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South Coast Dental Centre

Inspection report

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Overall summary

We undertook a follow-up focused inspection of South Coast Dental Centre on 26 October 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 was supported by a specialist dental adviser.

We undertook a focused inspection of South Coast Dental Centre on 17 September 2020 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 safe or well-led care and was in breach of Regulations 12, 15, 17 and 19 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 South Coast Dental Centre on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is it safe?

• Is it well-led?

Our findings were:

Are services safe?

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

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 17 September 2020.

Are services well-led?

Summary of findings

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 breaches we found at our inspection on 17 September 2020.

Background

South Coast Dental Centre is in Peacehaven and provides NHS and private treatment for adults and children.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes three dentists, three dental nurses, one dental therapist one receptionist and a practice manager. Staff work between this practice and the sister practice of Bright On Smiles. The practice has three 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.

During the inspection we spoke with three dentists, one dental nurse and the dental therapist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday from 9:00am to 5:30pm

Our key findings were:

- Medical emergency equipment and medicines reflected nationally recommended guidance with the exception of four sizes of masks for the self-inflating resuscitation bag.
- Infection prevention and control procedures reflected nationally recognised guidance.
- A fire risk assessment had been carried out and recommended actions were being implemented.
- Improvements had been made to the process for reducing the risks associated with COVID-19.
- A system to ensure general stock did not pass the expiry dates had been implemented.
- A system of clinical governance had been implemented to assist with good governance in the long term.
- Improvements could be made to the recruitment process.

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

- Improve the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Take action to ensure the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK).

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

Are services safe?

Our findings

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

At our previous inspection on 17 September 2020 we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our enforcement notice. At the inspection on 26 October 2020 we found the practice had made the following improvements to comply with the regulations:

- We checked the contents of the medical emergency kit. We found all medicines were available as described in nationally recognised guidance in the British National Formulary. When we checked the medical emergency equipment, we noted sizes 0, 2, 3 and 4 masks for the self-inflating bag were not available. We highlighted this on the day of inspection and were told that these items would be ordered immediately.
- Infection prevention and control procedures had been reviewed. Staff described the process for decontaminating and sterilising used dental instruments. Staff were fully aware of which instruments were re-usable, (and required sterilisation), and which were single use and required disposal after one use. The process for wrapping re-usable instruments had been reviewed. Staff were aware that pouched instruments required to be annotated with an expiry date. We looked at a selection of pouched instruments and found these to be annotated correctly. Decontamination procedures had been displayed in the decontamination room to assist staff with the processes. Staff had also completed infection prevention and control training.
- We checked a selection of dental materials and medicines and found these all to be in date. These included local anaesthetic cartridges.
- A new autoclave had been purchased and we saw evidence of a declaration of conformity for it.
- We were shown a gas safety certificate for the boiler which showed it was safe to use.
- We discussed the practice's COVID-19 standard operating procedure and risk assessment. We were told that aerosol generating procedures, (AGPs), would be carried out in two treatment rooms as one did not have sufficient ventilation. A baseline fallow time of thirty minutes had been implemented in line with nationally recognised guidance. Staff told us the correct personal protective equipment, (PPE), was available and we saw evidence of fit test certificates for enhanced PPE for members of staff who would be involved in the provision of AGPs. Staff described the process for donning and doffing personal protective equipment before and after an AGP. The doffing area was separate to the clinical area.
- A new fire risk assessment had been carried out. This had some high-risk actions. We saw the "housekeeping" action had been addressed to ensure clutter was removed from the stock room. The fire risk assessment had recommended that a hard-wired fire alarm system to be fitted. The provider told us they had acted to have this done as soon as possible. However, due to delays in tradesmen being able to carry out the work this had not yet been completed. We were sent evidence that this had been booked into be completed on 14 November 2020. We saw evidence a fixed wire installation test and Portable Appliance Test had been carried out as recommended in the fire risk assessment. These both showed the installation and appliances were satisfactory. In addition, the provider told us the other less urgent actions would be completed.
- Actions identified in the Legionella risk assessment dated 9 June 2020 had been completed. This included installing a new water tank. In addition, a new risk assessment had been completed which had no actions identified. Staff were aware of the need to carry out monthly water temperature checks and were aware of the correct temperature ranges.
- We saw evidence the provider had registered with the Health and Safety Executive (HSE) as required under the Ionising Radiation Regulations 2017 (IRR17).

These improvements showed the provider had taken action to comply with the regulations when we inspected on 26 October 2020.

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 17 September 2020 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 enforcement notice. At the inspection on 26 October 2020 we found the practice had made the following improvements to comply with the Regulations:

- Since the previous inspection, the provider had enlisted the help of a compliance organisation to assist with the governance arrangements of the practice. This included implementing systems and processes to ensure good governance is maintained in the long term. Policies and procedures were available to support staff. Staff demonstrated to us how to locate the polices. They were aware that this system required embedding within the culture of the practice. Certain staff members had been delegated roles within the practice such as checking emergency medicines and equipment and infection prevention and control lead responsibilities.
- We saw evidence of current public liability insurance which was displayed in the waiting room.
- A system had been implemented to ensure general stock, (such as local anaesthetics and other medicines), did not pass its expiry date. A named individual had been appointed to carry out these checks. Any stock which had passed its expiry date would be disposed of in accordance with the relevant guidance.
- Systems and processes had been implemented to ensure premises and equipment is maintained according to guidance and legislation. This included carrying out regular health and safety audits and using a task manager system through the compliance software system.
- An infection prevention and control audit had been carried out. This indicated that the provider was meeting required standards. However, there were some questions which had been answered incorrectly. We discussed this with the provider on the day of inspection who assured us that the audit would be reviewed.
- We reviewed documents in relation to the safe recruitment of staff. We reviewed eight staff folders. We noted that for three of these the Disclosure and Barring Service (DBS) check pre-dated the date of application by more than three months and was not location specific. In addition, there was no risk assessment in place to mitigate the risks associated with this. We discussed this with the provider who told us this would be addressed.
- We noted one member of staff had evidence of a recent course of vaccination against the Hepatitis B virus. We saw the blood test result indicated that the individual had not responded to the vaccination and they would not be immune to Hepatitis B. We discussed this on the day of inspection as the provider was unaware of this. This issue had not been identified by the provider. We were later provided with evidence that the provider had sent the individual for another blood test to check on their immune response and were awaiting confirmation of this.

These improvements showed the provider had taken action to comply with the regulations when we inspected on 26 October 2020.