Shayan UK Limited

North Street Dental Care

Inspection Report

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Overall summary

We carried out a follow up inspection on 19 October 2016 of North Street Dental Care. We had undertaken an announced comprehensive inspection of this service on 31 March 2016 as part of our regulatory functions and during this inspection we found a breach of the legal requirements.

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 checked whether they had followed their action plan to confirm that they now met the legal requirements.

We reviewed the practice against one of the five questions we ask about services: is the service safe?

We have not revisited North Street Dental Care as part of this review because the practice was able to demonstrate that they were meeting the standards without the need for a visit.

A copy of the report from our last comprehensive inspection can be found by selecting the 'all reports' link for North Street Dental Care 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.

Background

North Street Dental Care provides predominately NHS dental services with private treatment options for patients. The practice has three consulting and treatment rooms, has three dentists who are supported by four dental nurses. The practice is managed by a practice manager with a principal dentist supporting the whole team.

Surgery hours are Monday to Friday, 9am to 5pm. There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed.

Our key findings were:

- The practice had reviewed their infection prevention and control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Training on adult and paediatric basic life support and the use of a automated external defibrillator (AED) had been undertaken by all members of staff.
- Systems had been implemented to ensure that single use items were disposed of in line with the manufacturer's instructions and only used on one patient.

Summary of findings

- We were assured that the practice no longer used an unregistered laboratory for any dental prosthesis.
- References for all members of staff had been obtained following our comprehensive inspection.

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

- Ensure that all staff undertake a serum conversion to determine their level of immunity to Hepatitis B.
- Revisit their infection control audit to reflect the fact that a washer disinfector is not used in the practice.

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.

Following the comprehensive inspection on 31 March 2016 the practice assured us appropriate infection control procedures were followed in line with published national guidance; during the follow up inspection we were provided with evidence demonstrating that the practice monitored water temperatures. We were also provided with photographic evidence confirming that the decontamination process was now meeting HTM01-05 essential requirements. Staff had undertaken training on basic life support and how to use a automated external defibrillator (AED) in April 2016. We were assured that single use instruments were not reused. The practice manager provided us with evidence that references for all members of staff had been obtained after our visit in March 2016.

No action

North Street Dental Care

Detailed findings

Background to this inspection

We undertook a follow up inspection of North Street Dental Care on 19 October 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 31 March 2016 had been made. We inspected the practice against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some of the legal requirements in relation to this question.

The inspection was carried out by a CQC assistant inspector who had access to advice from a dental specialist advisor.

During the follow up inspection, we reviewed information sent to us by the practice that demonstrated how the concerns identified during the comprehensive inspection had been addressed.

No action

Are services safe?

Our findings

Medical emergencies

During the comprehensive inspection in March 2016 we observed the practice had arrangements to deal with medical emergencies and noted that one of the dentists was the lead for this. There was an automated external defibrillator (AED), which is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. However, staff had not received regular annual training in how to use this equipment. Staff when interviewed, did not know which medicine would be required to help specific conditions in an emergency scenario. We pointed this out to the provider and told them to take action.

During our follow up inspection the practice provided us with certificates confirming that all members of staff had undertaken training on adult and paediatric basic life support, how to use their AED and medical emergencies in April 2016.

Staff recruitment

At our previous inspection we observed that the practice had not obtained all of the required information for some members of the team before they had contact with patients. The practice's written procedures contained clear information about all of the required checks for new staff. This included protocol to follow for prospective employees explaining to them what documents they would be expected to provide and what checks the practice would carry out. For example, a valid UK Passport or National Identity Card, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. However we found that one of the dentists did not have evidence of current professional indemnity and proof of identity.

The practice had obtained Disclosure and Barring Service (DBS) checks for most staff employed there. However, one DBS certificate was not relevant to the practice and cited a previous employer. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The recruitment protocol informed applicants that the practice would carry out a DBS check and detailed what documentation would need to be provided for this. Applicants would be asked to provide a written explanation of any gaps in employment.

The protocol also explained that as well as requesting references from applicants' most recent employers, the practice would also contact previous employers where the work involved contact with children or vulnerable adults. We found that of the nine members of staff employed at the practice, seven had not had any references taken up. Therefore we could not be assured that staff had been recruited safely.

During our follow up inspection we were assured that employment references had been obtained for all members of staff and we were provided with copies of these. We requested evidence that appropriate professional indemnity had been arranged for the dentist who lacked cover and proof of identity at our comprehensive inspection. The practice immediately sent us documents to show these had been obtained.

