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Woodlane Dental Practice

Inspection Report

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Overall summary

We carried out a focused inspection of Woodlane Dental Practice on 24 May 2018.

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

We carried out the inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 22 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

At a comprehensive inspection we always ask the following five questions to get to the heart of patients' experiences of care and treatment:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

When one or more of the five questions is 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 was required.

At the previous comprehensive inspection we found the registered provider was providing safe, effective, caring and responsive care in accordance with relevant regulations. We judged the practice was not providing well-led care in accordance with Regulation 17 and Regulation 18 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 Woodlane Dental Practice on our website www.cqc.org.uk.

We also reviewed the key questions of safe and effective as we had made recommendations for the provider relating to these key questions.

We noted that the majority of improvements had not been made.

Our findings were:

Are services well-led?

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

The provider had not made improvements to put right the shortfalls and deal with the regulatory breaches we found at our inspection on 22 November 2017.

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 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.

Summary of findings

- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The Commission is considering its range of enforcement powers to secure improvements.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services well-led?

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

The Commission is considering its range of enforcement powers to secure improvements.

The provider had not made the required improvements to the management of the service.

Improvements had not been made to the arrangements for the assessment and management of risks to patients and staff.

Improvements had not been made to ensure the smooth running of the service. There was a lack of governance systems to ensure that equipment and medicines were available, accessible, regularly checked and fit for use.

Improvements had not been made to arrangements for staff training and appraisal and for monitoring staff training.

The practice had not made improvements to monitor clinical areas of their working effectively to help them improve and learn.

Enforcement action 

Are services well-led?

Our findings

At our inspection on 22 November 2017 we judged it was not providing well led care and told the provider to take action as described in our requirement notice.

At the inspection on 25 May 2018 we noted the practice had made the following improvements:

- The practice safeguarding policies had been reviewed and contained information and details about who staff should contact if they had concerns about the safety or welfare of children or vulnerable adults. Staff who we spoke with were able to access this information and said that they would report any concerns they had with the principal dentist or directly to the local safeguarding team.
- The principal dentist could demonstrate that they understood the principles of the Mental Capacity Act 2005 and their responsibilities under the act when treating adults who may not be able to make informed decisions. They were also aware of the Gillick competence by which a child under the age of 16 years of age can consent for themselves.
- Some improvements had been made in relation to monitoring the quality of dental radiographs. An audit of dental radiographs was carried out in November 2017. Some comments were made in relation to the findings. However there was no action plan as to how the required improvements were to be achieved and there was no review of the audit since this date.

Improvements had not been made in the following areas:

- Improvements had not been made to ensure that there were effective policies and procedures to report, investigate, respond and learn from incidents and significant events. One incident in relation to a needle stick injury had been reported in February 2018. The principal dentist told us that this had been discussed with relevant staff. However there were no records available to demonstrate this or that learning from the incident was shared or used to minimise future risks. The principal dentist was unable to demonstrate that they were aware of what incidents should be reported should they occur.
- The required improvements had not been made to the arrangements for dealing with medical emergencies to ensure that the recommended medicines and equipment were available and that staff were trained to deal with medical emergencies. There were ineffective systems for checking that emergency equipment and medicines were available, ready for use and within their use by dates. No records of checks were available since December 2017. The adult adhesive pads for the Automated External Defibrillator (AED) were past their use by date and there were no child sized paediatric adhesive pads available. The Glucagon was past its expiry date as was one of the Glycerine Trinitrate (GTN) sprays.
- Staff when we requested were unable to locate the oxygen cylinder as this had been moved and staff had not been informed.
- Similarly to what we found in November 2017 the battery pack had been removed from the (AED) which meant that it was not set up and ready for use in accordance with the manufacturer's instructions.
- The principal dentist was unable to demonstrate that they could set up the AED ready for use in a timely manner.
- The practice had not reviewed its responsibilities as regards the Control of Substances Hazardous to Health (COSHH) Regulations 2002. A risk assessment document dated July 2017 was made available to us. However this was a generic checklist and did not include details of the range of potentially hazardous materials used at the practice including cleaning materials. Risk and actions which staff should take in the event of accidental exposure to these substances were not recorded. There were limited safety data sheets available in relation to substances used at the practice.
- Improvements had not been made to the arrangements for assessing and managing the risk of fire at the practice. The principal dentist told us that the local fire authority had conducted a fire risk assessment and provided us with a document they said was the assessment. However this was a fire safety risk assessment completed by the principal dentist. The risk assessment was basic, lacked detail and did not include details of risks specific to the practice. There principal dentist told us that the smoke alarms were checked

Are services well-led?

every three or four months by a maintenance person. However there were no records for these checks and other fire safety checks and evacuation drills were not carried out.

- Improvements had not been made to the procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. The principal dentist told us that they carried out water sample analysis every three months to test for the presence of biofilm or other bacterial growth. However they were unable to provide records in relation to these. The principal dentist told us that a Legionella risk assessment had been carried out recently by an external company. However they were unable to say when this assessment had been completed and there was no record of the assessment available. We requested a copy of this assessment be sent to us following the inspection. This had not been provided at the time of completing our report.
- All of the required improvements had not been made to ensure that the practice arrangements for the safety of the X-ray equipment were in line with current radiation regulations. Records made available to us showed that the most recent maintenance check for the X-ray equipment had been carried out in March 2015 and this test was due again in March 2018. The principal dentist was unaware that it was their responsibility to ensure that these tests were carried out and they told us that they relied on the external company who carried out the tests to ensure that they were completed. Some recommendations made at that time of the last test in 2015 including the use of a rectangular collimator and annual mechanical and electrical tests for the X-ray equipment had not been acted upon. The principal was unaware that the mechanical and electrical tests should be carried out for the dental X-ray equipment.
- Improvements had not been made to the arrangements for reviewing and managing risks to patients and staff. There were some incomplete risk assessment documents available. However these were generic and lacked details specific to the practice in relation to health and safety, premises and equipment.
- Improvements had not been made to the arrangements for ensuring that staff were suitably trained and supported in relation to their roles and responsibilities. Records showed that some staff had undertaken training in areas such as infection control, consent and the Mental Capacity Act 2005. However staff had not undertaken training in basic life support or safeguarding children and vulnerable adults. There were no arrangements in place to monitor staff training and development and there were no staff appraisals carried out.
- The principal dentist told us that due to redecorating work to the office space within the practice that a number of items including paper records had been moved. We found areas of the practice were cluttered including fire escape routes. The oxygen cylinder had been removed from its usual place and was obscured from view by various items.
- Boxes containing quantities of expired dental materials and medicines including Midazolam were seen in one room.

Our findings showed the provider had not taken the required action to address the majority of shortfalls we found when we inspected on 22 November 2017.