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# The Willows Dental Practice

## Inspection Report

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Date of inspection visit: 22 April 2020
Date of publication: 21/05/2020

## Overall summary

We undertook a follow up desk-based inspection of The Willows Dental Practice on 22 April 2020. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who had access to a specialist dental adviser.

We undertook a comprehensive inspection of The Willows Dental Practice on 19 December 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing well led care and was in breach of Regulation 17 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 The Willows Dental Practice on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is it well-led?

When one or more of the five questions are 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.

**Are services well-led?**

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

The provider had made improvements in relation to the regulatory breach we found at our inspection on 19 December 2019.

**Background**

The Willows Dental Practice is in Belton, Doncaster and provides private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available at the practice.

The dental team includes two dentists, five dental nurses and one dental hygiene therapist. The practice has two treatment rooms.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

We reviewed updated documents which included policies, procedures and photographs submitted as evidence by the provider.

The practice is open:

# Summary of findings

Monday and Thursday 9am to 5:15pm, Tuesday and Wednesday 9am to 5pm and Friday 9am to 12:15pm.

**Our key findings were:**

- Legionella management systems complied with guidance.
- Fire safety systems complied with current regulations.
- Safer sharps systems were effective and reflected current regulations.
- The system to ensure appropriate medicines and equipment were in place was effective.
- The provider reviewed the current systems for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences.
- Clinical waste was managed and disposed of in line with guidance.
- The system to manage audit for quality assurance, learning and improvement was embedded.
- The provider had implemented systems to ensure staff continued to meet the professional standards.
- Leadership and clinical oversight were effective.

# Summary of findings

## The five questions we ask about services and what we found

We asked the following question(s).

| | |
|---|---|
| **Are services well-led?** | **No action**  |

# Are services well-led?

## Our findings

We found that this practice was providing well led care and was complying with the relevant regulations.

At our previous inspection on 19 December 2019 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 22 April 2020 we found the practice had made the following improvements to comply with the regulation.

During the comprehensive inspection undertaken in December 2019, we found Legionella management systems were not fully implemented. The provider sent evidence to demonstrate where improvements had taken place since our visit. These included:

- An external Legionella risk assessment was completed 31 January 2020, no additional recommendations were listed on the risk assessment for further action.
- A revised temperature testing log sheet was introduced to ensure hot and cold water from the taps remained within required parameters.
- A thermometer was in place to monitor the temperature of the water flowing through the water pipes which fed to the sink in the patient toilet.
- Treatment room log sheets were adjusted to document when taps and handpieces were being flushed.

The evidence submitted confirmed that Legionella management systems and processes were embedded and effective.

At the comprehensive inspection we identified some adjustments to the practice's fire safety systems were needed to ensure they were fully compliant and working in line with regulations. The provider sent written and photographic evidence to us to confirm where action had been taken, for example, additional fire extinguishers were obtained and were function checked with the outcome recorded. In addition, a process to complete fire evacuation drills was in place.

The provider had updated the practice safer sharps risk assessment to ensure it complied with current regulations. The risk assessment included all sharps in use, such as matrix bands, burs and scalpel blades.

At the comprehensive inspection we found all emergency equipment and medicines were available as described in recognised guidance. Records reviewed to ensure emergency equipment and medicines were available and in date was of a basic tick sheet format. The provider sent supporting evidence to demonstrate where improvements had taken place since December 2019, for example, a new comprehensive log sheet for every item in the emergency kit was implemented, this was updated to a new sheet whenever an item was used or replaced due to expiry. This process was now effective and embedded.

The provider had implemented systems for reviewing and investigating when things went wrong. Staff gave good examples of how they had monitored and reviewed incidents when we discussed this during the comprehensive inspection in December 2019. Records reviewed showed that improvements could be made to ensure when things went wrong, these were more comprehensively documented for learning and improvement. The provider sent us supporting evidence to demonstrate that the system had been reviewed. The team had set up a dedicated incident folder and this included a new incident recording form which gave the option for further discussion amongst the team if the incident was significant.

The provider had implemented policies and procedures to ensure clinical waste was segregated and stored appropriately in line with guidance. During the comprehensive inspection, we noted clinical waste was being placed into small household waste bags and then deposited into separate clinical waste bags, this process was not in-line with current guidance. Documented and photographic evidence was sent to us to show where improvement had taken place, for example:

- Large infectious waste receptacles were visible in the treatment rooms and the decontamination room.
- Separate bins were placed in the treatment room for the collection of non-hazardous waste.
- Waste separation notices were visible, and staff had received training and instruction on the correct disposal process.

The provider had reviewed the practice's audit systems to ensure they met the required standards. Evidence sent to us showed the audit process was now effective. Several audits had taken place, including, infection prevention and

# Are services well-led?

control, X-ray, dental care record and disability access. These showed the reason for the audit, method used to assess the process and outcomes for learning and improvement.

During the comprehensive inspection, we reviewed how staff were supported in training to meet the professional standards; we found this area could be improved. The provider sent documented and photographic evidence to confirm where action had been taken to improve this process. Evidence showed training in safeguarding vulnerable adults and children, infection prevention and control and Mental Capacity Act 2005 was completed by all staff. In addition, the practice had implemented a master training file where staff kept copies of training certificates to allow oversight and monitoring.

The provider had engaged fully with the subject areas we identified could be improved during the comprehensive inspection and had provided clear evidence of action taken since. Documenting at each stage where revised systems and improvements had taken place. This demonstrated a better awareness within the team and proactive engagement by the provider.

The practice had also made further improvements:

- The provider had installed closed-circuit television, (CCTV), to improve security for patients and staff. A policy and privacy impact assessment were in place to support its use.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulation when we inspected on 22 April 2020.