisal, reinforcing the complaints procedure, responsibility for governance tasks around the practice (including the backup person responsible in the evet of absence) and clinical governance.

The practice manager had implemented a series of schedules, these helped to keep oversight of governance aspects of a dental practice. This included equipment servicing schedules, audit and training schedules.

Leadership, openness and transparency

The practice had taken on a new practice manager since our last visit. They were at the practice full time. In addition the principal dentist had taken a more prominent role in the oversight of the practice. Between these they had established clear lines or responsibility and accountability. Communication between the members of the management team and the practice staff was constant and easy. Staff reported an open door policy where they could address concerns with either the practice manager or principal dentist.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern.

Learning and improvement

The practice had embraced the use of clinical audit as a tool to highlight areas of practice that could be improved, although these were not always carried out in a way to make the most effective use of them. An audit had been carried out on the quality of X-rays taken. This took a random sample of 20 X-rays across the practice and was completed on 15 July 2015. An action plan for improvement was generated, but the sample was small, and would not highlight failings by a specific clinician.

An information governance audit was completed on 23 February 2016, and a record keeping audit had been completed for one clinician on 20 July 2015. This had generated an action plan for improvement. We saw evidence that results from audits were discussed at staff meetings with all staff.

The practice had implemented a schedule of annual appraisals for all staff. These were carried out by the principal dentist and identified any training needs of individual staff.

Staff were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice manager kept CPD certificates for staff so that they could be assured that staff were fulfilling the professional requirement of continuous training as set out by the General Dental Council. Clinical staff were up to date with their recommended CPD as including medical emergencies and radiography.

The practice manager had also arranged an ongoing programme of training with an external trainer. This covered most of the core CPD topics described by the GDC.

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

The practice obtained feedback from patients in several ways. They had conducted a patient satisfaction survey in December 2016. The results of which were discussed with staff at the staff meeting. They were aware of the feedback that had been left by the NHS choices website, and they also sent comment cards for the NHS Friends and Family test for analysis.

Staff were encouraged to give feedback at any time either informally or formally, by way of an open door policy to either the practice manager or the principal dentist. In addition the implementation of appraisals and staff meetings afforded staff further opportunities to raise concerns.