Mr Michael Evans

Chingford Dental Care

Inspection Report

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Overall summary

We carried out a focused inspection of Chingford Dental Care on 10 May 2018.

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

We carried out the inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 7 September 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 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 Chingford Dental Care 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 been made.

Our findings were:

Are services well-led?

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

The provider had made improvements to put right the shortfalls and deal with the regulatory breach we found at our inspection on 7 September 2017.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

Summary of findings

- Review the practice's protocols for making, monitoring and following up on referrals made to specialists in primary and secondary care to ensure that patients were seen in a timely manner.

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 well-led?

No action

The provider had made improvements to the management of the service. This included reviewing and strengthening the practice policies and procedures so that they reflected current guidance and legislation. A system was in place for establishing clear roles, responsibilities and support for all the practice team.

A system for reviews and audits had been introduced and was being implemented. Areas for improvement were identified and there were ongoing arrangements in place to address these.

The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice.

Are services well-led?

Our findings

At our inspection on 7 September 2017 we judged the practice was not providing well led care and told the provider to take action as described in our Requirement Notice. At the inspection on 10 May 2018 we noted the practice had made the following improvements to meet the requirement notice:

There were systems and processes in place that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided:

- Audits were carried out to ensure that radiographs (X-rays) were graded, justified and reported in line with current guidance and legislation. The findings from these audits were used to identify areas where improvements were needed and the practice had introduced arrangements for addressing areas for improvement. The results from the most recent audit showed that improvements had been made so that the quality of dental radiographs was in line with current guidance.

There were systems and processes in place that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk:

- Improvements had been made to the arrangements for safeguarding children and vulnerable adults. The practice policies and procedures had been updated and included the contact details for the relevant local safeguarding teams.
- There were arrangements for dealing with medical emergencies to ensure that the recommended medicines and equipment were available to staff. The recommended range of emergency equipment and medicines were available. Regular checks were carried out to ensure that these were available, within their expiry date and in working order.
- There were arrangements for ensuring that equipment was serviced and maintained in line with the manufacturers' recommendations and that any recommendations arising from maintenance and servicing checks were carried out in a timely manner.
- Improvements had been made to the arrangements for assessing and managing the risk of fire at the practice. A fire safety risk assessment had been undertaken on 15 September 2017 and actions arising from this had been addressed. Fire safety equipment was regularly checked and fire evacuation drills were carried out regularly.
- Infection control audits were carried out in line with current guidance to assess the effectiveness of the infection prevention and control procedures within the practice.
- Improvements had been made to the procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A Legionella risk assessment was carried out in January 2018 and there were arrangements in place address the actions arising from this. There were systems in place for water testing and dental unit water line management to minimise risks.
- The practice had a health and safety risk assessment and this was reviewed regularly to assess and mitigate risk to patients and staff.
- The practice had systems in place to report, investigate, respond and learn from accidents, incidents and significant events. Staff understood their role in the process.

The practice had also made further improvements:

- Staff had undertaken training in infection control, basic life support and safeguarding children and adults and understood their responsibilities in relation to these areas.
- The principal dentist had undertaken training and was up to date with their continuing professional development (CPD) in respect of dental radiography.
- The practice had reviewed the protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- The practice had reviewed its protocols and procedures for use of X-ray equipment taking into account Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment. The practice had engaged the services of a Radiation Protection Adviser. We saw service and maintenance documentation in relation to the X-ray equipment.
- There were systems in place to monitor NHS prescriptions to minimise risk of their misuse.

Are services well-led?

These improvements showed the provider had taken action to address the majority of shortfalls we found when we inspected on 7 September 2017.

There were some areas where improvements had not been made:

- There were no arrangements for receipt, reviewing and acting on national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).
- The practice had not reviewed its systems when referring patients for specialist dental treatments. There were no arrangements to monitor referrals to help ensure that these were dealt with promptly. The principal dentist told us that they gave referral letters to patients to post or take to the referral dentist or hospital which meant they could not be assured that the referral was made.