We also requested evidence that the DBS check had been obtained for the member of staff whose DBS had been obtained by their previous employer. The practice manager informed us that this member of staff had left the practice.

Infection control

The 'Health Technical Memorandum 01-05:Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. During our comprehensive inspection in March 2016 we observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We were not assured that the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices. We saw that dental treatment rooms, decontamination room and the general environment were generally clean, tidy and clutter free. However, we found that one of the surgeries was dirty.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a poorly defined system which did not always separate dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a

separate decontamination room where the dental nurses cleaned, checked and sterilised instruments. Although the clean and dirty zones had been identified, the autoclave (equipment used to sterilise dental instruments) was in the clean zone and a radiograph image receptor was in the dirty zone. All of the nurses at the practice had completed online training so that they understood this process and their role in making sure it was correctly implemented. The dental nurses processed their own instruments in the decontamination room each day and transported instruments in boxes with lids. Different boxes were used for the dirty and clean instruments. However, we noted that the boxes used to transport the clean instruments were dirty, this posed a problem as instruments were not being pouched as per current guidance.

The dental nurse showed us the full process of decontamination including how staff rinsed the instruments, checked them for debris and used the autoclave to clean and then sterilise them. The practice used a manual scrubbing method followed by checking under an illuminated magnification device and then autoclaved. We found that this process was not effective. Instruments were being scrubbed in plain water under a running tap; according to published guidance manual scrubbing must take place whilst immersed in an enzymatic detergent to facilitate sufficient decontamination. Staff did not wear full personal protective equipment (PPE) whilst carrying out decontamination duties. Clean instruments were not packaged and date stamped according to current HTM01-05 guidelines, with the exception of extraction forceps. General instruments were processed and stored unwrapped in drawers and were not re-processed at the end of the clinical session.

The practice used single use dental instruments whenever possible which we found were reused, we saw rose head burs and matrix bands that were visibly contaminated with debris and ready for re-use on patients.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. However, we found that some of the actions identified had not been carried out, such as monitoring the temperature of the hot and cold water at the practice to ensure that it remained within a safe parameter. Legionella is a bacterium which can contaminate water systems in buildings.

The practice carried out audits of infection control using the format provided by the Infection Prevention Society (IPS). However, the last IPS audit carried out in February 2016 had attained a score of 99%. This did not reflect our findings on the day of the comprehensive inspection and is not an achievable result without a washer disinfector. We brought this to the attention of the practice manager who assured us that an audit would be carried out after all actions to improve these shortfalls had been implemented.

We also noted that some staff had not undergone a serum conversion to determine their level of immunity to Hepatitis B, a serious illness that is transmitted by body fluids including blood.

During our follow up inspection we were assured that infection prevention and control policies and procedures had been reviewed in line with the Department of Health's code of practice about infection prevention and control of healthcare associated infections (Health and Social care Act 2008: Code of practice for health and adult social care on the prevention and control of infections) and the Department of Health – Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). The practice provided us with photographic evidence demonstrating that all the aforementioned shortfalls regarding infection control processes had been addressed. For example, photographs sent to us by the practice manager showed that enzymatic detergent was being used to ensure sufficient decontamination when scrubbing instruments. We also observed the practice had made significant improvements in relation to the separation of dirty and clean instruments in the decontamination room, which had been rearranged. Instruments were pouched directly from the autoclave and transported in separate clean and dirty boxes. The provider and practice manager assured us that all staff wore full personal protective equipment (PPE) whilst carrying out decontamination duties.

The practice manager confirmed in writing that all single use items were disposed of in line with the manufacturer's instructions and would not be reused.

We were assured that dental water lines were maintained and water temperatures were monitored in line with the Legionella risk assessment recommendations to prevent the growth and spread of Legionella bacteria. These measures ensured that patients and staff were protected

No action

Are services safe?

from the risk of infection due to Legionella. The practice sent us copies of their logs where these checks had been recorded and we saw that they were complete and up to date.

We requested evidence that all members of staff had undergone a serum conversion to determine their level of immunity to Hepatitis B, wich we received but only pertaining to two members of staff. We noted that the rest had received the course of Hepatitis B vaccinations but information regarding the outcome of their serum conversion was not provided.

We asked the practice to send us their last IPS audit, this showed an overall result of 98% but this is not an achievable result without a washer disinfector and the current process that the practice had demonstrated to us.