The Smile Centre (UK) Limited

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Inspection Report

243 Bury New Road
Whitefield
Manchester
Lancashire
M45 8QP
Tel: 0161 7962404
Website: www.theuksmilecentre.co.uk

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Overall summary

We carried out an announced follow-up inspection at The Smile Centre (UK) Limited on 13 June 2018.

We had undertaken an announced comprehensive inspection of this service on the 27 March 2018 as part of our regulatory functions where a breach of legal requirements was found.

After the comprehensive inspection, the provider 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 two of the five questions we ask about services: are the services safe and well led? You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Smile Centre (UK) Limited on our website at www.cqc.org.uk.

We revisited The Smile Centre (UK) Limited as part of this review and checked whether they now met the legal requirements. We carried out this announced inspection on 13 June 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

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

• Is it safe?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

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

Summary of findings

The Smile Centre (UK) Limited is in the Whitefield area of Manchester and provides private dental treatment to adults.

There is level access for people who use wheelchairs and pushchairs. A ground floor surgery is available but this is only suitable for patients requiring denture work. Car parking spaces are available near the practice.

The dental team includes two dentists, two dental nurses (one of whom is a trainee), a treatment coordinator, a receptionist and a practice manager. The practice has two treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. At the time of the inspection the practice did not have a registered manager in post.

During the inspection we spoke with one dentist, two dental nurses, and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Thursday from 9:00am to 7:00pm

Friday from 9:00am to 12:30pm

Our key findings were:

- Improvements had been made to the process for reporting significant events.
- Improvements had been made to the process for managing risks associated with fire, Legionella and non-responders to Hepatitis B.
- Improvements had been made to the processes for auditing infection prevention and control minor improvements still needed to be made.
- Some of the issues with the X-ray machine had been addressed. One issue was still outstanding.

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

- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice’s protocols to ensure audits of infection prevention and control have documented learning points and the resulting improvements can be demonstrated.

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

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

Since the inspection on 27 March 2018, improvements had been made to improve the safety of the services provided.

A system and process had been put in place to report significant events and accidents.

Improvements had been made to the process for reducing the risks associated with fire and Legionella. A sharps risk assessment had been completed. This did not fully reflect the systems used within the service.

Medical emergency drugs and equipment were available as described in recognised guidance.

All the recommendations in the X-ray report had been addressed apart from one.

Are services well-led?

No action

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

Improvements had been made to the overall governance arrangements. Policies and procedures were now in place and individual leads had now been identified. A system had been put in place for the urgent referral of patients with a suspected malignancy.

Improvements had been made to the quality assurance processes. Further minor improvements are required to make the processes more effective.

Systems and processes had been implemented to enable the service to minimise the risks associated with fire and Legionella. An effective system had been implemented to ensure medical emergency drugs and equipment were present as described in recognised guidance.

A system had been implemented to ensure staff have had the immunisation to the Hepatitis B virus and their immune status checked.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, equipment & premises and Radiography (X-rays))

The practice had systems to keep patients safe.

Following the inspection on 27 March 2018, improvements had been made to decrease the risks associated with fire. We were shown that fire evacuation notices had been displayed, the fire alarm system and emergency lighting had been serviced and the boiler had been serviced.

At the previous inspection we had identified that there were outstanding actions from the critical examination of the Orthopantomogram (OPG) machine. We were shown evidence that the dose had been adjusted and a recommendation about the button had been addressed. The recommendation regarding the controlled area had not been addressed. The practice manager contacted the radiation protection advisor on the day of inspection to seek advice about this.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

A sharps risk assessment had been completed. This stated that a re-sheathing device must be used when re-capping needles. We discussed this with staff and we were told that safer sharps were also available at the practice. This had not been reflected in the risk assessment. There was no reference to other sharp instruments, such as matrix bands or scalpels, in the risk assessment. We were told this would be updated to reflect to processes and equipment used at the practice.

At the previous inspection the provider was unable to demonstrate to us that all staff had adequate immunity to the Hepatitis B virus. We saw that three new members of staff had recently been recruited. We were shown evidence that they were immune to the Hepatitis B virus.

At the previous inspection we noted that the medical emergency kit was incomplete. We were shown the medical emergency kit and this now reflected recognised guidance.

We noted that recommendations from the Legionella risk assessment had not been addressed in the last inspection. We were shown evidence that the boiler had been serviced, monthly water temperature testing had been completed and all outlets were flushed on a weekly basis. We discussed the management of the dental unit water lines with staff and we were told that they were not flushed at the end of the day as recommended in the risk assessment. We discussed this with the practice manager who told us this would be addressed.

We were shown an infection prevention and control audit which had been completed on 9 May 2018. There was no action plan associated with this audit. The practice manager advised us that they would re-do this audit using a different method so an action plan could be developed.

At the previous inspection, staff were unaware of a process to refer patients urgently to secondary care. We discussed this with staff during the inspection. The dentist described to us the processes for referring such patients. They also had access to the NHS online referral system and were confident in its use.

Lessons learned and improvements

A process had been put in place to report significant events and accidents.

The staff were aware of the process for reporting significant events. We were shown evidence of a significant event which had occurred. This had been documented but lacked sufficient detail of the actual event. This incident required a statutory notification to the CQC. The practice manger was aware of this and it had been actioned.

Are services well-led?

Our findings

Governance and management

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Since the previous inspection on 27 March 2018 improvements had been made to the overall governance arrangements. Policies were now available and staff were aware of how to access these. Individual leads had been identified and staff were aware of who these were.

Continuous improvement and innovation

Systems and processes had been implemented to ensure risks associated with fire and Legionella were reduced. We were shown evidence of regular testing of the fire alarm, emergency lighting and fire escape routes. We saw checklists for staff to complete Legionella control measures, for example to record the monthly water temperature checks and weekly flushing of all outlets.

At the previous inspection we identified that complaints had not been dealt with in line with the practice's policy. We reviewed the complaints which had been received since the last inspection. We noted that they had not all been acknowledged within the three days as stated in the practice policy. We discussed this with the practice owner and practice manager. We were told the reason for this is because any correspondence to The Smile Centre (UK) Limited was immediately forwarded to the administrators. As a result, this had led to a delay in acknowledging complaints.