Levine & Leslie Dental Surgeons

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Inspection Report

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Date of inspection visit: 8 March 2017
Date of publication: 10/05/2017

Overall summary

We carried out a follow up inspection at Levine & Leslie Dental Surgery on the 8 March 2017.

We had undertaken an announced comprehensive inspection of this service on the 27 April 2016 as part of our regulatory functions where breaches of legal requirements were found.

After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to each of the breaches. This report only covers our findings in relation to those requirements.

We reviewed the practice against two of the five questions we ask about services: is the service safe and well led?

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Levine & Leslie Dental Surgery on our website at www.cqc.org.uk.

We revisited the Levine & Leslie Dental Surgery as part of this review and checked whether they had followed their action plan and to confirm they now met the legal requirements.

Our findings were:

Are services safe?

We found that this practice was providing safe 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

Levine & Leslie Dental Surgery is situated in Leeds, West Yorkshire. It offers only privately funded dental treatments. The services include preventative advice and treatment and routine restorative dental care.

The practice has two surgeries, a waiting area and a reception area. All facilities are of the ground floor of the premises. There are toilet facilities but these are not accessible for wheelchair users.

There is one dentist, one dental hygienist, two dental nurses and one receptionist.

The opening hours are Monday to Friday from 9-00am to 5-30pm.

The practice owner is the registered manager. A registered manager is a person who is registered with the

Summary of findings

Care Quality Commission to manage the service. Like registered 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:

- An X-ray audit had been completed.
- Staff were up to date with mandatory Continuing Professional Development (CPD).
- A more robust log of antibiotics was now in place and all antibiotics were in date.
- We saw that several materials and local anaesthetics were out of date.
- The Control of Substances Hazardous to Health (COSHH) folder had been updated but still did not reflect all substances held at the practice. COSHH substances were not always held safely.
- We identified antibiotics had been inappropriately prescribed for a patient who had not been clinically examined by a suitably qualified dental professional.

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

- Review the practice's protocols for the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Review stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely.

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.

Some medical emergency equipment had been acquired, this included the oropharyngeal airways. On the day of inspection an automated external defibrillator (AED) had not been acquired. We were later sent evidence an AED had been purchased.

A more robust stock control system for the antibiotics had been implemented. All antibiotics were in date. We noted a patient had been remotely prescribed antibiotics without being examined by a suitably qualified dental professional.

The Control of Substances Hazardous to Health (COSHH) folder had been updated but still did not reflect all substances held at the practice. For example, we found that liquid mercury (which was not stored securely) was not contained within the COSHH folder.

We identified out of date materials and local anaesthetics in the surgeries.

No action

Are services well-led?

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

Staff were now up to date with their Continuing Professional Development (CPD).

Audits of X-rays and dental care records had been carried out.

No action

Levine & Leslie Dental Surgery

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Levine & Leslie Dental Surgery on 8 March 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our inspection on 27 April 2016 had been made. We inspected the practice against two of the five questions we ask about services: is the service safe and well led. This is because the service had not been meeting some legal requirements.

Are services safe?

Our findings

Medical emergencies

At the inspection on 27 April 2016 items in the medical emergency kit were missing. We saw these had been acquired with the exception of an automated external defibrillator (AED). We were later sent evidence an AED had been purchased.

Monitoring health & safety and responding to risks

The provider stated in their action plan the Control of Substances Hazardous to Health (COSHH) folder had been updated to reflect the materials and substances held at the practice. We identified several substances at the practice which were not contained within the COSHH folder. For example we found liquid mercury was held in a cupboard in the staff room. Neither the room nor the cupboard were locked.

Equipment and medicines

At the inspection on 27 April 2016 we identified several out of date antibiotics. We found these had been given to at least one patient. The practice had implemented a system to check the expiry date of the antibiotics prior to giving them to a patient. This was documented in the log book. We found all antibiotics in the store cupboard to be in date and there was now a more effective stock control system in place.

We identified a patient who had visited the practice when the dentist was not working. They had been prescribed antibiotics. When questioned about this, the dentist told us they had spoken to staff about the patient and had advised them it was acceptable to prescribe the antibiotics to the patient. We were told this patient had been prescribed antibiotics and was then also seen at another local practice to receive treatment. It was clear from the dental care records of this patient there had been no clinical examination of the patient to determine the cause or nature of the swelling. The dentist considered the remote prescribing of these antibiotics to be reasonable.

The GDC publication advises you should only use remote means to prescribe medicines for dental patients if there is no other viable option and it is in their best interests.

We also found out of date materials and local anaesthetics in the surgeries. These were present at the last inspection and had not been removed and disposed of.

Are services well-led?

Our findings

Learning and improvement

Staff were now up to date with their Continuing Professional Development (CPD). This included medical emergencies, CPR and safeguarding.

An audit assessing the quality of X-rays taken had been completed in June 2016. An audit of dental care records had also been completed in June 2016. These were both due to be completed again in June 2017.